Borderline Personality Disordered Clients' Experience and Understanding of Therapeutic Boundaries: A Q Methodological Study

CONCRETE WALLS TO CHICKEN WIRE – DO WE ALL WANT TO SIT ON THE FENCE?

Thesis submitted in partial fulfilment of the Professional Doctorate in Counselling Psychology for London Metropolitan University

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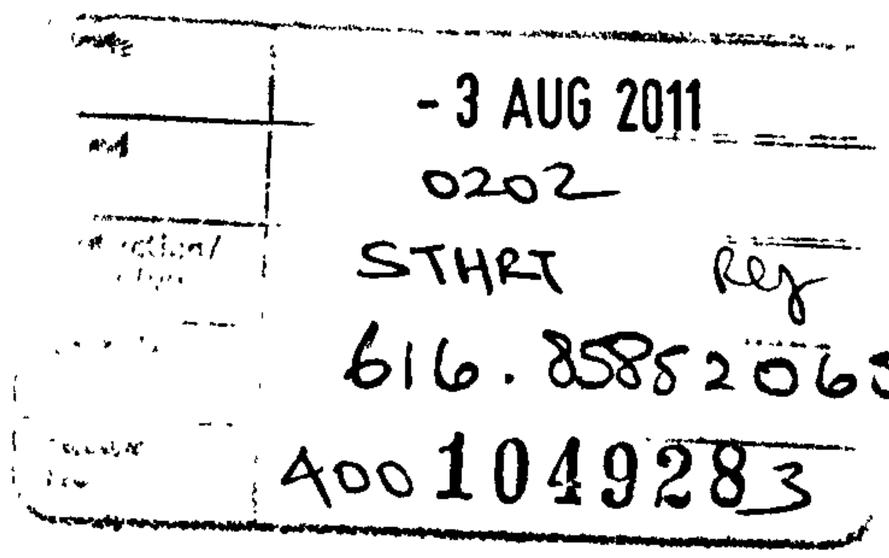
2010

Statement of Originality

I confirm that this is an original piece of work.

The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.



Abstract

Aims

Therapeutic alliance ruptures, due to boundary problems, and premature drop-out, from therapy, are common with clients who have a diagnosis of borderline personality disorder, limiting the effectiveness of psychological interventions. Therefore, it is hoped that researching clients' perspectives will promote therapeutic relationships that are more clinically effective with people attracting this diagnosis. The intention of this research study is to contribute to contemporary understanding of therapeutic relationships, and boundaries, from the viewpoint of clients with the diagnosis of borderline personality disorder.

Literature Review

The review identified that the diagnosis of borderline personality disorder, and the topic of therapeutic boundaries, are both related to ever changing and developing cultural norms. The research literature appeared, surprisingly, virtually non-existent in the specialist area of clients' perspectives upon boundaries. Therefore, this study offered a ground-breaking opportunity to bridge some of the fissures, between research on therapy and therapeutic practice, specifically in relation to therapeutic boundaries and borderline personality disorder.

Methodology

Q methodology was used to explore discourses about borderline personality disordered participants' views regarding therapeutic boundaries. A two-stage research methodology was adopted with the first stage involving online focus groups with 19 participants. The second stage of the study, involved an online Q sort procedure with 28 participants, and was partly informed by participants' views that were generated during the online focus groups. The research emphasised the effectiveness of Q methodology, with advantages over more traditional quantitative research methods, for identifying and understanding complex beliefs about therapeutic boundaries.

Findings

Four statistically distinct factors emerged from the Q methodology which represented the experiences and understandings, of therapeutic boundaries, for the participants in this study. These findings are discussed in the thesis and recommendations for therapists are outlined. The discourses, of these four factors, can be simplistically summarised as the following:

A. "HEDGE": Participants believed that boundaries should be flexible, evolving and 'firm-but-fair.' A balance between thick and thin boundaries.

B. "CHICKEN MESH": Participants thought that boundaries could be pushed, and crossed, but did not wish to totally violate them. Thin boundaries.

C. "BARBED WIRE": Participants maintained a stance of contradictory and extreme viewpoints, which may inadvertently involve the (re)creation of damaging relationships. Fluctuation between thick and thin boundaries.

D. "BRICK WALL": Participants assumed a position that was rigid, emotionally and/or physically distant. Thick boundaries.

Acknowledgements

Overall, I consider that completing this thesis has been a significant achievement for me. I am very aware that there are many people that I wish to thank for their support in enabling me to finish this research.

Firstly, I wish to thank my family. The write-up of this thesis was a time when inevitable temporary sacrifices needed to be made to my work-life balance. Therefore, I would particularly like to thank my mother, Helena, sister, Abi, and brother-in-law, Darren, for their patience and understanding. With special thanks to my loving partner Robert, for his patience and for his gentle, and not so gentle, reminders.

I would like to express my appreciation to my supervisors, Dr Charlotte Brownlow and Dr Elaine Kasket, for their advice, guidance and support during the course of this research study.

There are many other friends and colleagues, who shared this research journey with me and I wish to extend my thanks to each of them. Notably, I would like to say that I have felt privileged to have worked, and laughed, alongside Dr Clive Sims, who is the most 'human' of all Psychologists that I have been inspired by, despite his ongoing protestations that he is of 'ferengi' origins! (I am sure that my enhanced knowledge, of the ferengi's five stages of acquisition, will be invaluable during my career as a Psychologist). Also, I would like to express gratitude to my friend Dr Wesam Haboush, for his generous help with computer related issues.

Perhaps most importantly, it feels crucial to reiterate my deep appreciation to the research participants who gave up their time to explore their perspectives regarding therapeutic boundaries.

Contents

		Page Number
Title Page		1
Statement of Originality		2
Thesis Abstract		3
Acknowledgements		5
Contents		6
List of Tables		12
List of Figures		13
Researcher Statement		14
1	**Introduction**	21
	1.1 Background to the Research	21
	1.2 Defining Terms	24
	1.2.1 Counselling Psychology	25
	1.2.2 Therapy	26
	1.2.3 Therapeutic Alliance	26
	1.3 Style and Presentation of the Thesis	27
	1.4 Overview	28
2	**Literature Review**	30
	2.1 Introduction	30
	2.2 Client Perspectives	31
	2.2.1 Introduction to Client Perspectives	31
	2.2.2 Helpful and Hindering Aspects of Therapy	32

2.3 Therapeutic Boundaries 37

2.3.1 Introduction to Therapeutic Boundaries 37

2.3.2 History of Attitudes Towards Therapeutic Boundaries 41

2.3.3 Clients' Experience of Therapeutic Boundaries 43

2.3.3.1 Therapist Self Disclosure 43

2.3.3.2 Touch in Therapy 46

2.3.3.3 General Boundaries in Therapy 48

2.4 Personality Disorder 50

2.4.1 Introduction to Personality Disorder 50

2.4.2 Diagnostic Context of Personality Disorders 52

2.4.3 Diagnostic Criteria for Borderline Personality Disorder 54

2.4.4 Origins and/or Causal Context of Borderline Personality Disorder 56

2.4.5 Prevalence and Prognostic Context of Borderline Personality Disorder 59

2.4.6 Socio-cultural Context of Borderline Personality Disorder 61

2.4.7 Therapeutic Context of Borderline Personality Disorder 62

2.4.8 Borderline Personality Disordered Clients' Experience Of Therapy 66

2.5 Summary of Methodological Critique 71

2.6 Clinical Implications 72

2.7 Outlining the Research Questions 75

2.8 Summary 77

3 Methodology 79

3.1 Introduction 79

3.2 Epistemological Stance 79

3.2.1 Quantitative Methods 81
3.2.2 Qualitative Methods 83
3.2.3 Mixed Methods 84
3.3 Overview of the Research Design 87
3.3.1 Q Methodology 88
3.3.2 The Communication Concourse 90
3.3.3 The Theory of Limited Independent Variety 91
3.3.4 Participants 91
3.4 Online Research Methodology 92
3.4.1 Ethical Implications of Online Research 94
3.5 Two Stage Procedure: Focus Groups and Q Sort 96
3.5.1 Selection of Participants for Focus Groups and Q Sorting 96
3.5.2 Stage 1: Focus Groups 97
3.5.2.1 Pilot Focus Groups 97
3.5.2.2 Focus Groups 98
3.5.3 Statements 100
3.5.4 Stage 2: Online Q Sorting 102
3.5.4.1 Pilot Q Sort Process 103
3.5.4.2 Q Sorting 103
3.5.4.3 Socio-Demographic Information 105
3.6 Ethics 105
3.6.1 Informed Consent 105
3.6.2 Confidentiality 106

3.6.3 Participant Distress 106
3.6.4 Ethical and Research Approval 106
3.6.5 Transparency 107
3.7 Statistical Analysis 107
3.8 Answering the Research Questions 111
3.9 Summary 112
4 Presentation of Findings 113
4.1 Introduction 113
4.2 Stage 1: Focus Groups 114
4.3 Stage 2: Q Sort 118
4.3.1 Statistical Analysis 119
4.3.1.1 Interpretation of Factors 122
4.4 Extraction of Factors 127
4.4.1 Factor A: "HEDGE" 128
4.4.1.1 Interpretation of "HEDGE" 129
4.4.1.2 Discourse A – Qualitative Comments 131
4.4.2 Factor B: "CHICKEN MESH" 135
4.4.2.1 Interpretation of "CHICKEN MESH" 137
4.4.2.2 Discourse B – Qualitative Comments 140
4.4.3 Factor C: "BARBED WIRE" 142
4.4.3.1 Interpretation of "BARBED WIRE" 144
4.4.3.2 Discourse C – Qualitative Comments 146
4.4.4 Factor D: "BRICK WALL" 149

4.4.4.1 Interpretation of "BRICK WALL" 150

4.4.4.2 Discourse D – Qualitative Comments 152

4.4.5 Areas of Consensus 155

4.4.6 Areas of Divergence 158

4.5 Significance of Socio-demographic Characteristics 160

4.5.1 Socio-demographic Characteristics of Factor A 161

4.5.2 Socio-demographic Characteristics of Factor B 161

4.5.3 Socio-demographic Characteristics of Factor C 162

4.5.4 Socio-demographic Characteristics of Factor D 163

4.6 Summary 164

5 Discussion 166

5.1 Introduction 166

5.2 Summary of Findings 166

5.2.1 Discourse A: "HEDGE" 168

5.2.2 Discourse B: "CHICKEN MESH" 171

5.2.3 Discourse C: "BARBED WIRE" 173

5.2.4 Discourse D: "BRICK WALL" 175

5.3 Socio-demographic Observations 177

5.4 Implications for Clinical Practice 178

5.4.1 Methodological Discussion 178

5.4.2 Research Findings for Wider Clinical Practice 180

5.5 Research Questions 185

5.6 Future Research 187

5.7 Summary 193

6 Reflection 195

6.1 Introduction 195

6.2 Reflection Regarding Methodology 195

6.3 Research Journal 197

6.4 Ethical Concerns 197

6.5 Catharsis 198

6.6 Summary 200

7 References 202

8 Appendices 225

List of Tables

Table	Description	Page Number
1	Distribution of Q Sample Statements	104
2	PQMethod Data Analysis Items	110
3	Factor Loadings for the 28 Q Sorts	120
4	Eigenvalues Associated with the Four Factors	122
5	Factor Correlations	122
6	Item Concourse and By-Factor Ratings of the Merged Q-Sorts	123
7	Distinguishing Statements for Factor A	128
8	Distinguishing Statements for Factor B	136
9	Distinguishing Statements for Factor C	143
10	Distinguishing Statements for Factor D	149
11	Consensus Statements	156

List of Figures

Figure	Description	Page Number
1	Frequency of Participants Loading onto each Factor	121
2	Factor A: Length of Time Diagnosed with BPD	161
3	Factor B: Length of Time Diagnosed with BPD	162
4	Factor C: Length of Time Diagnosed with BPD	163
5	Factor D: Length of Time Diagnosed with BPD	163

Researcher Statement

It feels appropriate to begin this Counselling Psychology Doctorate thesis, on the topic of therapeutic boundaries, by saying something about my own motivation for pursuing this research area. This self-disclosure, which seems to parallel the ethical boundary dilemmas often faced by therapists when working with clients (ie. to self-disclose or to not self-disclose), is particularly important for reflexive research practice. I wish to share with the reader about how I became interested in researching this topic alongside my own understanding of therapeutic boundaries. In my opinion, transparency and reflexive practice underpin both the qualitative research paradigm and the profession of Counselling Psychology. Attending to these process issues has often been neglected in research literature and this parallels the research bias towards issues of 'content' rather than 'process' during therapeutic interventions with clients. It is hoped that my openness about my personal motivations will allow the process and outcomes of the research to be more open to rigorous evaluation by others.

After leaving University, but prior to my Doctorate training in Counselling Psychology, I worked as a National Health Service (NHS) Assistant Clinical Psychologist, within a Learning Disability setting, which I found incredibly enjoyable and rewarding. This experience allowed me to become more aware of the importance of relationships, within a clinical setting, and the value of modelling 'appropriate' boundaries for learning disabled clients. However, this was my first experience of working for the NHS and I started to become increasingly aware of, and frustrated by, how influential and prominent the medical model was, and continues to be, within the NHS and the United Kingdom. I believe my frustrations were borne out of my own growing awareness of the limitations of the medical model. Some people are willing to accept that they suffer from illnesses, such as 'personality disorder,' and accept the language of the medical model which talks about diagnoses and treatments. I accept that some people may get comfort and reassurance through having diagnostic labels

attached to them. However, I remain constructively critical of these ideas and believe that it can seem offensive that human distress is interpreted as an illness and 'diagnosed.' However, I acknowledge that diagnostic labels can be useful in order to access services, but these labels can also cause discrimination and stigmatisation. Overall, I would like to think that people have a right to interpret their experiences, in their own way, and to be allowed to receive therapeutic intervention in response to their individual understandings and experiences.

I chose to leave my post as an Assistant Clinical Psychologist, after one year, as I had been offered a job working at a service for adults attracting the diagnosis of personality disorder. Through this work I became increasingly aware that boundaries that seemed 'common sense' to me were sometimes viewed differently by other colleagues and clients. For example, sexual relationships between staff and clients occurred on a couple of occasions which were, in my opinion, highly inappropriate. Another example, which heightened my critical awareness of therapeutic boundaries, was the boundary of touch. During my time at this personality disorder service it was accepted, and encouraged by members of the Management team, that clients and staff hugged each other many times during a work-shift, which I felt was not therapeutically appropriate. Although all major professional organisations currently declare sexual relationships between therapists and clients as unethical, there are no firm ethical guidelines on the use of appropriate and therapeutic forms of touch (Durana, 1998). McRae (2008) corroborates this point by stating that "within the body of limited empirical research there is no consensus for or against the use of touch, though it is obvious that touch in the treatment room continues" (p.4). Working at this personality disorder service provided my main inspiration for researching therapeutic boundaries, as I wished to try to understand other people's perspectives, alongside heightening my own self-awareness of my own views, about boundaries.

At this stage I wish to share with the reader my own views about therapeutic boundaries, in order to clarify my interest in this research area. I believe that, to work ethically with clients, a professional needs to have consistent, but humane, boundaries. However, I believe that it is important to state that my own understanding of therapeutic boundaries has both influenced and been influenced by this research study. I believe that everyone's temperamental differences and personal histories affect our relational styles. Therefore, both clients' and therapists' preferences and expectations of boundaries need to be, in my opinion, negotiated. Therefore, I believe in a context-based, flexible yet relatively consistent approach to boundaries as in my opinion, rigid implementation of boundaries decreases therapeutic effectiveness. I support Lazarus' (1994) view that "One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions" (p.260).

During my time at the personality disorder service I began to think further about which area of Applied Psychology I wished to specialise in. It seems important to say a few words about my own motivation for training in Counselling Psychology and how this relates to the current research topic. In the chapter "The Dumbing Down of Psychology," Zur (2005) states that:

> "Graduate school professors endlessly quibble about which orientation is superior rather than teach students to intervene according to the client's condition, situation, personality, and culture. As a result, instead of thoughtful, knowledgeable, and sensitive therapists who are able to think critically, form intimate connections with their clients, and effectively employ proven clinical interventions, graduate schools mostly spit out highly technical, ethically and morally insensate, frightened, and theoretically rigid therapists ... the dumbing down of our profession is virtually assured" (p.274).

Llewelyn and Gardner (2009) add further weight to this idea in their article from the Clinical Psychology Forum. They state that:

> "the notion of a character-based approach to Psychologists' professional development in managing boundaries and ethical dilemmas, which explicitly addresses the need to cultivate good practical wisdom, is certainly intriguing, especially in the context of competency and skill-based frameworks for inducting people into the profession" (p.8).

My undergraduate Psychology degree, and the emphasis of Psychology as a 'Science,' focused me on the well established profession of Clinical Psychology for working clinically with clients. In addition, my undergraduate degree, which focussed on 'empirical research,' brain-washed me into believing that it had the power to uncover complicated areas of human behaviour. Therefore, Psychology clinical research, and the work of contemporary United Kingdom Clinical Psychologists, seemed more preoccupied with quantifiably analysing the effectiveness of therapy, rather than studying the process issues within, and between, therapist and client. Overall, my growing awareness left me feeling that there were huge gaps in Psychology research, and practice, which neglected human relationships. These insights drove me to find out more about other areas of Postgraduate training, in Psychology, which resulted in my ultimate commitment to train in Counselling Psychology.

Counselling Psychology is a values-based profession that has placed the therapeutic relationship at the centre of its professional philosophy. It is a relatively new profession, in the United Kingdom, with the creation of the British Psychological Society (BPS) Division of Counselling Psychology, in 1994. The rapid expansion of this profession, demonstrated by the figures reported in the British Psychological Society Annual Report (BPS, 2009), seems to reflect that other Psychologists acknowledge that relationships and humanity seem to have

been neglected, within psychology, in the past. One major finding that has emerged repeatedly from process-outcome research, is that despite differences in theory and technique, the main approaches to therapy appear overall to work equally well. There is a substantial amount of research literature demonstrating that the outcomes of different therapies, with different populations, are equivalent (Hubble et al, 1999). However, there has been opposition to this growing body of evidence (Rachman and Wilson, 1980) but this finding continues to accumulate support (Marzillier, 2004). This finding, often called the 'equivalence paradox,' seems to suggest that there may be common factors in different therapeutic approaches that are more significant than their differences. Personal qualities of the therapist, and their relationship with the client, appear to be the most obvious common factors. My chosen career path, as a Counselling Psychologist, reflects the importance that I place upon therapeutic relationships and the associated process issues.

After I had been accepted onto the Doctorate training programme in Counselling Psychology I chose to complete, during my first year, a Masters level thesis about how clinicians' resolve ethical boundary dilemmas when working with personality disordered clients (Boyle, 2007). The results from this study, using a grounded theory methodology, showed that, when participants were faced with situations that they had dealt with in an appropriate and professional manner, they had found ethically challenging, they looked for assistance from others (seeking assistance) and they attempted to weigh up the therapeutic value (therapeutic reasoning) of their possible interventions. Both seeking assistance and therapeutic reasoning seemed to be ways in which the participants safeguarded their integrity. The first two themes: seeking assistance and therapeutic reasoning, can be thought of as 'processes' and the third theme of integrity was a 'value.' Therefore, this current Doctorate level thesis builds upon this previous research but I have deliberately emphasised clients' perspectives due to the fact that I strive to adopt client-centred values. I endeavour to make

client-centred best practice central to my work with clients and to the profession of Counselling Psychology.

My work as a Psychologist is based upon a pluralistic approach, underpinned by a person-centred philosophy. However, I am currently a NHS employee, within a Clinical Psychology service, and I feel that I sometimes struggle to adhere to my personal philosophy, due to organisational and contextual pressures. The issue of pluralism, in psychological therapy provision, is especially relevant today in the United Kingdom and for my own professional practice, because of the introduction of new NHS 'Improving Access to Psychological Therapies' (IAPT) Services. Also, during the final few months of completing this research thesis write-up I was fortunate enough to be offered, and subsequently accepted, a 'qualified' Psychologist position within an IAPT Service. In the United Kingdom, recent NHS initiatives such as the new IAPT services and 'practice-based commissioning' are radically transforming state provided Psychology services. The aim of IAPT is to help people achieve improved mental health and well-being, thus improving their ability to gain and/or maintain employment. However, in this context, 'psychological therapies,' means evidence-based treatments as outlined in the National Institute for Clinical Excellence (NICE) guidelines which is currently brief Cognitive Behaviour Therapy (CBT). These initiatives and reforms have the potential to influence psychological therapy service provision in the United Kingdom, both within and outside of the NHS and seem largely to neglect what is being researched in this thesis: client experiences.

Overall, in my opinion, we can not hope to understand how therapy facilitates change without asking clients about their experiences. However, within the United Kingdom's NHS therapy provision there seems to be a contradiction. Within the NHS emphasis is placed upon evidence-based treatments with a focus upon outcomes and measurement of symptoms and/or behaviours, for example, practice based commissioning. However, there also seems to be an emphasis

upon service users' choice and them being able to choose treatments. If clients are only offered one therapy, such as CBT, this puts clients in a compromised position where the implicit message is that what is being offered is the only treatment that can work. In addition, service-user views in health service provision and clients' experiences are increasingly acknowledged as valuable in providing an understanding of what works. Therefore, it seems like a very appropriate time to reflect upon issues of choice being in tension with evidence-based guidelines in the United Kingdom's NHS.

The chapters that follow chart the process and outcomes for the research inquiry that I officially began three years ago, as part of my Doctorate training, but my prior experiences, including first-hand experiences of the challenges of establishing therapeutic relationships, and boundary management, with borderline personality disordered clients, were invaluable. These experiences allowed me to conclude that management of boundaries is at the heart of therapeutic relationships, influenced by contextual and personal factors and needs to be dynamic and flexible, yet consistent. I believe that my knowledge and experience of working in the personality disorder field, for approximately four years, adds further credibility to the study. This is because it minimises the difficulties that may occur when the researcher is the stranger in a strange land (Lincoln and Guba, 1985). Therefore, my journey, regarding therapeutic boundaries, started long before commencing my Counselling Psychology training programme and I look forward to it continuing for many more years to come.

CHAPTER 1

Introduction

"It is a profound mistake to think that everything has been discovered; as well think the horizon the boundary of the world" (p.120).

Lemierre cited by Edwards (2007)

1.1 Background to the Research

Personality disorders are possibly one of the most controversial mental health conditions. Classification, diagnosis and treatment are all topics that are hotly debated by researchers and clinicians. In recent years political and media interest has heightened these perceived controversies. Frequently, this interest appears to have negative connotations and 'forgets' about the individual person with the personality disorder. People living with the personality disorder diagnosis are rarely focussed upon in order to gather their perspectives. This seems to be a glaring omission and it is hoped that this thesis will contribute towards the research evidence-base, which allows the perspectives, of clients attracting the borderline personality disorder diagnosis, to be gathered. In light of the above-mentioned controversies it is hoped that this thesis may help reclaim some humanity for people diagnosed with a personality disorder.

It seems important to recognise, within this introductory chapter, that one of the reasons the 'personality disorder' diagnosis stirs controversy is because it seems to imply that someone's whole personality is flawed. Personality refers to "enduring patterns of cognition, emotion, motivation, and behaviour that are activated in particular circumstances" (Heim and Westen, 2009, p.17). Many people argue that it is impossible to treat someone's 'personality' and that it is wrong to apply medical terms and treatments to a personality (MIND, 2009). Clients sometimes find it more acceptable when personality disorders are

reframed, so that it is the symptoms of a personality disorder that are treated, rather than the person as a whole. Due to the focus of this thesis it is not possible to debate the ethics here of the label of personality disorder. Interested readers may locate further information, about current perspectives on personality disorders, in 'Personality Disorders in Modern Life' (Millon, Grossman, Millon, Meagher and Ramnath, 2004).

In the United Kingdom, recent reforms to the Mental Health Act (2007) have further fuelled controversies around personality disorders. Proposals to reform the Mental Health Act (1983), in England and Wales, seemed to grow out of the public outcry regarding some brutal murders committed by individuals diagnosed with a personality disorder. Individuals with personality disorders had been considered untreatable under the 1983 version of the Mental Health Act and the authorities had no power to detain them. A very famous example is the case of Michael Stone, who was diagnosed with antisocial personality disorder. He was convicted in 1998 of double murder and attempted murder. The high profile publicity surrounding cases such as Michael Stone, and subsequent proposals to reform the Mental Health Act, seem to have tarnished public perceptions of all 'personality disorders.'

The Mental Health Act 2007, in contrast to the Mental Health Act 1983, has an inclusive definition of mental disorder that enables the detainment of individuals with all forms of personality disorders, in the same way as those with mental illness. Moran (2002) argued that these reforms offered "further marginalization of an already disadvantaged section of society" (p.9). Overall, these changes to the Mental Health Act reflect the power of the medical model, which can be utilised to oppress individuals, within contemporary society. Therefore, it seems increasingly pertinent to advocate for disempowered sections of society, such as those with personality disorders, through conducting research that enables these valuable perspectives to be expressed.

There are various publications that are currently driving initiatives in relation to the treatment of personality disorders. For example, the National Service Framework for adult mental health services (Department of Health, 1999; 2004) outlines mental health professionals' responsibilities to provide evidence-based effective services to those who experience significant distress, or difficulties, as a result of a personality disorder. There is a clear message in a document authored by the National Institute for Mental Health in England (2003) that, for effective therapeutic relationships to be formed with personality disordered clients, professionals need appropriate training to fully understand personality disorder, to become confident with working with this client group. "Breaking the Cycle of Rejection, the Personality Disorder Capabilities Framework" (NIMHE, 2003) and "The Capable Practitioner" (Lindley, O'Halloran and Juriansz, 2001) provide an outline of the type of capabilities required by staff to successfully engage with personality disordered clients. However, they do not provide specific detail on how to build, and maintain, effective and well boundaried therapeutic relationships with clients attracting the personality disorder diagnosis.

Additionally, the debate on the meaning, experience, and management of therapeutic boundaries continues to provoke lively discussions. This seems to be due to the fact that psychological therapy occurs within the context of human relationships and ethical guidelines could never hope to account for all of the deep complexities that are possible. The discipline of Counselling Psychology has a firm value-base, that is grounded in the primacy of the therapeutic alliance, and boundaries are essential for establishing and maintaining therapeutic relationships. It has been proposed that personality disorders are associated with "pushing the limits" (Bender, 2005, p.73), particularly the borderline personality disorder diagnosis. This is perhaps unsurprising, as the borderline personality disorder diagnosis is predominantly based on a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity (American Psychiatric Association, 2000). Therapeutic alliance ruptures, due to boundary problems, and premature drop-out, from therapy, are

common with clients who have a diagnosis of borderline personality disorder, limiting the effectiveness of psychological interventions. Therefore, it is hoped that researching borderline personality disorder clients' perspectives will promote therapeutic relationships that are more clinically effective with this client group.

Finally, the client perspective is an increasing component of healthcare planning, delivery and evaluation in the United Kingdom. For example, the National Patient Survey Programme, co-ordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience, across a variety of services and/or settings in the NHS. However, it is notable that clients' views about therapeutic encounters seem to have been largely neglected. It could be argued that this has left a considerable gap between therapeutic practice and research. Counselling Psychologists are trained to recognise social contexts and discrimination and aim to work in ways that empower others. Therefore, it is hoped that this research thesis will contribute to the growing literature (e.g. Duncan, Miller and Sparks, 2004) that acknowledges the importance of researching clients' views in order to inform clinical practice.

1.2 Defining Terms

In order to provide clarity, for this thesis, a number of central concepts have been detailed below. Three concepts that are referred to throughout this study are 'Counselling Psychology', 'Therapy' and 'Therapeutic Alliance'. Clarification of each of these concepts is provided below. Alternative terms, that may be used to refer to the same concepts, are also mentioned.

1.2.1 Counselling Psychology

It is important to share an understanding of the author's professional background, as a Counselling Psychologist in Training, as this will have inevitably influenced the subject of inquiry. The profession of Counselling Psychology aligns itself with both a 'reflective-practitioner' model and a 'scientist-practitioner' model of practice (Woolfe, Dryden and Strawbridge, 2003, p.645). However, despite stressing the importance of an empirical basis for theory and practice, Counselling Psychologists are also critical of traditional views of science. Counselling Psychologists do not believe that there is one objective 'truth', so the discipline of Counselling Psychology is able to embrace all of the traditional approaches to psychological interventions (e.g. humanistic, psychodynamic and cognitive-behavioural) with each making a valuable contribution. Therefore, Counselling Psychology advocates a theoretically pluralistic approach but historically it is rooted in the humanistic tradition. This means that clients' individuality and subjectivity, the client-therapist relationship and the person of the therapist are central to the therapeutic process.

The definition offered within the Professional Practice Guidelines of the BPS's Division of Counselling Psychology (2005) states that:

> "Counselling psychology has developed as a branch of professional psychological practice strongly influenced by human science research as well as the principal psychotherapeutic traditions. Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology. It continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship" (p.1).

1.2.2 Therapy

Therapy is a term that can have many meanings and a number of alternative terms are used to reflect services of a similar nature. The word 'therapy', for the purposes of this thesis, could be substituted for other generic terms such as 'counselling,' 'psychotherapy,' and 'psychological therapy.' The broad definition offered by the United Kingdom Council for Psychotherapy (2009) states:

> "Psychotherapy aims to help clients gain insight into their difficulties or distress, establish a greater understanding of their motivation, and enable them to find more appropriate ways of coping or bring about changes in their thinking and behaviour" (p.1).

In addition, the British Association for Counselling and Psychotherapy (2009) clarify that therapy takes place when:

> "...a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' for counselling" (p.1).

1.2.3 Therapeutic Alliance

The following definition captures the essence of the therapeutic alliance: "A mutual collaboration between patient and the therapist in pursuit of common therapeutic goals, the therapeutic alliance is a critical ingredient in the success of psychotherapy" (Gabbard and Wilkinson, 1994; p. 40). Gutheil and Havens (1979) described the therapeutic relationship, using psychoanalytic language, in a way that seems useful for attempting to understand the therapeutic alliance with clients attracting the diagnosis of personality disorder. According to Gutheil and Havens' conceptualisation, a client's ability to form an alliance arises from

"the therapeutic split in the ego which allows the analyst to work with the healthier elements in the patient against resistance and pathology" (p.479). This conceptualisation is useful because it recognises that there may be parts of a personality disordered client's personality functioning that make therapeutic relationships difficult. This will be discussed further in the main body of the thesis.

1.3 Style and Presentation of the Thesis

The use of medical language, such as 'personality disorder,' can be problematic from a social constructionist perspective. By referring to individuals as personality disordered this thesis may inadvertently contribute to the literature that serves to pathologise, stigmatise and de-humanise these individuals. Therefore, the language within this thesis sometimes refers to 'clients diagnosed with personality disorder' but attempts are made at de-stigmatisation through the additional use of expressions such as 'clients who have attracted the personality disorder diagnosis.' The author is very aware that this expression has been borrowed from a Clinical Psychologist colleague, which demonstrates that other mental health professionals are aware of the importance of language. The content of this study could be viewed as constructing an illness, of personality disorder, through using medical discourse, such as 'diagnosis,' 'treatment,' and 'disorder.' Therefore, these thoughts have been included as an acknowledgement that language used within this thesis will inevitably construct people with borderline personality disorder in a particular fashion. It should be noted that some authors use the terms 'patient' or 'service user' while others prefer 'client.' The term client has been adopted throughout this thesis, as the author perceives it to be a more respectful term.

Throughout this thesis attempts have been made to write a piece of work that, despite its length, remains comprehensible and sound for the reader. Therefore, the structure has been kept as simple as possible, jargon avoided when it was considered unnecessary and attempts have been made to guide the reader

through each chapter. The writing style is consciously, relatively informal, where appropriate, in order to make this research accessible to as many people as possible. This style is in keeping with the phenomenon being discussed and may 'push the boundaries' of what has been expected regarding academic and scientific psychology research in the past. Therefore, attention is paid to the author's relationship with the reader of this thesis, which is consistent with the philosophy of Counselling Psychology. However, it is important to accentuate that this approach has been adopted without losing the rigorous nature of an academic piece of research.

1.4 Overview

This thesis adheres to most of the traditional conventions that exist within academic settings. In particular the write-up of this thesis adheres to the conventions of the Publication Manual of the American Psychological Association (APA, 2001). As detailed in the contents page there are six major chapters to the work ('Introduction,' 'Literature Review,' 'Methodology,' 'Presentation of Findings,' 'Discussion,' and 'Reflection.'). These sections offer the framework, or boundaries, for the work that has been conducted. The 'Introduction' chapter reflects upon the context within which this research is conducted. The 'Literature Review' then presents an overview of the existing research in this area and outlines the specific questions that are addressed by this study. The 'Methodology' moves on to discuss how the questions that have been proposed are to be answered. In particular, this section describes the philosophy behind this research study and the means by which these abstract concepts are applied in practice. The 'Presentation of Findings' chapter presents a descriptive summary of the data that has been collected. Numerical data is utilised, within this chapter, to provide a broad indication of the findings, while verbatim examples are used to give the reader a vivid sense of the phenomena being described. The 'Discussion' offers a critical overview of the project by reflecting back to the work presented within the 'Literature Review' and 'Methodology' to discuss the research study as a whole. In addition, the limitations and potential

avenues for further exploration are outlined within this chapter. Finally, the last chapter, entitled 'Reflection' offers reflexive insights about the thesis and the overall research process.

Chapter 2

Literature Review

"...clear and consistent therapeutic boundaries is for such patients much like a buoy in stormy, chaotic seas: that is, the only stable object to cling to for miles" (p.270).

Borys (1994)

2.1 Introduction

The previous chapter provided an introduction to the basic rationale and focus of this thesis. The aim of the present chapter is to consider, and evaluate, the relevant existing literature, through a critical review. Therefore, this chapter will begin very broadly by exploring the research, and narratives, relating to the perspectives of therapy clients. The literature pertaining to therapeutic boundaries will then be reviewed and the final section of Chapter 2 will consider the context of personality disorders and evaluate the small number of studies that have explored borderline personality disordered clients' experiences of therapy. Overall, the purpose of this chapter is to enable the reader to deduce how the research questions were developed for this thesis. This chapter will end with a summary regarding the current research aims alongside the reasons why this thesis offers such a compelling area of research inquiry.

It has been stated that the quality of any literature review depends upon the quality of the studies that it includes (Jones, 2004). In this chapter a thorough summary of the existing literature is provided, based upon searches using books, paper archives and online databases (predominantly PsychINFO, Medline and Google Scholar). These searches extend the academic knowledge, and sources, that had been acquired during the author's years of working in professional Psychology. The aim of the strategy was to identify informative and well evidenced literature in relation to clients' experiences of therapy, and therapeutic boundaries, particularly in relation to borderline personality disordered clients. In

order to offer general background information, regarding the development of thesis aims, this chapter will firstly explore the previous literature about clients' perspectives on therapy.

2.2 Client Perspectives

> "It is the clients, not the therapists, who make treatment work. As a result, treatment should be organised around their resources, perceptions, experiences, and ideas" (p.11).
>
> (Duncan and Miller, 2004).

2.2.1 Introduction to Client Perspectives

The United Kingdom media reflects a society that is increasingly concerned about psychological health. Magazines such as Psychologies; health articles and supplements in the national press; reality television programmes that focus on improving people's relationships; debates on radio and a variety of websites and self-help books all raise awareness of the benefits of nurturing our psychological health. National political debate, such as the United Kingdom government's multi-million pound investment in new Improving Access to Psychological Therapy services, is embracing mental health, wellbeing and the provision of psychological therapies. Researching clients' perspectives on therapy is consistent with the National Health Service objective of involving service users in the planning and delivery of mental health services (Department of Health, 1999). Government led models of good practice call for the involvement of clients in service planning and decision-making processes (Department of Health, 1999, 2000; Faulkner and Layzell, 2000). At the local level, initiatives and consultations that aim to engage patients and the public in service design processes are raising awareness and giving a voice to the public, that is generally in favour of improving provision. Therefore, it seems important to be aware of these current

trends and provide a platform for clients' viewpoints including through the current research.

Overall, significant differences have been reported between clients' and therapist's interpretations of clients' experiences of therapy (Gershefski, Arnkoff, Glass and Elkin, 1996). Therefore, as therapists and clients do not seem to match in their assessments of how therapy is progressing, this appears to add further evidence to researching clients' perspectives. Clients' perspectives on therapy have been neglected, and more recently, received limited attention in therapy process research (e.g. Clarke, Rees and Hardy, 2004). Messari and Hallam (2003) corroborate this belief, stating that "One neglected area of research is participants' experience of therapy" p. 172. This appears to be reflective of the influential power of the traditional positivistic paradigm in research, as introduced in the 'Researcher Statement' section of this thesis, which emphasises 'reliable' quantitative measures of research but neglects qualitative in-depth understandings of personal meanings and experiences. Therefore, early studies into therapeutic processes primarily used quantitative techniques, such as rating scales, which only allow respondents to answer using researcher-defined categories. More recent studies have utilised qualitative methods, such as interviews, to increase understanding of subjective experiences within therapy (e.g. Lietaer, 1992). The next section of this chapter explores some of these studies in order to portray what has been previously researched, regarding clients' experiences of therapy, and highlight potential gaps in knowledge.

2.2.2 Helpful and Hindering Aspects of Therapy

In an early review of the literature, Elliott and James (1989), found that the helpful factors, most often reported by clients across different therapy modalities, were the interpersonal aspects of therapy. A number of studies that support this finding will be appraised next. Glass and Arnkoff (2000) studied six American

clients' views about what they found helpful and unhelpful in mental health treatment. Research procedures are unclear. However, interview methods were used for two clients and the remaining four clients' views were summarised from written sources. Interestingly, no specific interventions were highlighted, but clients spoke about the personal characteristics and interpersonal behaviour of therapists. Glass and Arnkoff (2000) concluded that clients found the most helpful therapist characteristics to be warmth, acceptance, kindness, patience, empathy, compassion and genuineness. Also, the context of therapy was considered important, whereby clients found a protective setting where they could feel safe, helpful. In addition, problem solving skills, promotion of choice and personal responsibility and expressions of hope and encouragement were perceived as helpful. The focus will now be placed upon the hindering aspects of therapy in Glass and Arnkoff's (2000) study.

Glass and Arnkoff (2000) stated that clients believed that unhelpful aspects of therapy were therapists being judgemental and making assumptions, demonstrating a cold, rote, or impersonal manner, showing a lack of respect and coming across as superior, within therapy. Also, therapists' reluctance to explore sensitive areas, such as abuse, or communicating disbelief about clients' experiences, were considered unhelpful aspects of therapy. The Glass and Arnkoff (2000) publication offers a positive and valuable starting point for acknowledging and reviewing clients' experiences in therapy. However, four of the clients spoke mainly about therapeutic interventions during hospitalisation, while two clients focussed upon outpatient experiences and these differing therapeutic contexts may have influenced findings. Also, the authors do not adequately explain their methodology, for summarising helpful and unhelpful themes from these six clients' accounts. Overall, further studies are required, with a greater number of participants, before findings can be generalised to other therapy clients. Another, more recent study, exploring helpful aspects of therapy was carried out by Manthei (2007), and will be detailed in the following paragraph.

Manthei (2007) studied clients' experiences of therapy using questionnaires and semi-structured interviews. Twenty therapy clients, who were seen at a walk-in agency, in a mid-sized city in New Zealand, participated in the study. Having a constructive working relationship was important to all of the clients interviewed. Clients tended to depict therapists who met the clients' perceived needs, or demonstrated similarity to them, as reasons for good therapeutic alliances. Manthei (2007) states that therapists are being assessed by clients in much the same way as they are assessing their clients "...mutual appraisal is normal in any social interaction, but it is sometimes easy for counsellors to forget that it happens in counselling, as they concentrate on focussing their attention and appraisal skills on clients and their presenting difficulties" (p.6). The author concluded that "clients are decisive, self-motivated, skilled, and active participants in the process of resolving their difficulties" (p.22). It is important to recognise that there are some limitations to this study, such as most of the sample being in therapy with the same therapist, due to being the only person employed on a full-time basis at the walk-in agency. Also, there was a time-delay between clients completing their therapy and being interviewed, which may have compromised the data. However, Manthei's (2007) research offers additional evidence for the importance of the interpersonal aspects in therapy.

A further example of a study investigating clients' perspectives is Messari and Hallam's (2003) study, exploring clients' understanding and experience of cognitive behaviour therapy for psychosis. Four inpatients and one outpatient, who received CBT for psychosis, were interviewed, using a semi-structured format and transcripts were analysed using discourse analysis. The way that clients viewed themselves in relation to their therapist was focussed upon. Most participants saw the therapist as 'a healer who reduced distress' and described a trusting, equal relationship. Clients generally experienced therapy as a collaborative, educational experience enabling alternative ways of viewing events. Traditional cognitive behaviour therapists do not focus upon the

processes within the therapeutic relationship (Gilbert and Leahy, 2007). However, participants in this study described the relationship as an 'integral part of the context of therapy.' In terms of generalisability of these results it needs to be recognised that participants were primarily inpatients, who had been hospitalised for one to two years in a specialist unit. Therefore, other client groups, such as those who live in the community, might experience therapy differently. However, the in-depth analysis of the clients' experiences in this study allowed an exploration of views that could not have been conducted through the general statements of brief satisfaction questionnaires. The thesis will now divert attention, from studies which have primarily concentrated on client perceptions of helpful aspects of therapy, to hindering aspects during therapeutic encounters.

It has been stated that clients do not easily talk about their hindering experiences in therapy (Levitt, 2002), and tend to hide negative reactions (Farber, 2003). This may be due to the nature of memory, whereby, if clients experience the overall outcome of therapy as positive, their memories may cast a positive glow on all aspects of therapy (Henkelman and Paulson, 2006). Farber, Khurgin-Bott and Feldman (2009), writing in a paper about survivors of childhood sexual abuse, state that clients with personality disorders may find it difficult to let their therapists know when therapy is not going well and may act out their frustrations (e.g. by terminating therapy or missing sessions) rather than speaking about them with their therapist. Therefore, this adds even further weight for the need, by researchers and therapists, to actively research clients' therapy experiences. Studies supporting these ideas will be examined next.

Paulson, Everall and Stuart (2001), investigated client perceptions of hindering experiences in therapy. In-depth interviews and concept mapping techniques were used. Eight adult clients were asked about what was unhelpful, or hindering, in therapy, and what would have made it more helpful? A further sample of twenty participants was then asked to sort and rate statements derived

from the interviews. The analysis produced three core aspects of therapy that clients found unhelpful. These were therapists' behaviours, external and structural barriers and client variables. Thematic clusters developed by participants included concerns about vulnerability, barriers to feeling understood, lack of connection, lack of responsiveness and negative therapist behaviours. These themes emerged as Paulson et al (2001) allowed the participants to guide the thematic conceptualisations. Strengths of this study included the fact that the research took place in a naturalistic therapy setting, increasing ecological validity. In addition the data was not coded using predetermined categories which meant that categories emerged from the data. This meant that the concepts were not restricted by the researchers' framework. The relational aspect of therapy was highlighted by this study and it showed that much can be learned from clients' assessments of therapy. This is further demonstrated by the research of Pope-Davis et al (2002), outlined below.

Cultural sensitivity seems to be another neglected area in therapy research. This is particularly relevant for this thesis, as will be explained in more detail later in this chapter, personality disorders have been conceptualised as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture" (DSM-IV-TR, APA, 2000). Pope-Davis et al (2002), developed a theoretical model of clients' experiences accounting for cultural differences. They used qualitative interviews and grounded theory to develop a model of clients' perspectives of multicultural therapy. Clients in the study were ten undergraduate students who participated in two interviews each. This model was based on a core category of 'Client's Needs,' which critically influenced the interaction between 'Client Characteristics,' 'Client-Counsellor Relationship,' 'Client Process' and 'Client Appraisals.' Therefore, clients' experiences of therapy were dependent upon their self-identified needs and upon how well the therapist met these needs. In this model, if culture is seen as a contributory factor for the client's difficulties, the client may prefer a therapist from the same background. Therefore, in the model, perceptions and choices for the

clients are partly based on how the client sees their own culture impacting upon their difficulties and partly on the cultural competence of the therapist. This representation of the experiences of these ten participants offers a valuable starting point for further research in this area. Perhaps a combination of qualitative and quantitative research might further deepen researchers' knowledge about this and the other research areas outlined above.

2.3 Therapeutic Boundaries

> "Fixed boundary positions that set up and maintain a protective distance may well serve the safety factor admirably, but is likely to be deleterious to therapeutic involvement and outcome" (p.142).
>
> (Hermansson, 1997)

2.3.1 Introduction to Therapeutic Boundaries

Boundaries are generally recognisable in everyday life. For example, individuals do not normally telephone a friend in the middle of the night, unless there is an emergency, or walk into neighbours homes without knocking on the door first. These social boundaries exist to make people feel more comfortable with others. In therapy, it could be argued that boundaries exist for comfort and to protect the therapeutic experience. In contemporary therapy the word 'boundary' is now part of the everyday language of the field but it seems to evoke thoughts about boundary violations such as sexual exploitation (Hermansson, 1997).

In addition, boundaries are now a central feature of personality theory, as Hartmann et al (1991), identified boundary thickness as an important dimension of personality. According to Hartmann, boundaries can be imaginary lines we experience in our minds to differentiate between different concepts. Some people have very thick lines, with categories that are clearly separate and distinct, while others have very thin lines with categories blurring into each other.

For example, category boundaries can be seen as black and white, such as being young or old while others see things more in shades of grey and you could be both at the same time. Hartmann (1997), defines therapy as a space with thick boundaries around it within which boundaries can be safely thinned and psychological work can be done. This section of the chapter will now attempt to define boundaries within therapeutic relationships.

Boundaries are critical to the therapeutic relationship as they protect the client, the therapist and the therapeutic process (Smith and Fitzpatrick, 1995). The use of the term boundary, within the therapeutic context, implies that there are limits to what therapists can ethically do. However, there does not seem to be any clear agreement, or definition, for these boundaries. It appears that the reason for this may be due to the fact that boundaries can be defined differently, by each therapist, based upon individual, social, cultural, theoretical and administrative factors (Gutheil and Gabbard, 1998; Zur, 2007). For the purpose of this thesis, boundaries will be defined as the therapeutic limits that allow for the protection of clients' best interests. The reason for setting, and maintaining boundaries, is to ensure that therapy is client-centred and not motivated by therapist needs or agendas (Harper and Steadman, 2003; Smith and Fitzpatrick, 1995). Zur (2009), further elaborates upon the meaning, and definition, of boundaries by stating that boundaries in therapy:

> "...define the therapeutic-fiduciary relationships or what has been referred to as the "therapeutic frame." They distinguish psychotherapy from social, familial, sexual, business and many other types of relationships. Some boundaries are drawn around the therapeutic relationships and include concerns with time and place of sessions, fees and confidentiality or privacy. Boundaries of another sort are drawn between therapists and clients rather than around them and include therapists' self-disclosure, physical contact (i.e., touch), giving and receiving gifts, contact outside of the normal therapy session and proximity of therapist and client during sessions" (p.1).

When boundaries are functioning well they tend to go unnoticed but most individuals recognise when someone has crossed the line and violated their sense of self (Epstein, 1994). According to Sampson, McCubbin and Tyrer (2006, p.242), a standard therapeutic frame will involve setting boundaries in the following areas:

1. Timing of sessions.
2. Length of sessions.
3. Length of contract.
4. Location of sessions.
5. Setting of sessions.
6. Confidentiality.
7. Privacy.
8. The purpose, or goals, of therapy.
9. The essential tasks, responsibilities and interpersonal boundaries of the therapist.
10. The essential tasks, responsibilities and interpersonal boundaries of the client.

Different therapeutic orientations may debate the rigidity of boundaries, but knowledge of developmental psychology may provide further helpful insights here. Vygotsky (1978), proposed that effective learning in childhood requires a secure, but responsive, framework in order for the child to explore and develop. Therefore, this framework, or set of boundaries, should not be too rigid or too flexible, but should adapt to the child's stage of development. Therefore, it seems to be increasingly recognised that due to the nature of the therapeutic process a degree of boundary crossing is demanded for therapeutic gain (Hermansson, 1997).

All of the main contemporary therapeutic approaches, such as CBT, Humanistic and Psychodynamic therapy, seem to agree on certain boundaries in therapy. For example, Llewelyn and Gardner (2009) propose that:

1. "Client and therapist should not be sexually intimate or touch each other apart from perhaps a handshake; do not normally share food or alcohol; should not have another relationship (such as being neighbours or employers);
2. Therapy time should be reasonably sacrosanct;
3. Therapists should not disclose much about themselves or talk about their own problems;
4. Confidentiality should be maintained;
5. Therapy should take place in a professional, neutral setting;
6. Therapists should not gain financially beyond what has been agreed by contract" (p.5).

Gabbard and Lester (1995), distinguish between boundary violations and boundary crossings in therapy. Boundary crossing refers to any move away from traditional 'only in the office' therapy, or deviation from rigid risk-management protocols. Boundary crossing includes therapist self-disclosure, home visits, non-sexual touch and gift giving etc. Boundary violations occur when therapists cross the line of appropriate and ethical behaviour, such as violating or exploiting clients e.g. illegal breaches of confidentiality, financial exploitation and engaging in sexual relationships. Overall, it appears that boundary crossings, and violations, exist on a continuum ranging from adaptive (therapeutically useful boundary crossings) to maladaptive (non therapeutic boundary violations). Therefore, ethical considerations by therapists are imperative in order to manage the multitude of dilemmas that may be presented in therapy. These ethical considerations will be discussed next.

In current therapeutic practice ethical considerations are fundamental to the work being conducted. Often it is the more powerful person who defines the therapeutic boundaries i.e. the therapist. Many clients do not know the limits or the 'rules' of therapeutic relationships. Therefore, professional organisations publish codes of ethics in order to establish where boundaries should lie. The Health Professions Council (HPC), which is the statutory regulator for Practitioner

Psychologists in the United Kingdom, publication 'Standards of Proficiency for Practitioner Psychologists', states that Counselling Psychologists must 'be able to recognise appropriate boundaries and understand the dynamics of power' (HPC, 2009; p.6). Therapists are responsible for setting and maintaining professional boundaries, creating power asymmetry, and the BPS states that ethics are related to the control of power; "Clearly, not all clients are powerless, but many are disadvantaged by lack of knowledge and certainty." (BPS Code of Ethics and Conduct, 2006, p.6). Therefore, boundaries determine the context for power, authority, trust, and dependence (Pearlman and Saakvitne, 1995). Harper (2006), writing about working with survivors of child abuse, stated that it can be therapeutically beneficial to negotiate therapeutic boundaries with clients and to facilitate clients' understanding about therapeutic boundaries. Overall, it is evident that contemporary therapists can have slightly different attitudes regarding boundaries. However, the history of attitudes towards therapeutic boundaries is even more diverse and will be presented in the next section of this chapter.

2.3.2 History of Attitudes Towards Therapeutic Boundaries

The history of therapeutic boundaries has witnessed many debates and changes around the subject. For example, Freud advocated for strict psychoanalytically based therapeutic boundaries, yet he crossed many of these boundaries. There is a famous example where Freud offered a meal to his client known as the 'Rat Man' and gave gifts to some of his clients. Both Winnicott and Ferenczi touched their clients and Jung, apparently, slept with some of his clients (Gutheil and Gabbard, 1993). In the 1930's there seems to have been a shift in the debate on therapeutic boundaries because Freud became concerned with the image of psychoanalysis, which was a relatively new discipline. According to Zur (2007), Freud expelled two prominent Psychiatrists from the International Psychoanalytic Association for kissing and touching clients. Zur (2008), states that "...concerns with therapeutic boundaries came to the forefront of the field after Gestalt

therapy, with Frederick Perls at the helm, which became enormously popular during the sexual revolution of the 1960s" (p.7). Apparently, it was common for therapists and clients to have sexual relationships at this time. It seems that there was pressure on Psychology to provide guidelines for therapists' conduct as a result of the apparently permissive attitudes of the 1960's and 1970's. Therefore, Gutheil and Gabbard (1993) report that agencies were developed to articulate boundaries and therapists were instructed to avoid sexual relationships with clients and avoid dual relationships.

In the 1980's there was a shift towards 'risk management' in medicine and this had a knock-on effect for therapy. Therefore, according to Pope and Vasquez (1998), crossing boundaries, such as gift giving, touch and dual relationships, was seen as hazardous, from a risk management viewpoint and a first step in the 'slippery slope' towards sexual relationships and causing harm. However, during the 1990's, it was acknowledged by many that boundary crossings, such as limited self-disclosure, could be clinically helpful. Also, some 'dual-relationships' might be unavoidable due to people living in small towns, etc. Therefore, professional associations for therapy started to be more flexible about dual relationships. From the mid 1990's onwards there seem to be two main positions on therapeutic boundaries. The United Kingdom NHS, risk management experts and psychoanalytically oriented therapists support clearly defined boundaries. However, a growing number of professionals advocate for flexible boundaries as they can aid clinical interventions when applied ethically (e.g. Knapp and VandeCreek, 2006). The history and debates surrounding therapeutic boundaries continue. However, at present, it seems that flexible and context-based approaches towards boundaries appear to be adopted by a growing number of therapists in the United Kingdom and further afield. Many contemporary therapists believe that boundary maintenance is one of the most important experiences for clients in therapy, as clients learn that they are capable of having mature relationships in which a clear distinction is made between themselves and others (Binder, 2004; Williams, 1997). This section has

concentrated on therapists' developing views about boundaries. Unfortunately, it is not possible to report clients' possibly changing attitudes, over the years, as this area has been severely neglected in the literature until very recent years. Therefore, the following section in this chapter will centre attention on the limited literature pertaining to clients' views about therapeutic boundaries.

2.3.3 Clients' Experience of Therapeutic Boundaries

Research regarding boundaries, in clinical practice, has primarily focussed upon the medical field (e.g. Hurst et al, 2005; 2007), rather than experiences and implications of boundaries in mental health. Clinicians' experiences (Bennett, Parry and Ryle, 2006) and clients' experiences of therapeutic boundaries have been severely neglected with clients' perceptions receiving the least research attention. Also, the majority of research about therapeutic boundaries has focussed on professional practice in the United States (e.g. Zur, 2007, 2008, 2009). Overall, the experiences of clients seem to have been largely neglected in the research literature. However, there has been a handful of research studies that have indirectly focussed upon 'boundaries,' within therapeutic relationships, such as clients' perspectives on touch, in therapy. Previous research literature, regarding boundaries, has predominantly focussed upon therapist touch and self-disclosure and these studies will be outlined below.

2.3.3.1 Therapist Self-Disclosure

The use of therapist self-disclosure continues to be debated by therapists of different therapeutic disciplines. Even the definition of what constitutes self-disclosure continues to be debated. For the purpose of this thesis, self-disclosure is "...an interaction in which the therapist reveals personal information about him/herself, and/or reveals reactions and responses to the client as they arise in the session" (Knox et al, 1997, p.275). The most traditional of psychoanalytic positions support the proposal that therapists should be like a

mirror to their clients and any deviation, including self-disclosure, is incorrect and unethical (Langs, 1979; Rothstein, 1997). However, most Humanistic therapists would support the position that self-disclosure is expected and desirable as a way to exhibit congruence (Rogers, 1961) and transparency (Jourard, 1971). In addition, Feminist therapy values self-disclosure as a way to reduce the power imbalance between therapist and client (Mahalik, van Ormer and Simi, 2000). Therapist self-disclosure seems to be viewed with caution as some believe it could interfere with professionalism and the therapeutic process (Peterson, 2002). However, therapy process literature has described disclosure as a 'promising element' in terms of the counsellor's contribution to the therapeutic relationship (Norcross, 2002). Appropriate use of disclosure is important, from an ethical standpoint (Peterson, 2002). Within therapeutic relationships it is expected that the client is the primary discloser and the therapist reveals little about themselves. A therapist revealing personal information about themselves could potentially alter the therapeutic boundaries between therapist and client. The most common reason for not disclosing is that it might remove the focus from the client, burden or confuse the client, or blur boundaries between therapist and client (Mathews, 1989; Simone et al, 1998).

Therapist disclosure has been researched frequently (Watkins, 1990), but has most often used non-client participants in contrived therapeutic sessions (Robitschek and McCarthy, 1991). This has meant that the experience of clients, in genuine therapy sessions, has not been adequately researched. However, Knox et al (1997) conducted a qualitative analysis of client perceptions of therapist self-disclosure in therapy. They interviewed thirteen clients twice, early and later in therapeutic relationships, using a semi-structured interview format and found that many clients perceived limited therapist self-disclosure as a valued aspect of therapy. This is consistent with Hill, Helms, Tichenor, Spiegel, O'Grady and Perry (1988) who conducted a rare study on actual therapy and found that therapist self-disclosure occurred only 1 percent of the time, but received the highest client helpfulness ratings. Knox et al (1997) used a Consensual Qualitative Research methodology. They found that clients thought

that helpful disclosures included personal, non-immediate information which allowed the client to perceive the therapist as more real and human and brought balance to the relationship. Clients in this study found that self-disclosure could offer a model for change or allow additional insight into their own problems. However, it was reported that some clients thought self-disclosure produced negative effects on the therapeutic process in terms of reactions to the disclosure, or feelings about the therapist. For example, "One client, for instance, was wary about therapy boundaries and questioned what she was supposed to know as a result of the disclosure, and another client feared the closeness engendered by the disclosure and wanted to push it away" (Knox et al, 1997, p.280). Therefore, this study seemed to suggest that self disclosure, which is an area of boundary crossing, may be helpful, but needs to be done in an ethical, client-centred manner. The three principles that seem most relevant to ethical aspects of self-disclosure are beneficence, nonmaleficence, and the fiduciary relationship between clinician and client, where the interests and welfare of the client always predominate (Gutheil, 2010) and therapists' self-disclosure should be based upon therapeutic, supportive and alliance-building reasoning.

The study by Knox et al (1997) offered valuable insights into the controversial area of therapist self-disclosure. However, it should be acknowledged that some limitations may be present, due to the study's design. Firstly the qualitative nature of the research methodology meant that researcher expectations may have biased the outcomes. For example, participants were interviewed twice, once 'early' in their therapeutic relationships and once later, which meant that only participants who had formed a strong enough alliance with their therapist, and subsequently stayed in therapy, were eligible for inclusion in this research. The inclusion criteria for the first interview was that clients needed to have seen their therapist at least ten times. Perhaps these clients, who had chosen to stay in therapy for at least ten sessions, would have differing opinions on self-disclosure compared to clients who had terminated therapy prior to their tenth session. Also, the participants were initially given 'research packets', by their

therapists, about the project. Perhaps therapists consciously, or unconsciously, selected clients with whom they had a strong therapeutic alliance and this may have affected the results. Also, clients who chose to participate might be more prone to 'people-pleasing' tendencies compared to those who chose not to participate, which may have led to unrealistically positive perceptions of self-disclosure. However, these difficulties will be encountered in most studies about therapeutic interventions. It is important to highlight the worthiness of the data that has been collected in this ethically sensitive area.

Audet and Everall (2003) conducted a study which further informs understanding of therapist self-disclosure from clients' perspectives. Four adult clients were recruited through newspaper advertisements and from a University clinic. They participated in semi-structured interviews and the content was qualitatively analysed. For each interview, the transcript was read several times to gain an overall sense of the participants' experience. Portions of the transcript that revealed aspects of the participants' experience were highlighted, creating excerpts for analysis. Excerpts were paraphrased, from which themes were derived, and themes were reviewed to make sure they did not omit any aspect, or implication, from the original transcript. Case summaries were then developed for each participant. Overall, the impact of disclosure was found to be dependant on the context in which it occurred and the way it was delivered by the therapist. Audet and Everall (2003) concluded that this finding emphasised the importance of a responsiveness approach. Therefore, this research advocates for responsive and flexible attitudes towards therapeutic interactions. Flexibility, regarding therapeutic boundaries, will now be discussed further in relation to touch during therapy.

2.3.3.2 Touch in Therapy

Many research studies have demonstrated the importance of touch for physical and emotional wellbeing. For example, contact comfort from a care-giver has

been found to lead to bonding between infants and caregivers which then affects a person's relational style throughout their lifespan (Ainsworth, 1989; Bowlby, 1969; Harlow and Zimmerman, 1958). Massage has been shown to have positive effects on depression, immune system functioning, blood pressure and state anxiety (Field, 1998; Moyer, Rounds and Hannum, 2004). Despite the substantial evidence-base for the benefits of physical touch it continues to be a highly controversial boundary dilemma within psychological therapy. Frank (1957), highlights that language can never completely supersede the more primitive form of communication, physical touch.

Overall, it seems that little emphasis has been placed upon appropriate touch in therapy and clients' perspectives have, generally, been ignored. The research literature has primarily focussed upon harmful effects of sexual contact between therapists and clients (Pope, 1990). Pattison (1973), conducted an early study of both therapist's and client's experiences of touch in therapy. Pattison investigated whether touch effected perception of the relationship and whether it increased clients' 'self exploration.' It was found that touch increased self exploration but no significant relationship was found between touch and perceptions of the relationship. However, Pattison (1973), hypothesised that this lack of a significant relationship may have been due to a social desirability bias, as clients had verbalised that touch was meaningful for 'rapport.' More recently published studies will now be explored and evaluated in the remaining part of this section.

Many research studies of touch in therapy have been quite artificial, as they have used students as clients and/or therapists (e.g. Stockwell and Dye, 1980; Tyson, 1978). Therefore, generalisability to therapy is difficult. However, Horton, Clance, Sterk-Elifson and Emshoff (1995), conducted a research study to survey clients' experiences of touch in therapy. They developed a questionnaire to survey clients' experiences and attitudes towards touch alongside utilisation of the Working Alliance Inventory (Horvath and Greenberg, 1989). This survey

tested and extended Gelb's (1982), identification of four factors connected to clients' positive and negative evaluation of touch. Gelb's factors are 1) clarity regarding boundaries of therapy; 2) congruence of touch; 3) client's perception of being in control of the physical contact; and 4) client's perception that touch is for his/her benefit rather than the therapist's. Horton et al (1995), added two further hypotheses; 1) whether the therapeutic alliance could help predict client's evaluation of touch and 2) whether sexual attraction is related to evaluation of touch. Therapists, clinics, counselling organisations and self-help groups were contacted, and newspaper adverts placed, in order to distribute an anonymous survey. The results, from 231 adult participants, using stepwise multiple regression procedures, demonstrated that there was a positive association between Gelb's factors, the degree of therapeutic alliance, and positive evaluations of touch. However, sexual attraction was not significant in predicting evaluation of touch. It seems important to highlight that only ten respondents described negative touch experiences which makes generalisations difficult. This could be seen as another limitation of the study as the results primarily depict positive evaluations of touch in therapy and no generalisation can be made about negative experiences of touch. Also, wide variations in sample characteristics, such as age and time in therapy, further these generalisability problems. In contrast with the current research it is important to highlight that the quantitative methodology in Horton et al's study meant that individual clients' voices were marginalised by such an approach. This thesis intends build upon the valuable insights offered by Horton et al's study but it seems important to incorporate individual voices alongside adopting a rigorous quantitative approach.

2.3.3.3 General Boundaries in Therapy

After an intensive search of the literature the author managed to locate only one piece of research that specifically explored clients' views about general therapeutic boundary maintenance. This demonstrates the lack of research that has been undertaken in this important area of professional practice. Schafer and

Peternelj-Taylor (2003), studied therapeutic relationships and boundary maintenance for forensic inpatients enrolled in a treatment program for violent offenders in Canada. Participants were recruited, using purposive sampling, from an inpatient treatment program for violent male offenders and data collection took place over a six month period. A semi-structured interview protocol was used. Twelve male participants, ranging in age from twenty-two to forty-two years, were interviewed three times and eight of the twelve were interviewed for a fourth time to get feedback regarding the researchers' data analysis. During the second and third interviews participants were offered the opportunity to "review, confirm, clarify, correct, amend, or extend the transcripts" (p.609). A constant comparative method of data analysis was used (Glaser and Strauss, 1967), and data was reduced to the smallest unit reflecting an independent thought. Groups of categories emerged after which descriptive sentences were developed for each category. The development of therapeutic relationships was shown to be a complex process and the authors used the analogy of a house to describe the five themes that emerged from the data. "Treatment was 'a window of opportunity,' primary therapists 'opened a lot of doors,' 'doors open(ed), close(d), and lock(ed),' sometimes the 'wrong doors' were opened; and most importantly, primary therapists held and turned the 'key to everything that's going to happen' in the lives of the participants (Schafer and Peternelj-Taylor, 2003, p. 611). This study offers important insights into these specific clients' beliefs about boundary maintenance. However, it is clear that there are large gaps in the literature, regarding the perspectives of other client populations which this study hopes to partly address.

The use of self-disclosure, touch and other boundary crossings, in therapy, are still very much a part of the ethical concerns of the mental health profession. However, some of these boundaries are no longer as strictly adhered to as they once were. For example, Anderson (2007), states that the boundary of no touch in therapy is not as rigid compared to the past. These developments and shifts in attitudes, about therapeutic boundaries, have not seen a correspondingly

significant increase in research to enhance awareness regarding appropriate behaviour. The bulk of the literature, about therapeutic boundaries, neglects to include the voices of the clients involved in these therapeutic relationships. Therefore, it has been difficult to gather together an adequate number of research articles, representing clients' views about boundaries, for the purpose of this literature review. It is hoped that the current study will partly address this difficulty by contributing towards the literature which heightens awareness of clients' perspectives. The next section of this, Literature Review, aims to contextualise the inclusion of personality disordered clients in this research.

2.4 Personality Disorder

> "By marking these (clients)... through label or diagnosis, others may reassert control over them. The perception of manipulation itself is the ascription of power to individuals who themselves feel least powerful" (p.141).
>
> (Becker, 1997)

2.4.1 Introduction to Personality Disorder

There have been many definitions of 'personality' and it seems important to begin this section, about 'personality disorders' by attempting to explain what is meant by the term. It will then be conveyed why it is incredibly relevant and crucial to conduct research with this population. Hall and Lindzey (1957), state that "Personality is the essence of a human being" (p. 9), but this still does not clarify satisfactorily what is meant by the word. Mayer (2005), conveys a more comprehensive understanding, through the proposal that personality is:

> "...an individual's pattern of psychological processes arising from motives, feelings, thoughts, and other major areas of psychological function. Personality is expressed through its influences on the body,

> in conscious mental life, and through the individual's social behavior" (p.446).

Overall, there seems to be an assumption that when people talk about 'personality' everyone is talking about the same construct. However, there are numerous ways to construct a person's personality and Moran's (1999b), words below are thought provoking. This is because it is accentuated that different theories (e.g. Psychodynamic versus genetic theories) propose differing viewpoints regarding personality, its development, and associated disorders of personality. Moran (1999b), states:

> "Of all the mental disorders, the classification of personality disorders is probably the least satisfactory, borrowing elements from psychoanalysis (borderline and narcissistic), phenomenology (schizoid and anakastic), genetics (schizotypal) and behavioural psychology (anxious/avoidant). It is therefore hardly surprising that descriptions overlap and mixed categories of personality disorders are the rule rather than the exception" (p.18).

The quote, outlined above, draws attention to the fact that there are classification systems for personality disorders. This reflects how dominant the medical model theory is in Western cultures for making sense of mental distress and this will be discussed further in the next section. However, there are many other conceptualisations of personality and associated 'personality disorders.' For example, 'Psychodynamic' theories, heavily influenced by Freud (e.g. 1933, 1936), argue that human behaviour is based on unconscious and conscious influences. According to Psychodynamic theories, mental health problems and personality difficulties within adults are considered to have been caused from unresolved issues in childhood. Humanistic theories emphasise the importance of free will and individual experience in the development of personality. It is

suggested that people strive for success, and growth and that human personality traits continually change as people grow and mature. According to humanistic theories, problems arise when people lose sight of their traits that they were born with and destined to achieve. Humanist theorists include Rogers (e.g. 1951, 1961), and Maslow (e.g. 1954, 1968).

According to biological trait theories (e.g. Eysenck, 1963), a person's inherited traits determine how a person acts, and these traits can be used to describe the personality of the person. Trait theorists argue that these inherited traits combine in various ways that can cause mental health problems and undesirable personality types. A focus in trait theory is the fact that traits are permanent in the person and will not change much over life. Behavioural theories (e.g. Skinner, 1938; Bandura, 1965) suggest that personality is a result of interaction between the individual and the environment. Behavioural theorists study observable and measurable behaviours, rejecting theories that take internal thoughts and feelings into account. Overall, it seems that all of the theories outlined above make valuable contributions towards understanding personality disorders. Therefore, theories advocating bio-psycho-social perspectives (e.g. Millon, 1969; Linehan, 1993), which integrate aspects of all the theories above, seem most useful in conceptualising personality disorders. This thesis is based upon a pluralistic stance to personality development. However, it is acknowledged that the medical model pervades Western discourses, regarding personality disorders, and this will have inevitably had an influence on this thesis. This is explicitly displayed in the next section through reference to the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000).

2.4.2 Diagnostic Context of Personality Disorders

The diagnostic category, chosen to study in this thesis, was 'personality disorder.' This section offers the reasons why further research about this diagnosis is considered imperative. The fourth edition of the APA's Diagnostic and Statistical

Manual of Mental Disorders (DSM-IV-TR, APA, 2000), defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." (p.685). It is important to state that the diagnosis of personality disorder has been contested, characterised by a lack of agreement and full of confusion for clinicians and clients alike (Manning, 2000). For example, the assertion that personality disorder relates to "individual's culture" raises a number of doubts about the validity of the diagnosis. Therefore, the boundaries of the diagnosis of personality disorder are incredibly unclear for both clients and mental health professionals despite its inclusion in the DSM-IV-TR (APA, 2000). This lack of clarity could be improved upon through further research on personality disorders.

Personality disorders have a long and complex history with changing and unclear diagnostic criteria. The first Diagnostic and Statistical Manual of Mental Disorders (DSM-1), was published in 1952 by the APA. DSM I (APA, 1952), attempted to catalogue the different psychiatric disorders. The intention was to standardise psychiatric classification and language. The European version, entitled the International Statistical Classification of Diseases and Related Health Problems (ICD-7, WHO, 1958), was created with similar intentions. Both ICD and DSM have been revised and updated many times since their first publication, but they have both incorporated a variety of terms for personality pathology. DSM I (APA, 1952), referred to a 'sociopathic personality disturbance' but the term 'borderline personality disorder' was not introduced until the third edition of the DSM in 1980 (APA, 1980). The most recent editions of these diagnostic manuals, ICD 10 (WHO, 1992), and DSM-IV-TR (APA, 2000), recognise eight and ten categories of personality disorder respectively. Additionally, the DSM manual now groups personality disorders into three distinct clusters (A, B and C) and has assigned a separate axis (axis II) to differentiate them from other standard psychiatric syndromes covered in axis I. In order to clarify the

diagnostic criteria for personality disorders, which could easily become confusing. Appendix 1 shows a brief comparison of DSM and ICD criteria and Appendix 2 details a brief description of the personality disorders of DSM-IV-TR (APA, 2000). The following section of this chapter looks at the specific diagnosis of borderline personality disorder, which is the diagnosis that will be investigated in this thesis.

2.4.3 Diagnostic Criteria for Borderline Personality Disorder (DSM-IV-TR, APA, 2000).

The term borderline personality disorder (DSM-IV-TR, APA, 2000), is more widely used among mental health professionals, and international researchers, compared to its 'equivalent' in another diagnostic manual, 'emotionally unstable personality disorder' (ICD-10, WHO, 1992). The criteria are broadly similar for both, but the DSM-IV-TR highlights clients' need to avoid abandonment' as a primary feature, with self-harm and impulsive behaviour arising as a response to this fear of abandonment (p.706-710). The ICD-10 (WHO, 1992), centres on impulsivity, relating conflict and aggression to instances when impulsive needs are denied by others. This thesis treats borderline personality disorder and emotionally unstable personality disorder as synonymous, but uses the terminology 'borderline personality disorder', due to its wider use by practitioners and researchers.

The DSM-IV-TR (APA, 2000, p.710), states that the essential feature of borderline personality disorder is "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and is present in a variety of contexts as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. identity disturbance: markedly and persistently unstable self-image or sense of self

4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

6. affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).

7. chronic feelings of emptiness

8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

9. transient, stress-related paranoid ideation or severe dissociative symptoms" (p.710).

Pilgrim (2000), writing in The Psychologist, questions the reliability of psychiatric diagnoses using both the ICD-10 (WHO, 1992), and DSM-IV-TR (APA, 2000), classification systems. The high levels of comorbidity of personality disorders makes discrimination difficult. Herman (1997), expresses concern about diagnosing and treating borderline personality disorder. Herman (1997), reframes the diagnosis as a "sophisticated insult" (p.123), and accuses mental health professionals of blindly referring, shaming and mistrusting diagnosed clients instead of working with them to normalize their symptoms. However, an alternative viewpoint is that the diagnosis of borderline personality disorder allows clients, with a collection of distressing symptoms, to access mental health services in the hope that these symptoms can be treated and/or managed.

In terms of relevance for this thesis, the diagnostic criteria for borderline personality disorder highlights the distress and difficulties that can result from emotions and behaviour. Therefore, pushing the limits, of what is generally considered to be acceptable, is a core feature of the diagnosis of borderline personality disorder. Bender (2005), recommends exercising great care to avoid crossing inappropriate lines in a quest to build an alliance with clients with these disorders. Establishing relationships and maintaining boundaries are recognised as a particular challenge for all therapists, but particularly for those working with clients diagnosed with borderline personality disorder. It has been stated that borderline personality disordered clients are more likely than other clients to file complaints and initiate legal actions against their therapists due to alleged boundary transgressions (Zur, 2008; p.1). It seems pertinent to gain an understanding, from clients with borderline personality disorder, of these boundary limits, in order to enhance the success of therapeutic alliances. The aspects of instability in interpersonal relationships and impulsivity, outlined in the DSM-IV-TR (APA, 2000), lie at the heart of the difficulties in the creation and maintenance of the therapeutic alliance. In order to further contextualise borderline personality disorder possible origins will be outlined next.

2.4.4 Origins and/or Causal Context of Borderline Personality Disorder

In line with most mental health diagnoses, no single factor explains the development of borderline personality disorder. Multiple factors, including biological, psychological and social, are all likely to play a role. Theories emphasizing 'nature,' as opposed to 'nurture,' include genetic factors, neurotransmitter depletion, cerebral pathology and chromosomal abnormalities. These contributions to personality disorders have traditionally had less attention than the role of traumatic experiences so I will attempt to address this by firstly reviewing some of the 'nature' variables. For example, Depue and Lenzenweger (2001), hypothesise that adults with borderline personality disorder have high sensitivity to dopamine and poor functioning of serotonin, and this makes them

impulsive because they desperately seek instant gratification of their needs (dopamine-reward pathway) but have little constraint (poor serotonin functioning). Also, Depue and Lenzenweger (2001), argue that those with borderline personality disorder have high affiliation and high fear traits which are also linked to serotonin and dopamine. This may result in the characteristic need for relationships and affiliation combined with an intense fear about abandonment. Overall, individuals may have different sensitivity to the neurotransmitters involved in regulating emotion and this is supported by studies with identical twins showing that impulsivity is twenty-eight to seventy-nine percent hereditable (Torgersen, 2000; Livesley, 2005). Such a wide variance is accounted for by a person's experience of their environment with genetic traits only contributing to a predisposition. Therefore, genetic predispositions to impulsivity are mediated through environmental factors such as traumatic events and attachment experiences.

The theories that emphasise 'nurture,' in the development of borderline personality disorder, involve psychosocial adversity. Principle risk factors include dysfunctional families (e.g. parental mental illness, family breakdown, poor parenting practices), traumatic childhood experiences (e.g. emotional, sexual and physical abuse) and wider social stressors (e.g. economic and social barriers leading to a dysfunctional childrearing environment), (Paris, 2001). However, these factors only increase the risk of developing borderline personality disorder, so can be balanced with protective factors which make children resilient to adversity (Paris, 2001). Resilience can be heightened by the presence of at least one stable care-giver as well as supportive experiences which create self-esteem and self-efficacy (Johnson et al, 2005; Rutter, 2006). Traumatic experiences may lead to the development of borderline personality disorder by damaging the attachment between a child and caregivers and may actually effect the neural sensitivity to stress reactions (Livesley, 2005).

Issues of 'nurture' have received the most attention in the development of borderline personality disorder. Bowlby's (1969,1973,1980) work on attachment seems particularly important when working with personality disordered clients. Bowlby devoted extensive research to the concept of attachment describing it as a "...lasting psychological connectedness between human beings" (Bowlby, 1969, p.194). He believed that there are four distinguishing characteristics of attachment:

1. Proximity Maintenance – the desire to be near people we are attached to.
2. Safe Haven – returning to the attachment figure for comfort and safety in the face of a fear or threat.
3. Secure Base – the attachment figure acts as a base of security from which the child can explore the surrounding environment.
4. Separation Distress – anxiety that occurs in the absence of the attachment figure.

Inconsistency and unreliability are recurrent themes in the childhoods, and attachment experiences, of many clients with borderline personality disorder. Therefore, maintenance of boundaries is basic to the development of a safe therapeutic environment in which a trusting relationship can be developed, *(*Briere, 1996; Dalenberg, 2000*)*, which could be likened to Bowlby's 'secure base.' Therefore, if the therapeutic boundaries are unclear, the therapeutic space is likely to be experienced as unsafe by the client. This 'insecure base' of therapy may recreate an insecure early environment base and hence make therapeutic interventions difficult or impossible. Winnicott (1955), argued that the more fragile the client's sense of self, the more central frame (boundary) management becomes, compared to other therapeutic techniques. Therefore, maintenance of boundaries may become the therapeutic priority with borderline personality disordered clients. However, because boundaries emerge from interactions, they are unique to each therapeutic relationship and rigid

maintenance is not always possible or helpful. In order to display how useful and relevant the current research will be, for both borderline personality disordered clients and people around them, the following section details how common the diagnosis is.

2.4.5 Prevalence and Prognostic Context of Borderline Personality Disorder

The BPS publication "Understanding Personality Disorder" (Alwin, Backburn, Davidson, Hilton, Logan and Shine, 2006), outlines the large number of people who have attracted the personality disorder diagnosis. The prevalence of borderline personality disorder, in the general population, continues to be debated. While estimates variously range from 0.7 percent to two percent, there is agreement that eleven percent of people who come for out-patient psychiatric treatment and twenty percent of psychiatric hospital admissions meet DSM-IV-TR (APA, 2000), criteria for borderline personality disorder (Hoffman, 2007). Research cited by Alwin et al (2006, p.10), suggests that, in primary care, five to eight percent of patients have borderline personality disorder as their main clinical diagnosis, with estimates rising to twenty-nine to thirty-three percent when all clinical diagnoses are considered. A systematic review of eight epidemiological studies by Torgersen (2005), found that a reliable estimate for the prevalence, in general western populations is approximately 1.45 percent for borderline personality disorder. However, personality disorders are equally distributed between males and females but the sex ratio varies for the different types of personality disorders. Overall, this data needs to be interpreted with caution, as studies use a variety of diagnostic standards. Therefore, due to the nature of the personality disorder diagnosis and the reportedly high prevalence rates, it seems important that research should be conducted to enhance general understanding of working with this client group.

This thesis now turns to how borderline personality disorder may manifest throughout the life cycle. Research does not support the ICD-10 (WHO, 1992) and DSM-IV-TR (APA, 2000) consensus that a personality disorder is a pervasive life-long condition. A longitudinal study of sixty-four people with borderline personality disorder, by Paris and Zweig-Frank (2001), found that only five still met the diagnostic criteria after twenty-seven years. The authors cannot define the causes of this, but theorise it is due to later social learning and biological change in impulsive neural pathways. A longitudinal study by Zanarini et al (2006), found a remission rate of eighty-eight percent (two hundred and seventy-five people) over ten years, thirty-nine percent (ninety-five people) of which remitted in two years. Specific factors which improved rates of remission were absence or lower severity of childhood abuse of all kinds, absence of substance misuse, absence of family psychiatric history, good vocational history and personality factors including higher extraversion and agreeableness. These can be thought of as protective factors, which need to be balanced with the environmental stressors which may contribute and consolidate the prognosis of borderline personality disorder (Livesley, 2005, p.33).

Torgersen (2005), found that people with 'impulsive' type personality disorders, including borderline personality disorder have the lowest quality of life (rated by subjective-wellbeing, social support, negative life events), and the highest relationship dysfunctionality of all personality disorders, but research is lacking on employment and education. For Fonagy and Bateman (2005), maladaptive ways of relating may make those with borderline personality disorder attracted to abusive relationships, where they can continue to project negative feelings on to others. This may explain the high-rates of 're-victimisation' of female child abuse survivors through rape and domestic violence (Coid et al, 2001). Yet, this is only a correlation; causal mechanisms are unknown; and vulnerable women could be easily targeted by male abusers, or there may be economic and social barriers which prevent female victims from living independent lives and perpetuate cycles of abuse. However, in general, those with mental health problems do experience

social exclusion, with lower rates of employment, poorer education, access to health services is limited, and considerable stigma adding to isolation (Webber, 2005). Hence, those with borderline personality disorder are more likely to experience stressful events which may cause a relapse in maladaptive coping styles (Casher and Gih 2009). Indeed Reich (2005) has recently developed the concept of an episodic 'state' rather than a 'trait' personality disorder caused by adversity, at any point in the life cycle.

It should be noted that in the past personality disorders had been considered untreatable and hazardous for therapists to attempt therapeutic interventions. However, there has been a re-conceptualisation of personality disorders over the last decade, so that the prognosis of people labelled with the disorder has improved. Longitudinal studies (e.g. Paris and Zweig-Frank, 2001), which have found that only a small number of borderline personality disordered clients still meet the diagnostic criteria, after a number of years, adds further weight to this re-conceptualisation that personality disorders do not have to be life-long conditions. Therefore, it seems important for research, such as the current thesis, to attempt to explore and understand therapy with this 'treatable' client group.

2.4.6 Socio-Cultural Context of Borderline Personality Disorder

The diagnosis of borderline personality disorder is contingent on what is socially and culturally 'normal' behaviour. Hence, the values and prejudices of practitioners and the societal response to the person with the 'disorder' are crucial to the diagnosis. In the book, The Psychiatric Persuasion, Lunbeck (1994) asserted that "Psychiatrists entered the public sphere aggressively promoting an agenda of defect and difference" (p.62). Lunbeck (2006) proposed that the emergence of borderline personality disorder may represent a mirror to a Western society characterised by meaninglessness and emptiness. Lunbeck (2006) argues that impulsive need for shopping, work, substance misuse or other

relationship substitutes could be perceived as vacuous attempts at relationship (p.151) and these characteristics are similarly identified in people diagnosed with borderline personality disorder. More recently, values are particularly apparent in the gender bias of diagnoses. In clinical samples, women are more likely to be diagnosed with borderline personality disorder and men more likely to have anti-social personality disorders associated with violent conduct (Morey, 2005). Depue and Lenzenweger (2001), argue that different genders may have different genetic personality trends based on serotonin and dopamine systems. Conversely, Torgersen (2005), argues that the social construction of femininity may bias practitioners to view more borderline personality disorder symptoms in women. Social constructions of gender may also legitimise women accessing services. Men are less likely to report mental health conditions to health professionals than women (MacIntyre et al, 1999, O'Brien et al, 2005), and may talk about mental illness as an embarrassing 'feminising' experience (Emslie et al, 2006). There is little research on ethnicity and personality development, let alone personality disorder, so it needs to be acknowledged that the models we have for borderline personality disorder are primarily white, westernised perspectives (Ndegwa, 2003).

2.4.7 Therapeutic Context of Borderline Personality Disorder

According to Waldinger and Gunderson (1984), people attracting the diagnosis of personality disorder experience greater difficulty than most, in making and maintaining a therapeutic alliance. Overall, it is generally recognised by mental health professionals that therapeutic intervention for personality disordered individuals is a difficult and challenging task. Although borderline personality disordered clients can improve spontaneously, irrespective of therapy (Grilo, Sanislow, Gunderson, Pagano, Yen, Zanarini et al, 2004), this is the exception (Stone, 1993).

Establishing therapeutic relationships with borderline personality disordered clients can be difficult for a number of reasons and some of these will be detailed within the current chapter. Main (1957) focussed upon the relational conceptualisation of borderline personality disorder and his famous paper 'The Ailment' (1957) stated that the hospital as an institution should study its own processes, thereby enhancing its therapeutic powers. 'The Ailment' did not focus upon the characteristics of clients with borderline personality disorder but emphasised the interaction between client and therapist. 'The Ailment' reflected Main's observations on clients, and the experience of nurses treating these clients, evoking relational difficulties. These relational problems included issues of primitive defence mechanisms which will be further explored in the following paragraphs in this chapter. Therapists undertaking treatment with people attracting the diagnosis of borderline personality disorder are often subject to internal misunderstandings and other relational difficulties such as intense feelings of rivalry and powerlessness which can damage their ability to offer effective treatment to clients (Gairdner, 2002) In an article called 'The Ailment – 45 Years Later,' Gairdner (2002) suggested that teams treating children and adolescents are particularly prone to the relationship dynamics and problems outlined by Main (1957). Gairdner (2002) stated that openness is essential if therapists are to be able to effectively manage these dynamics involving defence mechanisms.

Defence mechanisms have been explored in many areas of psychology, such as addiction (Garrett, 2002), but especially in Psychodynamic theories (Freud, 1937). Defence mechanisms are the ways in which we behave or think, to better protect or "defend" ourselves. Defence mechanisms are one way of looking at how people distance themselves from a full awareness of unpleasant thoughts, feelings and behaviours. Psychologists have categorised defence mechanisms based upon how primitive they seem. The DSM-IV-TR (APA, 2000) gives a glossary of specific defence mechanisms and coping styles (p.811-813). An example of a primitive defence mechanism is passive aggression, which is where

an individual deals with emotional conflict by indirectly and unassertively by expressing aggression toward others. However, a mature defence mechanism is humour where a person may deal with emotional conflict by emphasising the amusing or ironic perspectives. The more primitive a defence mechanism, the less effective it generally works for a person over the long-term. However, more primitive defence mechanisms are usually very effective short-term, and hence are favoured by many people and children (especially when such primitive defence mechanisms are first learned during childhood which is often the case in borderline personality disorder). Adults who have not learnt better ways of coping with stress in their lives will often resort to primitive defence mechanisms. Most defence mechanisms are relatively unconscious meaning that people do not realise they are being used.

The primitive defence of 'splitting' has received a lot of attention in the literature (Neilson, 1991). This defence is characterised by a polarisation of good feelings and bad feelings such as love and hate or attachment and rejection. Therefore, someone who is seen as all good one day can be perceived as all bad the next. Clients with borderline personality disorder have problems with a sense of continuity and consistency about people, and things, in their lives. An example of splitting would be a client telling a therapist, who is not responding to a boundary request, that other therapists always respond to requests, such as adding five minutes to the end of a therapeutic session or disclosing personal information. In practice, this exerts a coercive pressure on the therapist, who is attempting to maintain consistent boundaries and communicates that the borderline personality disordered individual believes there is a 'good' therapist and a 'bad' therapist. Splitting is unconsciously, or sometimes consciously, used to make an individual, or group, feel differently (either better or worse) than their peers (Melia, Moran and Mason, 1999).

It is important to understand the process of 'rejection' in therapeutic relationships with borderline personality disordered individuals, as this could be considered a

primitive defence. Due to the nature of the diagnosis, individuals attracting the label have often been exploited or abused and let down. Therefore, often, borderline personality disordered clients expect to be rejected, so use rejection as a way to protect themselves. Thus, many borderline personality disordered clients can be difficult to establish a therapeutic relationship with, because they will often reject the therapist before the therapist can reject them. This rejection process could lead to boundary crossings from a therapist who is desperately attempting to form a relationship with a client.

A number of different treatment approaches have been proposed, which have developed from the variety of theories accounting for the origins of borderline personality disorder (e.g. pharmacotherapy, therapeutic community treatment, psychodynamic therapy and CBT). Many psychological therapy approaches have been proposed for the treatment of borderline personality disorder (Bateman and Fonagy, 1999; Davidson, 2007; Linehan, Armstrong, Suarez, Allmon and Heard, 1991; Linehan, 1993; Ryle, Leighton, and Pollock, 1999; Yeomans, Selzer and Clarkin, 1992; Young, Klosko and Weishaar, 2003). Meta-analysis has revealed that these psychological methods may be helpful (Perry, Banon, and Ianni, 1999), but between forty two percent and sixty seven percent of personality disordered clients drop out of treatment prematurely (Gunderson, Frank, Ronningstam, Wahter, Lynch, and Wolf, 1989; Skodol, Buckley, and Charles, 1983). Therefore, it is important to understand how borderline personality disordered clients perceive and manage potential threats to their therapeutic relationships, such as boundary difficulties, in order to promote favourable outcomes.

Contrary to common myths that borderline personality disorder is 'untreatable', some therapies, as outlined above, have demonstrated that they can be clinically effective. There is a growing body of evidence of the positive impact the therapeutic alliance has on outcome of treatment with personality disordered clients (Bennett, 2006). However, due to the diagnostic criteria of the disorder,

which is based upon behaviours that would be considered outside the social norm, the client group presents specific clinical management challenges for therapists. Zur (2008), states that:

> "No other mental disorder has stirred and evoked more fascination, volatility, trepidation and dread in therapists as borderline personality disorder. We have all heard statements like the following: 'You are one Borderline away from losing your licence" (p.1).

In response to the quote above, it seems that Borderline Personality disordered clients are clearly vulnerable, yet this vulnerability is rarely understood and people attracting this diagnosis are more commonly seen as a threat. It is clear that individuals presenting with the borderline personality disorder diagnoses can present challenges within the therapeutic relationship, as relationship problems are part of the diagnostic criteria. However, these challenges have been explored from the viewpoint of professionals, working with borderline personality disordered clients (e.g. Bennett, Parry and Ryle, 2006), but there is very little research on borderline personality disordered clients' perspectives. Clients' views and experiences regarding the limits of therapeutic relationships have largely been neglected. To date, no study, that I am aware of, appears to have focussed on boundaries in therapeutic relationships from the perspective of borderline personality disordered clients. Due to the numerous reasons outlined above, this is an important topic area that requires further research, and the following section will explain this further.

2.4.8 Borderline Personality Disordered Clients' Experience of Therapy

The literature specifically exploring the therapeutic relationship, from the viewpoint of clients with borderline personality disorder, is limited. However, there are a number of authors who have advocated for the importance of the therapeutic alliance for clients with personality disorders. For example, in a small

research study by Bennett et al (2006), of four positive outcome cases and two poor outcome cases involving clients attracting the borderline personality disorder diagnosis, they found that the ability of the therapist to identify threats to the alliance, and to focus on addressing these threats as they arose, were fundamental to successful outcomes in therapy. Gabbard et al (1994), proposed that whatever therapeutic technique is used, a strong therapeutic alliance needs to be the foundation upon which to base treatment for borderline personality disordered clients. In a study involving 36 women (aged 18-45 years), with the borderline personality disorder diagnosis, Yeomans et al (1994), found that an adequate treatment contract and a positive therapeutic alliance were the most important factors for positive treatment outcomes.

The first longitudinal study, according to the authors, researching the therapeutic alliance with clients attracting the diagnosis of borderline personality disorder, was conducted by Gunderson et al (1997). The quality of alliance was rated by thirty four patients, and their therapists, using the Penn Helping Alliance Questionnaire (Alexander and Luborsky, 1986), at six weeks, six months and then annually for up to five years. Eleven patients dropped out due to dissatisfaction with the therapy. Both the clients' and therapists' alliance ratings provided at the six week stage for this group of eleven and the twenty three who remained long term were compared. The clients who remained scored significantly higher, on the therapist rating scales, than those who left. The authors proposed that this finding indicated that as early as six weeks into therapy, the assessment by the therapist may be a good predictor of who will drop out and who will stay in long term therapy. This contrasts with the findings of Horvath and Symonds (1991), referred to earlier in this chapter, whose meta analysis identified the clients' ratings as the most reliable predictor of outcome. However, maybe there is a possibility that the clients who rated the alliance low at week six, in the Gunderson et al (1997), study were influenced by not wanting to appear to no longer need treatment. Rather than accepting that drop out is inevitable, Gunderson et al (1997), suggested that where this is indicated

communication could facilitate the 'rupture' and/or 'repair' cycle (Safran et al, 1990). However, there is a need for the Gunderson study to be replicated, as the research was conducted approximately twelve years ago and a larger sample size would allow the results to be generalised to other clients. However, more recent research has been conducted and this will be described below.

Araminta (2000), explored both therapist and client experiences of dialectical behaviour therapy (DBT) in a doctoral dissertation. Araminta found that therapists and borderline personality disordered clients' perspectives about therapy differed in important ways. For example, clients felt that their dialectical behaviour therapist's 'self-disclosure' was incredibly important, whereas the therapists really focused upon the value of the 'therapeutic techniques' they used. Hodgetts, Wright and Gough (2007), explored clients', with borderline personality disorder, experiences of DBT. Participants were recruited from a NHS DBT service and five clients were interviewed, using a semi-structured questionnaire, about their experiences of the programme. All interviews lasted between one and one and a half hours. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) and three superordinate themes, which consisted of sub themes, were identified. These were 'joining a DBT programme' (external and internal factors), 'experience of DBT' (specific and non-specific factors), and 'evaluation of DBT' (change, evaluation and role of the past and future). Research limitations of this study include that there was a gap of up to twelve months from the time they left the DBT programme to the time they were interviewed and it is possible that their recollections were affected by this gap. In addition, the researcher felt that participants' knowledge, that she had once been part of a DBT skills group, prompted overly positive accounts. However, this study offers valuable insights that can hopefully be built upon, as this is an area that has been neglected by research in the past.

Chiesa, Drahorad and Longo (2000), interviewed eighteen personality disordered clients who had dropped out of a therapeutic community. The early drop-out group clients were interviewed, in depth, to explore their admission experiences and these interviews were subjected to content analysis. Clients reported that their experiences and reasons for leaving were down to the institutional culture and structure, organisation of treatment and relationships with other clients. However, the relationship with staff was not a focus of this study. Therefore, within the context of a therapeutic community this study appears to suggest a move from specific, therapeutic, relationship issues towards clients' relationship with the organisational approach. It seems important for the current study to be aware that organisational boundaries have been demonstrated to affect clients with the diagnosis of borderline personality disorder. Chiesa (2000), concluded that process variables were particularly relevant, in terms of early drop-out, for personality disordered clients. Interestingly, it was stated that "...a rigidity in applying the rules and an excessive confrontational attitude at the expense of containment and understanding, constitute the main findings" (Chiesa et al, p.110). Due to the highly specialist nature of therapeutic communities, the generalisability of the findings from this study are limited. However, it further supports the view that, in order to work effectively with clients attracting the diagnosis of borderline personality disorder, it is important to explore the process issues, from the perspective of clients.

As outlined above, a history of childhood emotional, physical, sexual abuse and neglect, has been proposed to be associated with the diagnosis of personality disorder (e.g. Johnson, Brown, Cohen and Smailes, 1999), and it has been well documented that survivors of abuse can equate love and intimacy with abuse. Therefore, these clients may have distorted physical and emotional boundaries, and may dissociate from cues of danger (Kroll, 1993). Therefore, clients with personality disorder can present relentless boundary difficulties for therapists, because their physical and emotional boundaries have often been violated by perpetrators of abuse. These clients have often not been able to develop

appropriate boundaries, for themselves, as they have learned to get their needs met through interactions based on ill-defined and ever-changing boundaries (Harper and Steadman, 2003). Therefore, when borderline personality disordered clients are with a therapist, they may expect to be let down, harmed and/or exploited in some way and perhaps they are alert to signs that they are about to be abused or rejected. While in this defensive mode clients may 'test' fidelity and loyalty within the relationship that they are establishing. In acknowledging these points, and attempting to offer therapeutic interventions with individuals with borderline personality disorder, it is fundamental to attempt to understand, through research, some of the deep complexities that can occur in therapeutic relationships.

Overall, personality disorders could actually be conceptualised as being a disturbance of boundaries, particularly with regard to the self and others. Due to the importance of boundary issues, during the development, diagnosis, and life-cycle of borderline personality disorder, it seems particularly appropriate to study this client group's perceptions about therapeutic boundaries. Melia, Moran and Mason (1999) argue that personality disorders are associated with clients denying any responsibility for their actions and developing complex rationalisations about how the cause of any of their problems always lies with others. Melia at al (1999), go on to state that personality disordered clients are "...most strongly drawn to those staff who are less challenging and more accepting" (p.17), which could have clear implications for therapists managing boundaries within therapy with these clients. However, it is important not to make sweeping generalisations and acknowledge that there is incredibly limited research in the area of client views about therapy and therapeutic boundaries. The main driving force behind this research is the desire to bridge some of the gaps in the literature, regarding work with this client group, and to enable their perspectives to be voiced and heard. In the next section of this thesis an overview will be given for the critical appraisal of studies that have been included in this Literature Review.

2.5 Summary of Methodological Critique

The studies included in the literature review reflect a diverse range of clients, which makes generalising the findings more difficult. Sample sizes were relatively small for most of the studies included in the literature review. However, this may reflect the emerging consensus, within qualitative literature, particularly in Interpretative Phenomenological analysis (Smith, 2004), of the utility of small sample sizes. Also, sampling tended to be purposive, for most of the studies in this review. For example, Schafer et al (2003) explored violent offenders' experiences of therapeutic relationships and boundary management by interviewing participants enrolled on a treatment programme for offenders. However, none of the studies appeared to significantly discuss the potential influences, regarding sampling techniques, or how saturation was considered.

Inclusion and exclusion criteria differed between the research studies. For example, Horton et al (1995) stated that "...participation is restricted to adults (twenty years or older) who are, or have been, within the last two years in individual therapy with a non-body-oriented psychotherapist for at least two months and have experienced some sort of physical contact with their therapist" (p.446), whereas Paulson et al (2001) described how "participants were drawn from a sample of adult clients aged 18 and older who sought counselling services at an educational training clinic, affiliated with a large Canadian university" (p.54). The cultural and ethnic backgrounds of participants in these studies revealed that most participants were white Caucasian. For instance, Horton et al (1995), stated that ninety percent of their sample was white making their results difficult to generalise to other groups of individuals. However, none of the studies' authors claimed that findings could be extensively generalised. In-depth understanding of the areas in question appeared to be the primary motivation of most of the authors, of the studies outlined above, which is consistent with the current research.

The methodological critique of relevant research studies suggests that they adhered to the criteria for qualitative, and quantitative research, where appropriate. However, despite the methodological appraisal of studies in this literature review no studies were excluded on the basis of methodological weaknesses. It could be argued that this was a limitation of the literature review, but it seemed more appropriate to evaluate how methodologies shaped emergent findings and this could be considered to be a strength. In addition, researchers' views about what is methodologically weak varies according to their own disciplines, training and preferences (Paterson et al, 2001), and this is consistent with the pluralistic stance outlined in this literature review, which values the contribution of each piece of literature described. Overall, this literature review has outlined, and considered the methodological strengths and weaknesses of previous research about clients' experiences of therapy and boundaries and allows the reader to reach their own conclusions.

2.6 Clinical Implications

Research into clients' experiences of therapy has many clinical implications. Firstly, it can be used to identify processes and events that clients find helpful or unhelpful in therapy. However, it needs to be stated that there may be therapeutic processes outside clients' awareness that are also significant. Despite this, clients' views of what makes a difference for them, whether it is positive or negative, seems to be a strong starting point for understanding what contributes to effective therapy and then endeavouring to facilitate this clinically. All therapeutic orientations make assumptions about processes that are experienced by clients. Actually gathering clients' perspectives, through research, allows these theories and hypotheses to be challenged and tested. Finally, by asking clients about their views, researchers can attempt to ascertain 'non-professional' perspectives as clients normally do not have a 'therapeutic language' to account for what happens in therapy. Counselling Psychology

trainees need to complete approximately three years of their own personal therapy, in order to achieve the qualification, which allows for an 'insider's' perspective. However, it needs to be acknowledged that interpretations of what happens within therapy, for a trainee therapist, is likely to be from a 'professional' perspective with theoretical language used to account for some of what happens. Therefore, this makes researching clients, who often have little knowledge of theoretical frameworks, views and perspectives, even more valuable.

If, as reported within this literature review, clients' subjective beliefs about the therapeutic relationship impact upon clients' experiences of therapy, then this suggests the importance of developing therapists' skills for establishing and maintaining relationships. The role of inter-subjective meanings and beliefs, within and between therapist and client, supports the use of interpersonal models of working with clients. In particular, clients with borderline personality disorder, who have often experienced negative relationship patterns as part of the development of the disorder, may particularly benefit from therapists attending to these process issues. Also, therapists could aim to develop their skills and techniques for learning more about their clients' experiences. The personality, temperament and relationship-building skills of therapists are rarely evaluated. However, these factors partially shape the relationship that a therapist has with the client. Therefore, this literature review suggests the value of supporting therapists to identify training requirements for personal and professional development.

For the purpose of this Counselling Psychology thesis it is important to contextualize this literature review within the discipline of Counselling Psychology. It is hoped that this may have beneficial clinical implications for the profession of Counselling Psychology and the wider mental health professions. Shillito-Clarke (1996, 2003) suggests that Counselling Psychologists should be trained and encouraged to develop personal awareness of ethical issues and

boundaries, and promote awareness in colleagues. Ethical issues, and implications, will be discussed further in the next chapter, Methodology.

The literature within the Counselling Psychology field, about general client perspectives, has a firm research base and is rapidly growing (e.g. Giovazolias and Davis, 2005; Kramer, de Roten, Beretta, Michel and Despland, 2008). Research that specifically explores clients' viewpoints about therapeutic interactions has been published in Counselling Psychology journals by authors including Paulson, Truscott and Stuart (1999). This could be considered to be reflective of the humanistic stance which underpins the profession of Counselling Psychology. Other professions, that are more dominated by the medical model, such as Psychiatry, have traditionally neglected clients' viewpoints compared to other discipline. As demonstrated in the research evidence described earlier in this chapter, the profession of Counselling Psychology has not significantly attended to the topic of personality disorder. Again, this may be due to the profession of Counselling Psychology's critical stance regarding diagnostic labelling which may have discouraged researchers from studying people with controversial diagnoses such as borderline personality disorder.

A thorough search of the relevant literature reveals that personality disorders have most frequently been researched and published within the fields of Psychiatry and Clinical Psychology (Clarkin, Levy, Lenzenweger and Kernberg, 2007; Bateman and Fonagy, 2008), and the majority of literature on personality disorders can be drawn from psychodynamic perspectives (Levy, Wasserman, Scott and Yeomans 2008; Davidson, 2009). Therefore, the historical bias in the literature which views personality disorders mainly from a psychodynamic perspective, that emphasize the influence of the unconscious mind and childhood experiences on personality, will inevitably influence viewpoints and assumptions about these topics and it is important to be mindful of this. Overall, it is hoped that this research will make a contribution to both Counselling Psychologists and other professionals' understandings of therapeutic boundaries, and add to a

knowledge base that can be used to inform decisions relating to staff training, treatment of people with a diagnosis of borderline personality disorder and education of both borderline personality disordered clients and the general public.

2.7 Outlining the Research Questions

The previous three main sections of this Literature Review (1. Client experiences of therapy; 2. Therapeutic boundaries; 3. Personality disorders), have outlined primary pieces of work on the subject area of interest for this thesis. In addition, readers have been introduced to some of the debates which continue about these topics. Through this process, it has been highlighted that there is substantial literature on all three of these main areas. However, it is more important to stress that there are large gaps in the literature. Notably, when moving from the broader area regarding client experiences of therapy, to the narrower area of borderline personality disordered clients' experiences of therapy, the gaps increase in size and become more apparent. Most importantly, the literature seems non-existent when narrowing the topic of inquiry to borderline personality disordered clients' experiences of boundaries in therapy. This highlights the need for further investigation into the areas where there are gaps. These gaps have been reflected upon and principle areas of inquiry have been identified and three research questions posed.

The primary research question is:

1. **How do borderline personality disordered clients understand therapeutic boundaries?**

Historically, clients diagnosed with personality disorders were often considered 'untreatable.' Sherer (2008), wrote an article entitled 'Personality Disorder: Untreatable Myth Is Challenged' which emphasises this point. Also, personality disordered individuals were considered too difficult to engage in productive

therapeutic relationships (Yeomans et al 1994). Silk (2008), writes "Much has changed in the last 10–15 years, but unfortunately too many therapists still feel that borderline personality disorder is untreatable and is a lifelong drain on the energy of the therapist, the psychopharmacologist, and the entire mental health system...the idea that these patients never change or improve needs revision" (p.413). This thesis demonstrates that mental health professionals are beginning to conduct further research into understanding therapeutic interventions with people diagnosed with borderline personality disorder. This will, hopefully, promote favourable treatment outcomes with clients attracting the borderline personality disorder diagnosis. Additionally, the viewpoint of clients is being valued, and voiced, in the current study.

In the hope of gaining greater insight into these concepts the following secondary questions were posed:

2. **What experience do borderline personality disordered clients have of therapeutic boundaries?**

3. **Do borderline personality disordered clients report positive or negative perspectives about therapeutic boundaries?**

Due to the flexibility of some therapeutic boundaries, as discussed during this Literature Review, this creates a 'grey area' between healthy and unhealthy boundary related behaviours. There is a fine line between appropriate, and inappropriate, boundary transgressions. As stated above, it appears that boundary crossings, and violations, exist on a continuum ranging from adaptive (therapeutically useful boundary crossings), to maladaptive (non therapeutic boundary violations). However, part of the diagnostic criteria for borderline personality disorder is 'black and white' rigid thinking. Therefore, it seems likely that these 'grey areas' around therapeutic boundaries may be experienced in a negative way, by borderline personality disordered clients. Therefore, it seems

important to understand, from clients' viewpoints, how these boundary experiences are evaluated.

2.8 Summary

This review aims to outline and appraise the literature available in the following three domains, alongside the relationships between all three: 1. Clients' experiences of therapy, 2. Therapeutic boundaries and 3. Personality disorder. It is argued that many of the studies reviewed offer a valuable and positive shift towards enabling the subjective experiences and voices of clients, to be heard. This is a primary motivation for the current thesis and advocating for clients' viewpoints will be observable throughout this thesis. The studies outlined in this literature review reflect a diverse range of methodologies and client samples, mostly utilising small sample sizes, which makes generalising findings difficult. However, this research offers insights into, and contributes to, the current understanding of this largely neglected area of study.

The current review has highlighted the strong evidence in support of positive therapeutic alliances, for good treatment outcomes, with all clients, but particularly those with the borderline personality disorder diagnosis. This is in accordance with the philosophy of Counselling Psychology, which advocates for a relational framework to therapeutic interventions. The first section, entitled 'Clients experiences of therapy,' particularly demonstrated how clients' perceptions of helpful and hindering aspects of therapy were entrenched in the therapeutic relationship and feeling understood within the relationship. Boundary setting offers the conditions under which the therapeutic relationship can develop and this was explored in more detail in the second section entitled 'Therapeutic boundaries.'. Perceptions and attitudes towards therapeutic boundaries have changed over time, including the permissive attitudes often advocated in the 1960s and 1970s and the 'risk management' type attitude prevalent in the 1980s. A more flexible and context-based approach to therapeutic boundaries is often

adopted by contemporary therapists. The final section, entitled 'Personality disorder' contextualises this disorder. In particular, the diagnosis of borderline personality disorder, and the topic of therapeutic boundaries, are both related to ever changing and developing cultural norms. However, the available literature has not satisfactorily reflected these developments and seems to have largely neglected these areas of research interest. It is possible that this is due to the controversial and ethically sensitive nature of these topics, as discussed in this review. Overall, the author of this thesis argues that personality disorders could be conceptualised as being a disturbance of boundaries, particularly with regard to the self and others.

The intention of this research study is to contribute to contemporary understanding of therapeutic relationships, and boundaries, from the viewpoint of clients with the diagnosis of borderline personality disorder. The research literature appears, surprisingly, virtually non-existent in this specialist area. Therefore, this study offers a ground-breaking opportunity to bridge the fissures between research on therapy and therapeutic practice. The next chapter 'Methodology' further introduces the reader to the author's theoretical position, and how this relates to the aims and questions that have been proposed above, alongside outlining methodological choices and procedures.

Chapter 3

Methodology

"While diversity in theory and methodology appears to be an important goal for researchers, diversity requires breaking down of traditional boundaries. Breaking down boundaries is a formidable task" (p.306)

Freyd and DePrince (2001)

3.1 Introduction

The first two chapters of this thesis (Introduction and Literature Review) have defined the area of interest, described the driving forces behind this work, and specific questions have been presented. The current chapter moves away from the background to this research study and introduces and describes the methodology adopted. In order to progress towards active generation of data, different methods of investigation were critically considered in order to choose methods that would be appropriate for the research aims and overall philosophy of the study. When undertaking any research it is important to be mindful of the decisions underpinning the work. Therefore, an overview will be given of the methodological framework for this study, with an associated rationale. This chapter will start with epistemological foundations of the research, moving on to methodological perspectives and ending with a description of the choice of methods utilised. This research design was carefully considered in order to successfully implement the research project and aims.

3.2 Epistemological Stance

Decisions about research methodology can be influenced by researchers' beliefs about the nature of reality, which is known as ontology, and ways of accessing that reality, commonly referred to as epistemology (Guba and Lincoln, 1994). Additionally, this piece of research formed part of the academic requirements to qualify as a Counselling Psychologist and the chosen research methodology

needed to be conducted within the time constraints imposed by my examining University. Traditionally, within the discipline of psychology, 'knowledge' is acquired from the results of studies using a positivistic framework. The positivistic framework assumes that 'truth' is waiting to be found and can be revealed through scientific methods such as testing hypotheses by manipulating variables. This stance dominated psychology until the 1970s when psychologists, who were influenced by social constructionist thinking, began to challenge these ideas. Social constructionism originated from many different theorists, such as Wittgenstein, (1953), Austin, (1962), Foucault, (1972), Gergen, (1973), but Potter and Wetherall (1987), seem to be credited with bringing these theories to the discipline of psychology. Social constructionist thinking is a radical epistemological shift away from the more traditional positivistic theories. There is no one definition of social constructionist theory since it is more of a framework. However, Gergen (1985), argued that there are four main assumptions in most social constructionist work. These assumptions are: a radical doubt in the taken-for-granted world; the viewing of knowledge as historically, socially and culturally specific; the belief that knowledge is not primarily dependent on empirical validity but sustained by social processes and, finally, explanations of phenomena can never be 'neutral.' Therefore, as a culture or society, we construct our own versions of 'reality' and 'truth' among ourselves.

Quantitative, qualitative and mixed research methodologies were considered for this project. Traditionally quantitative research, also known as the R approach, works from an objective positivist paradigm whereas qualitative research is conventionally more subjective. Authors such as Flick (2009), state that qualitative research often adheres to a more constructionist viewpoint. During the process of formulating the research proposal for this study, it became acutely apparent that individuals could potentially bring varying perspectives to this research project. Therefore, as a consequence, a post-positivistic epistemological stance, incorporating social constructionist values, which could

be most simply termed 'epistemological pluralism' (Turkle and Papert, 1991), was adopted. Epistemological pluralism utilises multiple research approaches and from this position it is believed that multiple approaches are needed to better approximate 'truth.' The different methodologies that were considered for this research study, will now be briefly outlined, alongside the rationale for the eventual decision to use Q methodology and its associated epistemological stance. In particular, the implications associated with quantitative and qualitative methods will be examined in Sections 3.2.1 and 3.2.2 respectively, Section 3.2.3 considers combined methods, and introduces Q methodology as an alternative method capable of overcoming the problems of both quantitative and qualitative methodologies.

3.2.1 Quantitative Methods

The ontological and epistemological foundations of quantitative perspectives regard reality as existing. This means that from this viewpoint reality can be independently and objectively measured. Therefore, typical methods of quantitatively measuring people's attitudes involve questionnaires, surveys and scales. Quantitative methods have originated from the natural sciences and traditional conceptions of empiricism and positivism. According to Pidgeon (1996), quantitative methods aim to find causal relationships between phenomena and reduce them to natural laws and propositions that can be tested. The hypothetico-deductive (Willig, 2001), philosophy of science operates by looking for evidence that disproves, rather than looking for evidence that confirms, a theory. This means that these quantitative methods do not freely allow participants to qualify their answers so it could be considered that they do not really explore the attitudes people hold but instead examine how people respond to statements. According to Sayer (1992):

> "Advocates of quantitative methods usually appeal to the qualities of mathematics as a precise, unambiguous language which can extend

> our powers of deductive reasoning far beyond that of purely verbal methods" (p.175).

Quantitative methods, generally, gather data from larger number of participants and can be viewed as making generalisations that can extend beyond the research participant sample. This type of research can have the benefit of producing statistically rigorous results but it remains debateable what these statistics actually mean. Quantitative research has been criticised because, as noted by Layder (1993):

> "Such research tends to impose the researcher's assumptions and therefore reduces the chances of discovering evidence which would question the basis of these assumptions" p.39.

Advocates of Q methodology argue that not only do quantitative surveys and scales, using predetermined categories, not measure anything 'real' at all (Stainton-Rogers, 1991, p.130), emphasis is placed on the measurement of attitudes rather than understanding them. Stephenson (1964), argues that understanding people's opinions is not necessarily furthered by researching the quantitative attributes of opinions. For example, he believes that voting for a winner is far removed from an understanding of why people voted as they did. In summary, the problems of quantitative methods lead critics such as Stainton-Rogers (1995), to claim "that attitude scales produce consistent, replicable results, that attitudes shift in certain systematic ways or are predictive of conduct... are artefacts of the approaches used and the assumptions upon which the work has been based" (p. 112). This Q methodological study intends to circumvent these problems associated with quantitative methods as the results of a Q methodological study can be used to describe a population of viewpoints and not, like in R, a population of people (Risdon et al. 2003).

3.2.2 Qualitative Methods

It appears that, perhaps as a reaction to the criticisms of the hypothetico-deductivism of quantitative methods, qualitative research is increasingly being utilised (Coyle, 2007). Qualitative research normally focuses upon the analysis of textual rather than numerical data (McLeod, 1996b). There are many methods of data collection used in qualitative research, including case studies, interviews and focus groups (Willig, 2001). These methodologies take an ontological and epistemological viewpoint that emphasises how meanings, and multiple realities, are constructed primarily through language. Therefore, qualitative methods can be seen as focussing more upon 'understanding' rather than 'explaining' and are consistent with social constructionist viewpoints. Qualitative research methods seem particularly useful when studying topics that have little prior research and are of a complex and ambiguous nature, (McLeod, 1996b; Richardson, 1996), such as the current research area of therapeutic boundaries. Also, qualitative methodologies tend to advocate that the researcher, subjectively, participates in the process of data gathering. This is contradictory to the philosophical stance of quantitative methods, where the researcher is often perceived as an objective observer and discoverer of facts. Qualitative research methodologies generally perceive that the researcher influences the object of inquiry but that the researcher is also affected by the object of inquiry. This is concordant with the reflexive stance that underpins the profession of Counselling Psychology (Coyle, 1998). Qualitative approaches allow participants to 'say what they think' and generates rich data. However, these data are not amenable to statistical analysis and the lack of 'statistically significant' results from qualitative studies is sometimes seen as a problem. Qualitative research has been criticised because, as Denzin and Lincoln (2000), point out, qualitative researchers are sometimes:

> "...called journalists, or soft scientists. Their work is termed unscientific, or only exploratory, or entirely personal and full of bias. It

is called criticism and not theory, or it is interpreted politically, as a disguised version of Marxism, or humanism." (p.4).

Overall, advocates for qualitative methodologies, including proponents of Q methodology, recognize that neither quantitative, nor qualitative discourses have any claim to epistemological superiority. This also applies to "...the discourse by which the research is told is just as much a 'story' as the 'stories' it seeks to elucidate" (Stainton Rogers et al, 1995, p. 240). Therefore, the pluralistic stance adopted for this thesis highlights that both qualitative and quantitative methods have valuable contributions to make to research procedures.

3.2.3 Mixed Methods

Debate around the quality of research has often been overshadowed by a kind of 'disciplinary tribalism' (Pawson, 2001), whereby the extreme positions between quantitative versus qualitative theory has eclipsed the needs of researchers trying to effectively apply their findings (Meyrick, 2006). The strength of the quantitative approach lies in its reliability (repeatability). This means that the same measurements should yield the same results time after time. The strength of qualitative research lies in its validity (closeness to the 'truth'). Therefore, qualitative research, using a variety of data collection methods, should touch the core of what is going on rather than just skimming the surface. The validity of qualitative methods is greatly improved by using a combination of research methods. Yardley (2008) suggested criteria to enhance validity of qualitative methods such as asking 'open ended' questions so that participants can influence the topic and data. Thus, it seems possible that one way of combining the strengths of both quantitative and qualitative methods, or partially overcoming the problems of both quantitative and qualitative methods, is to combine the two.

Within the literature, mixing research methods has been limited. This seems to be because, according to Goss and Mearns (1997), individual researchers have adhered to specific conceptual frameworks with natural scientists using

experimental designs in one corner and social scientists having a more qualitative bias in the other. Boyle (1997b, 1998) queries whether debates regarding quantitative and qualitative methodologies are entirely intellectual and epistemological, or whether they may be partly emotional and ideological. Boyle argues that Psychology's historical resistance to qualitative and social constructionist approaches may be due to loss of authority and status of the researcher in these traditions, loss of control over the subject matter, revelation by these approaches of gaps in psychological theories, the threat of breaking down disciplinary barriers and the threat of controversial topics. This thesis attempts to see past the tensions of these different paradigms and achieve a synthesis of methodologies. Also, other authors such as Goss and Mearns (1997) have encouraged a more accepting pluralistic stance in researching therapy:

> "The authors outline and posit the futility of the 'paradigm war' between reductionistic / positivistic and phenomenological / naturalistic philosophies within counselling evaluation, pointing out that the notion of such competition is itself based on positivistic thinking. They trace attempts at creating a 'truce' in the war based on strict demarcation of territory. They conclude that in the longer term more might be gained by accepting the veracity of both philosophies and creating a pluralist model which will be more fully equipped to evaluate the human process of counselling" (p.189).

There is a perceived incompatibility of qualitative and quantitative research paradigms in academic literature. Smith (1983), believes that mixing these stances is untenable but Reichardt and Rallis (1994), have negotiated these challenges. For example, there are philosophical complexities associated with mixed methods of working, but concordant with Johnson and Onwuegbuzie (2004), it is believed that qualitative data can be used to 'add meaning' to quantitative results or quantitative data can be used to add precision to

qualitative findings. It is important to acknowledge that, despite the perceived benefits of mixed research methods, there may be some negatives associated with this research design. For example, design issues may not appropriately account for how quantitative and qualitative data will interact. Also, there may be dissemination issues where specific journals are biased towards publishing either quantitative or qualitative research.

Despite historical biases and the difficulties outlined above, studies that use mixed methodologies are becoming increasingly common (Alvesson and Sköldberg, 2009; Leech and Onwuegbuzie, 2009; Tashakkori and Teddlie, 2002). However, this is typically seen as one epistemological value system complementing another, rather than a paradigmatic choice. In order to try to overcome some of the criticisms of quantitative and/or qualitative methods of analysis one approach would be to combine the methodologies. Both qualitative and quantitative methodologies can contribute different but valid perspectives. However, this raises the difficulty of how these different perspectives can be combined. Methodological 'pluralism' is becoming increasingly popular in contemporary research and authors such as Hammersley (1996) propose that quantitative and qualitative methods can complement each other and be beneficial within the same study. It became apparent, while formulating the research proposal for this project, that methodological pluralistic values seemed consistent with the discipline of Counselling Psychology. Dryden and Woolfe (1996), identify that the profession of Counselling Psychology is founded upon a post-modern, pluralistic and integrative philosophy.

Overall, it was decided, after weighing up the pros and cons, as highlighted above, that a post-positivistic epistemological stance would be adopted, incorporating social constructionist values, as this would offer an effective framework for researching borderline personality disordered clients' viewpoints in a rigorous manner. It was felt that through combining methods, a more comprehensive picture could be achieved compared to engaging in one research

methodology. Also, this offered the opportunity to allow a wider variety of clients' voices to be heard as some participants may prefer quantitative methods compared to qualitative and vice versa. It is important to recognise, that the personal beliefs, philosophical stance and interests of the researcher influenced these choices.

Epistemological pluralism was primarily achieved through choosing Q methodology to provide a bridge between quantitative and qualitative analysis. As will be explored in more detail, in the following sections of this chapter, Q methodology was the preferred theoretical framework for data generation in this thesis because it is more 'abductive,' meaning that it does not force a preconceived framework of categories, unlike traditional quantitative methods that are 'hypothetico-deductive.' Stephenson (1964), advocated Q methodology as a means to replace quantitative methods of public opinion measurement by one that is more qualitative, but includes quantitative analyses, and is capable of exploring the diversity and structure of attitudes rather than their attributes. Q methodology does attempt to address subjectivity from participants' viewpoints, but it is not the 'constructors' (the participants) who are the focus of this Q methodology study, but the 'constructions' themselves and this will be explored further in the following sections.

3.3 Overview of the Research Design

The research design utilised for this study will be outlined in this section. As described above, and as is evident from the title of this thesis, this research was based upon Q methodological procedures. Q methodology has not been used extensively within research about psychological therapy. However, Shinebourne and Adams (2007) explored the suitability of Q methodology, in a pilot study about therapists' understandings of working with clients with problems of addiction. This study concluded that Q methodology has "the capacity to identify commonalities and diversity in viewpoints which do not conform to a priori

conceptualisations" (p.211). It seems important to firstly detail the background to Q methodology.

3.3.1 Q Methodology

Q methodology is considered particularly suitable for the study of human subjectivity, such as a person's opinions, beliefs or attitudes (Barbosa, Willoughby, Rosenberg and Mrtek, 1998). It is particularly appropriate for "addressing the critical kind of research questions which are concerned to hear 'many voices.'" (Stainton Rogers, 1995, p.183), such as those with the borderline personality disorder diagnosis. Q methodology was first proposed by Stephenson (1935) and his main publication about the topic was called *The Study of Behaviour: Q-technique and its Methodology* (1953). Other authors who have contributed to the development of Q methodology include Brown (1980, 1993) and McKeown and Thomas (1988). Stephenson (1964) advocated for Q methodology as a way to replace large-sample quantitative methods, of measuring opinion, with one that is more qualitative and able to explore diversity of attitudes.

Recent increases in the use of Q methodology could be seen as qualitative researchers' discomfort with science and apparent preoccupation with objectivity (Barry and Proops, 1999). The Q methodological approach does not force preconceived frameworks on people's opinions and combines the richness of qualitative data with the statistical technique of factor analysis. Factor analysis is used to help systematically identify the range of discourses that occur among study participants. Therefore, Q methodology combines both qualitative and quantitative stances, but is most closely related to post-positivistic ideas. For clarity, the Q methodology procedures will now be outlined.

Q methodology normally proceeds in a number of steps. Firstly, interviews, or focus groups, are conducted with a sample of the relevant population.

Statements are then selected to use in the next stage, called Q sorting. During Q sorting individuals rank-order these statements, for example, from 'most agree' (+6) to 'most disagree' (-6). Q sorts from all of the participants are then correlated and factor-analysed in order to seek patterns, or communalities across individuals. Therefore, Q methodology allows typical discourses to be drawn about topics. In addition, interpreting these factors can reveal groups of individuals with commonly shared attitudes. Overall, Q methodology attempts to address subjectivity, from participants' points of view, in a statistically rigorous way.

Q methodology was given its title to distinguish it from more familiar quantitative R methodology. As described earlier in this chapter, the R approach presumes that the phenomenon of interest is objective and measurable. Q methodology is fundamentally different, compared to traditional scientific methods, in terms of what is being measured and in whose terms. Q methodology is based on the mathematical statistical tool of factor analysis, but, unlike R factor analysis, which correlates variables (such as traits or tests), in Q it is the individuals who become the variables and are correlated in a by-person factor analysis (Barbosa et al, 1998). It should be noted that in Q methodology there are no absolute scales, such as a thermometer measuring temperature, but that the importance is in the relative position of viewpoints to each other. Therefore, typical scientific measurement (comparing a measured item with a known standard) is not involved in Q methodology. In R methodology, however, the differences between subjects' scores are assumed to measure variability. Brown (1980) makes the important point that:

"Two people responding in the same way to the same questionnaire item may actually mean different things, or that two people responding differently may actually mean the same thing. For example, does 'agree strongly with' expressed by respondent a necessarily mean that a is stronger in his agreement than b who

checks 'moderately agree with'...? Their frames of reference may differ in a way such that in reality b>a" (p.19).

Q methodology seemed to be an arguably ideal alternative to more traditional research methods for this study. Its capacity to uncover differing attitude types without sacrificing complexity of these viewpoints was the fundamental reason for choosing this methodology. The following sections in this chapter outline, and clarify, some of the important terms and stages in Q methodology. It is hoped that this will allow readers to further understand the methodological procedures, used in this research, which could enable critical reflections to be made about the research outcomes.

3.3.2 The Communication Concourse

The communication concourse, in Q methodology, consists of all statements that might be used in any discourse about an issue. These statements are drawn from diverse sources and typically derived from naturalistic sources, such as semi-structured interviews, and focus groups, to reflect maximum diversity and to express the statements in language relevant to the subject. Statements are collected to provide as comprehensive a set as possible. According to Stainton Rogers (1995), this process results in a collection of statements which is "typically around three times the size of the aimed-for Q set" (p.185). When additional interviews and/or focus groups produce few new unique ideas "...the law of diminishing returns has asserted itself..." (Brown, 1980, p.259). Dudley, Siitarinen, James, and Dodgson (2008), reduced the total number of statements in their study through adding together statements that overlapped, or substituting closely related statements with more general statements. It is important to acknowledge that judgements need to be made when selecting statements. However, Stainton Rogers (1995) stresses "...Q methodology is a very robust approach. A less than ideal Q sort, because it invites active configuration by participants ('effort after meaning'), may still produce useful results: more so than one might expect of a poor questionnaire" (p.183).

The 'Q set' or 'Q sample' consists of written statements taken from the communication concourse, typically ranging between forty and sixty, and the ranking of them by participants is known as Q sorting. Q sorting involves participants rank ordering the Q sample (normally consisting of separate cards with a statement on each) according to a 'condition of instruction' (i.e. normally 'from most agree' to 'most disagree'). The act of Q sorting and the structure of forced normal distribution required by the response structure allows comparison of individual Q sorts, which can be correlated and factor analysed. This analysis normally identifies a limited number of common ways of sorting which can be termed as 'factors.' Finally, attention is focussed upon the relationships between statements and these factors are interpreted by the researcher until the 'best' explanation is reached.

3.3.3 The Theory of Limited Independent Variety

Q methodology is based on the theory of limited independent variety (Brown, 1980), or what Stainton Rogers (1995), calls 'finite diversity.' It is expected that sortings will form a limited number of ordered patterns (factors) and that in most Q studies no more than five factors normally emerge. Therefore, Q studies do not need large numbers of opinion statements or large numbers of participants. However, it is important to select participants who reflect a wide range of potential opinions, so that all factors are, it is hoped, identified in relation to the research topic.

3.3.4 Participants

Q methodology is sometimes criticised for often having small sample sizes because "...one can never claim that one's subjects are statistically representative of some larger population" (Dryzek and Berejikian, 1993, p. 51). However, this is not the priority in Q methodology as Q is concerned with why and how people believe what they do. A Q-methodological study does not generalise well to a wider population, but it is believed that the major strength of

Q methodology is that it is a technique for identifying similarities among individuals beliefs and attitudes that might not have been known and "...it can force us, as researchers, to strive to express accounts or readings of a topic which would not otherwise have occurred to us" (Curt, 1994, p.125). Representativeness is related to the concourse so that factors identified "...will generally prove a genuine representation of that discourse as it exists within a larger population of persons; and this is the kind of generalisation in which we are interested" (Dryzek and Berejikian, 1993, p. 52). Stephenson (1953), considered that quantative approaches "exaggerated regard for measurement ... a plague," and "the use of large numbers has become a dogma" (p.5). Large numbers of participants are not required in Q methodology because Q methodology is concerned with identifying distinct viewpoints rather than, for example, percentages of people who have a particular viewpoint.

3.4 Online Research Methodology

A very important stage in the methodological planning of this research was accessing participants. Initially, it was intended that all participants would engage in the research, face-to-face, and preliminary investigations had been made into the viability of this. Managers from two personality disorder organisations, listed on the UK National Personality Disorder Programme website (www.personalitydisorder.org.uk), had provisionally expressed interest in this research study. However, from the author's knowledge of working in the personality disorder field, derived from working within it for approximately four years, it had been observed that many clients, attracting the borderline personality disorder diagnosis, used the internet to connect with others with the same diagnosis. Therefore, conducting research online would, potentially, enable access to a wider variety, and a greater number, of participants. A website dedicated to user perspectives of different treatment approaches, for people considering their treatment options, through ratings and reviews (www.revolutionhealth.com), revealed how important internet social connections

were for many individuals. On this website, borderline personality disordered clients had reviewed and rated 'online discussion groups for borderline personality disorder.' These clients were repeatedly stated how beneficial these groups were, and highlighted how commonplace it was for clients with borderline personality disorder to access these web-based groups, which developed enthusiasm for conducting this research project online. For example, one reviewer stated:

> "For the past six years I have been either a member or list owner in various support groups for BPD. I find it extremely helpful because I can make contact with others who really understand me. I also love helping others so it gives me that opportunity as well. In real life, I am very reclusive and isolated, so the online groups are a Godsend for me! I have met some wonderful friends as well as learning and working as a team for self-improvement."
>
> www.revolutionhealth.com (2005)

It was decided to conduct the entire research study online as, following online contacts with website moderators, it proved to be an invaluable and successful resource for recruiting a variety borderline personality disordered participants. Overall, the online communities for clients with borderline personality disorder offered a potentially large sample of participants. Also, collecting data online meant that the process was more convenient for both participants, and researcher, as participation could be undertaken at a time and location convenient to everyone. It is probable that because this research study was more convenient to access and because it was potentially less threatening, for clients to take part online rather than meeting in person, a diverse sample of borderline personality disordered individuals was encouraged to take part. Rodham and Gavin (2006), believe "the internet is more suited to collecting such data as people feel freer to express their 'true' feelings." (p. 94). In addition,

collecting textual data from the internet focus groups meant that the labour intensive process of transcribing recorded information was eliminated, although creating the research website and maintaining online focus groups was incredibly labour intensive. It should be acknowledged that visual non-verbal cues were lost by conducting online research and the research. It was decided that asynchronous (spread over time) communication would be the most appropriate method of data collection as this would mean that the participants would not be pressured for immediate responses, would be encouraged to be more reflexive, and would be most convenient for both participants and researcher. There is no guarantee that the participants had the diagnosis of borderline personality disorder, nor that people stated their 'true' beliefs, but this can also often be the case when meeting a person face-to-face.

3.4.1 Ethical Implications of Online Research

Rodham and Gavin (2006), state that "the practice of conducting research online is in its infancy. Consequently there is debate concerning the ethical implications of online data collection" (p. 92). For example, there is a lack of clear consensus about ethical issues such as confidentiality and consent. Currently, it seems that the more private venues require more effort on the part of researchers to ensure that the individuals whose words are being used for research purposes are made aware of this, and their consent sought, whereas the more open forums can be considered to be public domains and treated as such in research terms, thereby the issue of consent is implied by the act of writing in such forums (Rodham and Gavin, 2006; p.96). However, the standard ethical guidelines for psychological research in the United Kingdom (BPS Code of Ethics and Conduct, 2006; London Metropolitan University Psychology Department Graduate School Research Ethics Working Group, 2009), for meeting a participant face-to-face, were adhered to. Further ethical implications, for conducting online research were raised, and protected against, through consultation of the publication "*Conducting Research on the Internet: Guidelines for ethical practice in psychological research online*" (BPS, 2007). For example, the main ethical implications for

conducting research online include gaining informed consent from participants and ensuring confidentiality and anonymity of online participants. In order to ensure informed consent, all potential participants were informed of all aspects of the research, through the research website, so that they could decide whether they wished to take part, or not.

Additionally, the moderators of the internet forums approached were contacted and their consent gained for the proposed research. All of the focus groups took place within closed message boards which meant that participants formally registered with a dedicated research site (http://londonmetresearch.proboards.com) to gain access. This meant that access was restricted to those who were registered and approved by the author rather than being open to the public. However, more borderline personality disordered clients were registered with the online message areas, than actually posted, which meant that some people had registered with the closed board possibly with the intention of observing the discussions. These people are commonly referred to as 'lurkers' and it was not possible to do anything about this handful of people. It should be remembered that absolute confidentiality or anonymity can not be guaranteed on any website. Therefore, all participants used pseudonyms and were requested not to mention any person, or institution, by name, as an additional ethical safeguard. Online research reaches larger numbers of potential participants, at a relatively low cost to the researcher, and can guarantee the anonymity that may make candid responses to a sensitive topic much more likely. However, participants needed internet access in order to take part. Overall, Rodham and Gavin (2006), conclude that "providing the overarching principle of 'do no harm' is abided by...conducting research via the internet poses no more ethical dilemmas than when conducting research by more traditional means" (p. 96). It was clear that the benefits of conducting this research study online far outweighed the costs, which led to the development of this comprehensive online research study.

3.5 Two-Stage Procedure: Focus Groups and Q Sort

This section will detail the procedure and processes used in the current research study. This thesis involves a two stage research process whereby online focus groups were conducted followed by an online Q sort task. The purpose of these stages was to gather a range of borderline personality disordered clients' views about therapeutic boundaries, through online focus groups, and then provide data for statistical analysis, by utilising Q methodology, to reveal clients' attitude types about therapeutic boundaries. Stage one involved engaging clients with borderline personality disorder in focus groups, in order to generate statements for the subsequent Q sort. Stage two involved the Q sort process and statistical procedures used to analyse the data. This two-stage process, involving both qualitative and quantitative methodologies, adheres to the pluralistic position adopted throughout this study. Section 3.5.1 provides details of participant recruitment, 3.5.2 describes the procedures for conducting the focus groups, 3.5.3 details the development of the statements for Q sorting and 3.5.4 gives the procedure for Q sorting.

3.5.1 Selection of Participants for Focus Groups and Q Sorting

The current research was aimed specifically at people with the diagnosis of borderline personality disorder. Participants were selected, using purposive sampling, if they fulfilled the criteria of belonging to an internet chat forum for people with the diagnosis of borderline personality disorder. The inclusion criteria, expressed on the information pages of the research website, can be viewed in Appendix 4. It was important to maximise the range of participants' demographic characteristics, with the hope of generating a diverse range of views, so no exclusions were made on the grounds of age, geographical location and so forth. The total number of participants was not predetermined. The aim of the first stage of the research process was to conduct enough focus groups so that 'theoretical saturation' would be achieved reflecting the full diversity of opinions. Nineteen participants actively took part in the online focus groups and

twenty eight participants completed the following online Q sorting task. These research stages will be described in greater detail later in this chapter. Some people chose to take part in both stage one (focus group) and stage two (Q sort). Therefore, fourteen of the participants had taken part in both the online focus groups and the Q sorting stage. In Q methodology the P sample (participants completing the Q sort task) is normally smaller than the Q sample (Brouwer, 1999), and this was the case in this research thesis as the P sample equalled twenty eight participants and the Q sample equalled sixty statements.

Demographic characteristics were collected from participants as these were considered to be possibly relevant to the perspectives held by individuals. The intention was to explore the potential diversity of attitudes about therapeutic boundaries, which might be enhanced through recruiting participants from diverse backgrounds, so characteristics such as age, gender and work status were collected. See 'Appendix 5' for a screen shot of the online form used to collect participants' background information.

3.5.2 Stage 1: Focus Groups

Focus groups were utilised because they allowed for individual understandings and experiences to be presented and for the groups to then discuss and attempt to collectively make sense (Morgan and Spanish, 1984), of therapeutic boundaries.

3.5.2.1 Pilot Focus Group

Prior to collecting data, from the borderline personality disordered participants, a focus group was piloted. This pilot focus group was conducted with three participants to ensure that procedures were clear. Due to the potential difficulty of engaging an adequate number of clients with borderline personality disorder this focus group was conducted with three participants who did not have the diagnosis of borderline personality disorder. These participants were selected,

through purposive sampling, and were already known to me as friends. Therefore, this data was not included in the study's findings. The purpose of the pilot group was to ensure that the practical side of the internet focus groups functioned smoothly and to highlight any potential problems. This pilot group was invaluable because it demonstrated the need for the researcher to be constantly attending to the internet group for administrative reasons (e.g. 'accepting' people into the group, by emailing participants with forum joining instructions, after completion of their online demographics form) and prompting discussions. Egalitarian cooperation was encouraged during all focus groups, which involved collaboration, in order to encourage open and spontaneous discussions that might not happen during individual interviews (Stevens, 1996).

3.5.2.2 Focus Groups

Potential participants were invited to visit an internet link to a website for the current study through three internet based borderline personality disorder groups. A post was placed on the message boards for these groups which said a small amount about the research and included a hyperlink to further information on the research web pages. For potentially interested readers these web pages may be observed at www.codeland.co.uk/londonmetresearch. The aim of the research was outlined to participants before they decided whether, or not, to participate. It was stressed to participants that there were no right and wrong answers and the purpose of the focus groups was simply to gather their points of view about therapeutic boundaries. The research web pages contained background information about the study and a short questionnaire, with questions about demographics, which was automatically sent, by email, to Rebecca Boyle, upon completion. Willing participants completed the demographics questionnaire and a hyperlink was subsequently emailed to them with joining instructions, to a 'closed' (password required), online forum.

The online focus groups were conducted with a range of people until additional discussions did not generate significantly new views or ideas. Ideally focus groups should involve six to twelve participants (Stevens, 1996). The first focus group consisted of thirteen participants and the second and third groups both had three participants. It seems important to recognise that the size of these focus groups may have implications for the research. Three participants were present in the second and third groups and this is generally considered to be the minimum size for a focus group (Edmunds 1999). Group size may have influenced subjective measures regarding group interactions. For example, the larger the group the more vulnerable a person may feel infront of others. However, these variables have not been adequately researched, in relation to online focus groups, to date. It is difficult to know with any certainty the effect this may have had on the data. In the current study, participants were initially asked to consider their experience of therapeutic boundaries. This provided direction for the participants while eliciting information of relevance for this research study. The group was encouraged to self-manage but Morgan and Spanish (1984) identify that self-managed focus groups have the potential to stray from the topic or come to a halt. Therefore, the groups were monitored and facilitated more actively, when required.

Towards the end of these focus groups, although various personal examples of experiences of therapeutic boundaries were being described, views about boundaries in general were being increasingly reiterated. It was felt that no significantly new opinions were being generated, so the three groups were then allowed to run until the stated deadline on the research web pages, October 2008, and no new focus groups were established. The online focus groups were stopped after nineteen participants had taken part. All three focus groups were held simultaneously, but participants were only able to access their own online discussion board, due to password protection. Participants were free to take part in this activity at a time and place that was convenient for them, as the discussions were asynchronous, meaning that people did not need to be online

at the same time to take part. The final part of the focus group stage involved inviting participants to share their reflections upon having taken part in their focus group. A question was posted on the final day of the focus groups asking for participants' reflections about having taken part in the research. The transcriptions of the three focus groups can be found in 'Appendix 6.'

3.5.3 Statements

The statements that were selected for the Q sample are not facts but are opinions held by people about therapeutic boundaries. However, it is important that these be chosen in order to represent as wide a range as possible of opinions on the topic under investigation. The paragraphs below summarise the selection of the statements, for Q sorting, which can be observed in Appendix 7.

The Q sample is a collection of stimulus items, and in this study these were statements about therapeutic boundaries, which were presented to participants for rank ordering (McKeown and Thomas, 1988). For this study, forty one statements were obtained from the transcriptions of three focus groups with clients attracting the borderline personality disorder diagnosis. The focus group data was analysed by theme through a process called thematic analysis and resulted in forty-one statements that contributed toward the final Q sort. This type of analysis is highly inductive as themes emerge from the data and are not imposed upon it by the researcher. Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, and Gliksman, 1997), such as therapeutic boundaries in the current study. The emergent nature of thematic analysis was a key reason for its use in this study. The process involved the identification of themes through "careful reading and re-reading of the data" (Rice and Ezzy, 1999, p. 258) by the researcher. Thematic analysis is a form of pattern recognition within the data where emerging themes can be coded. The coding process involved the researcher recognizing an important moment in the data and encoding it (seeing

it as something) (Boyatzis, 1998) by writing the appropriate code on the transcript paper. A "good code" is one that captures the qualitative richness of the phenomenon (Boyatzis, 1998, p. 1). The researcher encoded the transcript data in order to identify and develop themes from the codes. Boyatzis defined a theme as "a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon" (p. 161). This process continued until the researcher was satisfied that no new themes were arising.

In thematic analysis, the data collection and analysis takes place simultaneously and in the current study the researcher also drew upon sources, such as internet commentaries and books about therapeutic boundaries, that were in addition to the transcripts. This was an important part of the analysis process because it helped to enhance and explain the emerging themes and enabled diverse viewpoints to be represented. Therefore, the forty-one statements from the focus groups were supplemented by nineteen further statements taken from available relevant literature, such as internet commentaries, books and newspaper articles. The aim of the selection process was to select statements that reflected the widest range of viewpoints, relating to therapeutic boundaries, while reducing the original concourse of statements to a minimal number of statements that would allow factors to show themselves. The nineteen statements from the literature enhanced the quality of the Q sort by offering additional viewpoints that were not represented during the focus group discussions. Donner (2001) acknowledges that drawing upon additional sources may assist the quality of the Q sort. Donner states that "there is no clear rule of thumb for the number of elements that should be included, but sorts with as few as twenty or as many as sixty items are possible." (p.27).

Initially, two hundred and seven statements were collected from all available sources, including the transcripts, and written on individual pieces of paper. The number of statements, from both the transcripts and additional sources, were

then reduced through removing the pieces of paper with obvious duplications. Next, the written statements were placed into piles that were concordant with the themes that had emerged from the thematic analysis of the focus groups. The most representative statements were then selected from each pile. Also, statements were occasionally reworded slightly in order to make them as concise as possible without losing meaning but with the intention of leaving them in participants' own words as much as possible. Overall, sixty statements were selected which is towards the maximum number that is generally considered manageable in Q methodology (Donner, 2001). The quantity was large enough for there to be enough statements for different factors to potentially emerge but small enough for participants to be able to remember the general content of the statements. However, it is important to note that due to the large number of possible combinations contained in a Q sort, the researcher is able to exert little influence over the factors that emerge through statement selection (Watson, McKenna, Cowman and Keady, 2008). Therefore, in a Q study it is the relationship between statements that it is focussed upon and Watson, McKenna, Cowman and Keady (2008) give the example that a simple ten item Q sort contains 1, 209 600 potentially unique sorts (p.323). The statements, which are listed in 'Appendix 7,' were randomly numbered and entered manually into a computer software programme called WebQ (Schmolck, 2002), and then published on the web pages of this research study. Completion of the online WebQ will be detailed later in this chapter. See 'Appendix 8' for an example of the WebQ programme.

3.5.4 Stage 2: Online Q Sorting

Q sorting of the statements by participants is the second major part of data collection in this study. Section 3.5.4.1 outlines the piloting of this stage, and Section 3.5.4.2 details the administration of the Q sorting process as used in this research

3.5.4.1 Pilot Q Sort Process

The Q sort process was piloted prior to collecting data from borderline personality disordered participants. The second major part of data collection in this study was the Q sorting of the Q sample (statements). Q sorting is the process whereby participants present their perspective on a topic, such as therapeutic boundaries, by sorting the Q sample in rank order. Prior to inviting borderline personality disordered individuals to complete the online Q sorting, trial runs were conducted with individuals who were unfamiliar with the Q sort process. This involved inviting three friends to participate in completing the Q sort to check that the instructions were comprehensible and to check the clarity of the statements. As a result of this trial the step-by-step instructions for participants were substantially revised, in order to make the Q sorting process clearer for participants. These instructions can be found in Appendix 9.

3.5.4.2 Q Sorting

After the trial Q sorting had been completed, and alterations made to the instructions, the final version of the Q sort was published on the research study website. Every participant initially invited to take part through an internet forum, for borderline personality disorder, provided demographic information on age, gender, education and so forth when they clicked the web-link to participate in the research study. This data was used to describe participants whose Q sorts were most highly correlated with each factor. Those who participated in the Q sort process were free to complete the activity at a convenient time and place. Each participant was asked, in clear and simple wording, to rank the set of Q statements into a 'forced quasi-normal distribution.' This means that participants followed a step-by-step set of instructions asking them to sort and rank the 60 statements along a scale of 'most agree' to 'most disagree' (+6 to -6). The

distribution of Q sample statements is shown in Table 1 and the associated layout can be viewed in Appendix 10.

Table 1. Distribution of Q Sample Statements

	Most Disagree												Most Agree
Value	-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
Number of Statements	3	4	4	5	5	6	6	6	5	5	4	4	3

There was a limited number of statements that could be placed into each score category and this meant that participants were forced to make a choice about the order of importance of statements to them. In particular, this was true of extreme scores (-6 and +6) as the distribution restricts participants to put fewer statements about which they feel strongly.

Once participants were satisfied that the distribution adequately reflected their viewpoint they were requested to click on the online 'submit' button. This action automatically generated an email that was sent to the researcher's email account, with the participants Q sorting results attached (11). Participants were required to 'confirm' that they wished to send this email, with their results attached, and in order to help with the interpretation of factors additional qualitative information was gathered from participants at this stage. This qualitative information, comprising participants' comments, could be added to the automatically generated email, which included the individuals' Q sort results, before they clicked to confirm sending it. This qualitative information was saved by the researcher in order to possibly enhance the evidence for emergent factors. Participants were asked "Would you like to provide any additional information regarding your choice of statements," "Would you like to offer any further comments about statements that you most agreed/disagreed with?" and "Do you have any further comments or reflections about taking part in this research?"

Typically, participants expressed their appreciation that research was being undertaken about borderline personality disorder. Additionally, two participants expressed frustration regarding the forced choice Q sort methodology because they had found it difficult to rank all items accurately for themselves (See Appendix 11 for an example email generated after Q sort completion).

3.5.4.3 Socio-Demographic Information

As noted, participants who were willing to take part in the Q sort task were asked to provide socio-demographic information on age, gender, nationality, education and occupation ('Appendix 12'). This data was used to describe participants whose Q sorts were most highly correlated with each factor. Additionally, participants were encouraged to provide reasons for their choice of statements that they most agreed, or most disagreed with, and space was provided for participants to make any further comments they wished.

3.6 Ethics

Ethical implications of conducting online research has been considered in section 3.4.1. However, sections 3.6.1, 3.6.2, 3.6.3, 3.6.4 and 3.6.5 explore the wider ethical aspects of this study in order to demonstrate the rigorous planning that ensured this research was ethically sound.

3.6.1 Informed Consent

Every participant was directed, through an internet link, to a web-page describing the aims of the study and the processes to be undertaken. If participants wished to take part, after reading the information about the study, consent was obtained through participants clicking upon "I AGREE" at the bottom of the web-page. By clicking the "I AGREE" hyperlink they were directed to a short questionnaire regarding background information, such as age and gender. Therefore, informed

consent was obtained from all participants before focus groups and Q sorting commenced.

3.6.2 Confidentiality

Participants were advised, in the written 'boundaries' of the focus groups ('Appendix 13'), that they should not reveal any personal information that could identify them, other people or institutions. All information gathered during the research project was anonymised and names and/or web-pseudonyms were removed from the transcripts. For the purposes of reporting research findings, participants were given a 'false' name. Also, conducting this research study over the internet minimised possible stress a participant might have had about identification as a respondent.

3.6.3 Participant Distress

The participants were informed, through the information available on the research website, that should they experience any uncomfortable emotions during their focus group experiences and/or Q sorting, that they could contact the main researcher for further sources of emotional support. It was made explicit that participants could make contact, by University email, if they had any further queries and/or concerns about the research study. Conversely, an incidental benefit of taking part in this research was that participants may have gained from their involvement in the study by the opportunity given to share their experiences and understandings and to influence other clients' and clinicians' ideas about therapeutic boundaries.

3.6.4 Ethical and Research Approval

Following the submission of a research proposal, to the research supervisory team at London Metropolitan University, ethical approval was obtained from the Research Ethics Review Panel at London Metropolitan University. These

processes offered opportunities for further reflecting upon online research procedures such as the complexities regarding participant consent, confidentiality and debriefing through online media.

3.6.5 Transparency

The context in which the focus groups and Q sorting occurred was considered throughout the research process. It was made explicit, on the research web-pages, that the study was part of a Doctorate in Counselling Psychology. In the initial invitation, for participants, posted on the three borderline personality disorder websites, it was clear that the main researcher had experience of working in the personality disorder field and was keen to promote awareness of client perspectives. There was no compensation or material benefit to respondents from participation in this study. Participants were informed that all research data would be kept secure in a locked location for five years, and that after five years, the materials would be kept secure, or destroyed if no longer needed. The following section of this chapter moves away from the stages of data generation and focuses upon statistical analysis of the Q sorts.

3.7 Statistical Analysis

To provide an overall view of the people who participated in this study, data were initially analysed using descriptive statistics. To this end, demographic information was inputted into SPSS version seventeen (Statistical Package for the Social Sciences), a computer package designed to analyse statistical data.

The data from the participants' Q sorts were subjected to Q factor analysis in order to systematically reduce the data down to a small number of factors representing statistically significant patterns of relationships among the Q sorts. In this study the Q sorts were correlated and factor analysed using the software package PQMethod version 2.11 (Schmolck and Atkinson, 2002). PQMethod is a freeware statistical programme that fulfils the analysis requirements of Q

methodology. This programme allows the array of statements, interpreted as numbers, to be entered and analysed. The data from all of the Q sorts were entered manually into the programme. The size and shape of the curve, as depicted in the Q sort template above, was included as input. Individual Q sorts were entered and data analysis, using PQMethod, began by producing a correlation matrix showing the correlation coefficients between each Q sort.

Once the correlation coefficients were determined for the pairings of all Q sorts the extraction of factors was then possible. Two factor analytic techniques, centroid factor analysis and principle component analysis, can be employed in Q methodology and there is little difference in the factor structures produced by these two techniques (McKeown and Thomas, 1988). Principle component analysis produces eigenvalues, which are expressions of how much a particular factor contributes to the total variance (Donner, 2001). This factor analytic technique was employed to identify the number of natural groupings in the Q sort. Eigenvalues were calculated based on the sum of a factor's squared loadings and values greater than 1.0 were considered to be significant. This identified the number of factors to include in the initial factor rotation. The use of eigenvalues can be problematic in determining the number of factors to rotate, as the more factors that are rotated the more dispersed they become. The PQMethod software allowed for factors to be rotated judgementally, or, analytically, using orthogonal rotation (Varimax) method (Schmlock and Atkinson, 2002), and helped to identify simple structure (McKeown and Thomas, 1988). Judgemental rotation was not necessary as no individual participant held special interest. Varimax rotation maximised the variance between each of the factors (Donner, 2001), and helped further define the factor structure.

Following on from the rotation, factor loadings were reproduced (where loadings of 1.0 or -1.0 indicate perfect agreement). For the purpose of analysis, factor loadings greater than 0.6 were considered strong. Loadings at 0.8 or greater were considered very strong (Donner, 2001). Data were also analysed for cross-

loadings, which is where an individual loaded strongly (greater than 0.6) onto one or more factors. When cross-loadings occurred the number of factors rotated was increased and the data re-analysed. If cross loadings continued consideration was given to excluding a participant from the analysis in order to produce a cleaner factor structure minimising the production of excess subgroups and the number of consensus statements in the data, as per Donner (2001). How participants loaded onto a particular factor was determined through the process of pre-flagging. This is an automatic process in PQMethod that identifies participants as loading cleanly onto a particular factor. In addition, the data was assessed manually to decide whether adjustments to pre-flagging were required.

After the factor rotation, PQMethod generates twelve output items during the QANALYZE process. Table 2 offers a summary of the items that are useful for the interpretation of the data in this research study. Firstly, data were interpreted by considering the Factor Q-sort values that offered an overview of each group's perspective on the issues of usefulness and accessibility. Normalised factor scores were considered, so that items ranked as more or less important could be identified, in order to get a sense of the relative priorities of groups. Lastly, distinguishing and consensus statements in the sort for each group were analysed to determine distinguishing characteristics for the groups.

Table 2. PQMethod Data Analysis Items (Schmolck, 2002)

Item	Description
Correlation matrix	Shows correlation between individual pairs of Q sorts.
Unrotated factor matrix	Produces factor loadings before rotation. For principal component analysis, eight factors are produced with associated eigenvalues and the percentage variance for each factor.
Rotated factor matrix	Produces item loadings and percent variance explained for the number of factors selected for rotation.
Correlations between each factor	Demonstrates how similar each factor is to other factors.
Normalised factor scores	List all statements for each factor in descending order of ranked importance. Useful in determining the perspective of participants who load on to a particular factor. The Z score shows how far from the overall mean (measured in standard deviations) each item is for the group.
Array of differences between factors	Allows for per-item comparisons between each factor.
Factor Q sort values	Z scores are translated back into the original scale for the sort. Data is presented in order of statement number, then by degree of agreement between groups.
Factor characteristics	Reports the number of defining variables that are statistically distinct from other groups and other indexes of how well the factor holds together.
Distinguishing characteristics	For each factor, highlights contention statements that participants have ranked significantly differently from other subgroups. Helps to define the key differences among subgroups.
Consensus statements	These items do not distinguish between any pair of subgroups.

3.8 Answering the Research Questions

It is important to consider how it was hoped the data generated from this study would answer the questions posed. Therefore, this section outlines the questions that were stated in the Introduction chapter and how the elements of the research design intended to answer them. The priority is to develop an understanding of borderline personality disordered individuals' perspectives on therapeutic boundaries. The secondary questions complement the understanding of this phenomenon of interest.

1. How do borderline personality disordered clients understand therapeutic boundaries?

It was hoped that the data generated through focus groups, and a literature search, would indicate how people attracting the diagnosis of borderline personality disorder understand therapeutic boundaries. A Q sorting task, created as a result of focus groups and literature search and completed by people attracting the borderline personality disorder diagnosis, was designed to enable patterns of attitude types to emerge from the data. It was anticipated that this would serve to compare and contrast people's attitude types, regarding therapeutic boundaries, with the perspectives from the initial focus groups. It was planned that quotes from the initial focus groups, and subsequent Q methodology written feedback, would then be utilised to corroborate the findings from the Q sorting task in order to enhance the rigour of this research study. It is acknowledged that this may sound like a circular methodology. However, the Q sorting was a reductionistic technique and it was felt that additional quotes would enable key themes to be elaborated upon and clearly displayed for the reader.

2. What experience do borderline personality disordered clients have of therapeutic boundaries?

It was anticipated that the focus groups would offer a substantial insight into clients' experiences of therapeutic boundaries due to the in-depth nature of this research procedure. Again, both stages of the research, focus groups and Q sorting, were designed to enable observation of patterns of clients' attitudes, regarding experiences of therapeutic boundaries, to be observed.

3. Do borderline personality disordered clients report positive or negative perspectives about therapeutic boundaries?

The focus groups were primarily intended to answer this question. It was planned that the data, from the focus groups would be analysed in order to ascertain whether clients disclosed positive or negative perspectives about therapeutic boundaries, and that these data would then be used to complement the information gathered during the other strands of this study.

3.9 Summary

This chapter has outlined the principle elements of the research design and methodological procedures that were adopted for this study. In this chapter a description was offered of the practical steps involved in the collection and analysis of data, for this Q methodological study, about borderline personality disordered clients' understanding and experiences of therapeutic boundaries. Details, and interpretation, of the resultant data from this research study is presented in chapter 4.

Chapter 4

Presentation of Findings

"When people work together on not totally dispensable fences, they might just build bridges across them and learn to tolerate each other in a congenial humane way" (p.78)

Mieder (2004)

4.1 Introduction

This chapter presents the findings from the research study described in the previous chapter and details the interpretation of the factors identified through statistical analysis. As described in the previous chapter, the data generation in this thesis comprised two stages, involving focus groups and a Q sort task. Therefore, this chapter firstly reports the research findings from the focus groups and then depicts the findings from the Q sort task. However, these two distinct steps are partly integrated in section 4.4, through using the qualitative data from the focus groups to corroborate the Q sort findings. It is crucial to highlight that it is possible that not all factors, or discourses, that may exist about therapeutic boundaries have been identified in this study. Nonetheless, it is important to stress that the factors described in this chapter do represent distinct types of attitudes, about therapeutic boundaries, which seem to prevail among clients attracting the borderline personality disorder diagnosis. Throughout this chapter the style of presentation attempts to offer the data, to the reader, in a 'reader-friendly' manner. Therefore, where possible, and when relevant, visual chart representations of quantitative data have been presented. Also, the qualitative findings have been provided in a narrative format that directly relates to the views expressed by participants. In order to give readers an authentic sense of the participants in this study verbatim quotes have been included. Finally, a brief conclusion gathers together the main findings from each of the sections.

4.2 Stage 1: Focus Groups

As described in the Methodology chapter, stage one of this research study involved 19 borderline personality disordered individuals participating in three online focus groups. The three focus groups offered an introductory overview of participants' experiences, and understandings, of therapeutic boundaries. Therefore, the data from stage one of the research began to address research questions 1: How do borderline personality disordered clients understand therapeutic boundaries? and 2: What experience do borderline personality disordered clients have of therapeutic boundaries? However, the qualitative data from the focus groups also demonstrated the extreme variety of viewpoints regarding therapeutic boundaries. This rich data seemed positive, for the aims of the current study, as these varied and divergent perspectives enabled the emergence of many differing statements for the stage two Q sort.

It should be noted that all of the participants described in this study have been given pseudonyms, to protect their anonymity. Pseudonyms, such as 'wood' and 'brick' have been adopted because they are building materials that often mark physical boundaries. The use of these asexual names further protects the anonymity of participants. It seems notable, at this stage, that a number of key themes emerged from the analysis of the focus groups. The main themes were 'safety,' 'power,' and 'boundary thickness.' For example, the following three participants explicitly addressed issues relating to safety, and therapeutic boundaries, but had differing views on the subject. Overall, 'Rock' thought that boundaries meant that a safe relationship could develop between therapist and client. Timber seemed to agree with Rock's opinion and clearly expressed that both therapist and client need safety. However, Timber believed that it was the client who was more in need of this safety due to perceived vulnerability. Finally, Vinyl stated a differing view about safety by saying that clients would be safe with therapists who do not have boundaries.

"I think boundaries in therapeutic relationships are the limits that allow a safe connection between the therapist and the client." (Rock, Group 2, line 5, p.267)

"The safety is for both service user and counsellor but the service user is the vulnerable one who needs protecting." (Timber, Group 2, line 11, p.267)

> "I have to admit I do find strict boundaries very hard to deal with as I think I would feel safe enough with a therapist who had no boundaries." (Vinyl, Group 1, line 148, p.247)

Another theme that emerged from the data was power and the following quotes have been selected to portray participants' views. Tree talks about feeling empowered through therapy. She/he stated the importance of the therapist guiding the therapy with appropriate boundaries. However, Thatch describes the desire for power and control over therapists through sexual contact.

> "So much of my past had felt out of control for me but, after a while, it also felt empowering that I could thumb my nose at those people in my past who had caused me so much pain and anguish, and that they would no longer have power over me...I am getting stronger and more able to cope knowing that my therapist is there with me, with appropriate boundaries, to help and guide me, has helped me to progress in ways that I never thought would be possible." (Tree, Group 1, line 648, p.264)

"I too feel powerful when I flirt with men. It would be great to have a sexual relationship with my therapist. It's like a sense of being in control." (Thatch, Group 1, line 71, p.245)

The final key theme was boundary thickness and this concept seemed to encompass the meanings that emerged from the data and further accentuate the variety of perspectives held by the participants in this study. The following three excerpts demonstrate this variety and further examples can be located in Appendix 6. Wire appears to be advocating for thick and firm boundaries which are identical for each client. Oak seems to believe that boundaries could be thinner and more flexible. Finally, Thatch states a desire for no boundaries in therapy:

> "They (boundaries) should be identical for every single client that a therapist sees." (Wire, Group 1, line 27, p.243)

> "I think it is good to have the flexibility to bend the rules as necessity or compassion dictates." (Oak, Group 3, line 10, p.272)

> "There should not be any boundaries in therapy because I have problems being told, by someone else, what I can do." (Thatch, Group 1, line 533, p.260)

In addition, the third research question was addressed at this stage in the study: Do borderline personality disordered clients report positive or negative perspectives about therapeutic boundaries? Thematic analysis of the focus groups revealed that participants disclosed a similar number of positive and negative views, regarding therapeutic boundaries. However, the exact number of distinct positive and negative perspectives has not been included as examples tended to describe situations that were perceived as both positive and negative in nature. This represents the complexity of the multi-layered topic of boundaries and how it would be misleading to reduce experiences to either positive or negative views. For example, a therapist maintaining a boundary could be perceived as negative in the short-term but beneficial and positive in the longer-term. The following participants differentiated between short-term and long-term

perspectives. Oak initially thought that being given a present by a therapist was positive (short-term) but this view changed to a more negative perception over time (long-term). Conversely, at the beginning of therapy Tree thought that it was negative that his/her therapist did not soothe through giving hugs (short-term). However, Treee's perspective altered over time so that s/he can see the benefit of not being hugged and working through emotional pain (longer-term):

"I was once given a present from my therapist when I was in rehab which everyone got. It was nice at the time but soon became pretty meaningless." (Oak, Group 3, line 83, p.274)

"I found this tough as I sometimes wanted another person to comfort me by putting an arm round me. Over time I have begun to see that my therapist is not there to take away my pain but help me work through my stuff. I think it would not help me in the longer term if she were to hug me." (Tree, Group 1, line 43, p. 244)

The resultant Q sort purposefully reflected a variety of both these positive and negative understandings and experiences of therapeutic boundaries in order to offer a relatively balanced view. The next section will describe this further.

Overall, the focus groups outlined above informed the Q sort that is described in the following section of this chapter. Relevant statements about therapeutic boundaries were extracted, from the focus group transcripts, through thematic analysis, and partly contributed towards the content of the final Q sort. Transcripts from these focus groups can be viewed in Appendix 6. For this study, forty one statements were obtained from the transcriptions of three focus groups with clients attracting the borderline personality disorder diagnosis and these statements can be viewed in Appendix 7. These statements were supplemented by nineteen further statements taken from available relevant literature, such as internet commentaries, books and newspaper articles.

Overall, sixty statements were selected which is towards the maximum number that is generally considered manageable in Q methodology. Therefore, the quantity was large enough for there to be sufficient statements for different factors to potentially emerge, but small enough for participants to be able to remember the general content of the statements. The statements, which are listed in Appendix 7, were randomly numbered.

4.3 Stage 2: Q Sort

The findings from the Q sort stage of this study will now be presented. This section begins with a brief overview of the data that has been collected and exemplifies the processes that were described in the Methodology and Research Procedures chapters of this thesis. A large proportion of the working content of this process can be found in the Appendices of this thesis, as this section provides a summary of the key elements that have been undertaken. Following this, the factors that emerged from the analytic process are described and interpreted. The factors that emerged are corroborated by participants' comments that were made during the feedback stages of the Q sorting methodology. These comments are further enhanced by selected comments that were made during the stage one focus groups. The reason for displaying the results in this manner is to provide the reader with grounded examples of the concepts being described. A total of twenty-eight borderline personality disordered participants were involved in stage two, of this research study. A detailed overview of the Q sort participants' backgrounds is displayed in Appendix 12 and observations of demographics that seemed interesting are further discussed in the Discussion chapter.

4.3.1 Statistical Analysis

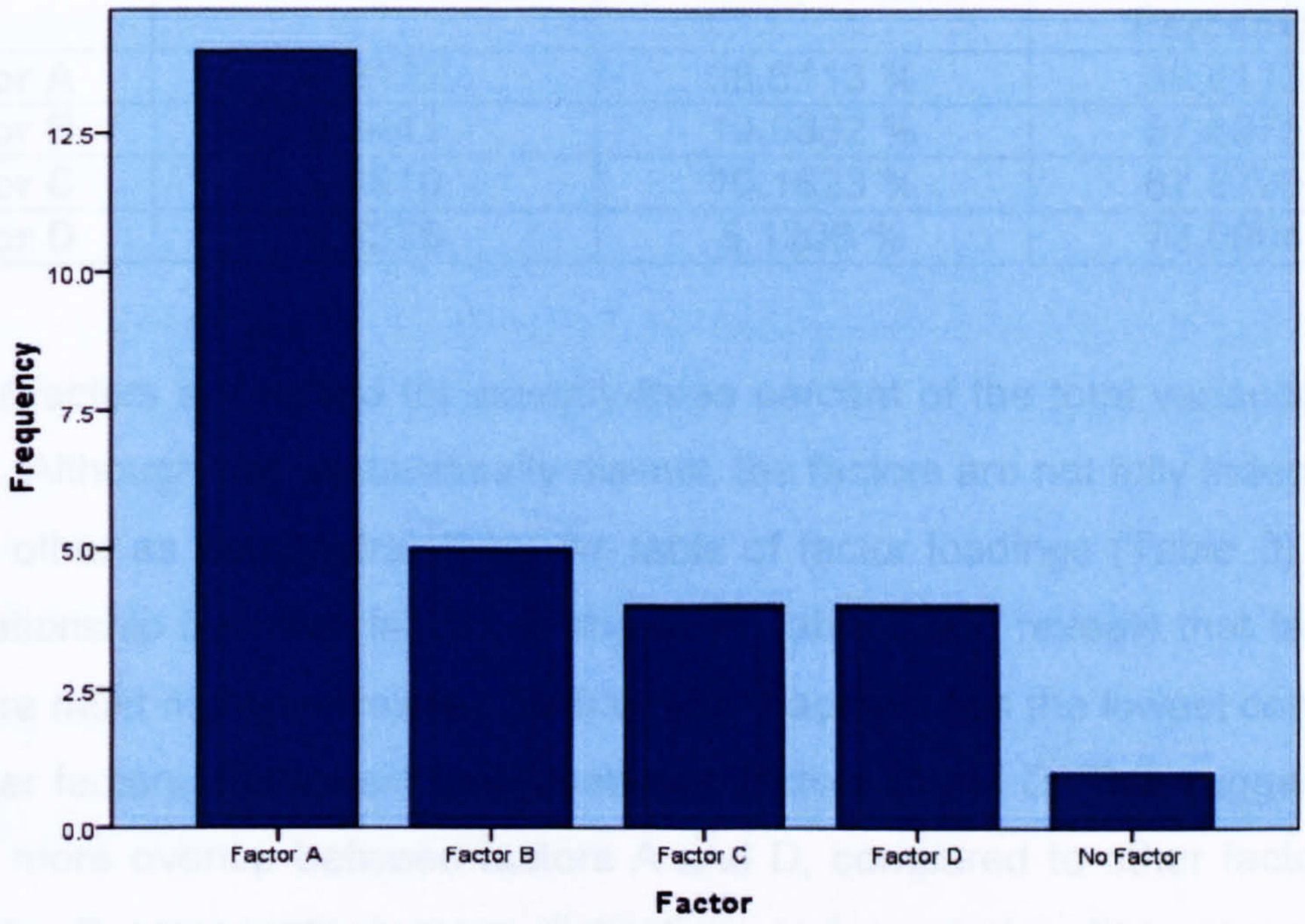
The twenty-eight completed Q-sorts were analysed, using the aid of an established Q methodology computer software programme called PQMethod version 2.11 Schmolck and Atkinson, 2002), as described in the previous

chapter. In comparison to the more commonly used R methodology, in Q methodology the factor analysis of the data matrix is performed by rows, rather than columns, so that participants, rather than traits, constitute the variables. Therefore, Q sorts which are highly related cluster together and will emerge as a factor. Q sorts which are unrelated will possibly load onto other factors, or fail to load onto a factor. Factor analysis (principal components) was conducted and this process resulted in the identification of four factors from the twenty-eight Q sorts. The correlation of each participant's Q sort, to the extracted four factors, is given by 'factor loadings.' For this research, theoretically significant correlations are those above 0.6 and are marked by an X in Table 3. A table of factor loadings for this study (as produced by PQMethod) is given in Table 3 and shows that fourteen participants' Q sorts loaded on Factor A, five on Factor B, four on Factor C and four on Factor D. In addition, Figure 1 visually displays the number of participants who loaded onto each factor. One Q sort was confounded, as the data loaded above 0.6 on two factors, and thus found to be 'non significant,' and this was participant thirteen's Q sort.

Table 3. Factor Loadings for the 28 Q sorts (X represents non-confounded factor loadings greater than 0.6)

Participant	Factor Loadings			
	A	B	C	D
1 Stone	0.0667	0.8998**X**	0.0762	-0.0432
2 Clay	0.5169	-0.1220	-0.1913	0.6843**X**
3 Glass	0.6144**X**	0.5267	-0.0082	-0.0312
4 Metal	0.0892	0.8867**X**	0.0948	-0.1868
5 Wood	0.6584**X**	-0.3075	-0.0182	0.5019
6 Rock	0.7035**X**	0.0789	0.0132	0.3265
7 Thatch	0.1007	-0.0492	-0.9251**X**	0.0471
8 Block	0.7140**X**	-0.0971	0.0197	0.4972
9 Cement	0.8309**X**	-0.1105	-0.0330	0.2645
10 Plaster	-0.1209	0.8562**X**	-0.1371	0.1287
11 Timber	0.7356**X**	0.0588	0.1101	0.5360
12 Terracotta	0.6264**X**	0.1307	0.0602	0.2132
13 Fibreglass	-0.2197	0.6276	0.0466	-0.6092
14 Oak	0.7048**X**	0.0461	-0.0209	0.1679
15 Rubber	0.0302	0.8988**X**	0.0182	-0.1724
16 Plywood	0.8960**X**	-0.0946	-0.1076	-0.0944
17 Foam	0.6899**X**	-0.0475	-0.0135	0.5457
18 Aluminium	0.8873**X**	-0.1221	-0.0802	-0.0746
19 Laminate	-0.0956	0.3912	0.0672	-0.6454**X**
20 Pine	0.6941**X**	0.2874	-0.1147	0.2887
21 Mortar	0.0410	0.0479	0.8388**X**	-0.0712
22 Vinyl	0.0277	0.8408**X**	0.1391	-0.1887
23 Iron	0.5002	-0.0583	-0.1145	0.7333**X**
24 Wattle	-0.0136	0.1333	0.9229**X**	0.0281
25 Steel	0.8267**X**	-0.0061	-0.0063	0.1225
26 Polystyrene	0.0707	0.0434	-0.6209**X**	0.0702
27 Plastic	0.6451**X**	0.1312	-0.1480	0.3260
28 Ceramic	0.5980	-0.1990	-0.0221	0.6318**X**

Figure 1. Frequency of Participants Loading onto Each Factor



The results, shown in Table 3 and Figure 1 above, indicated that the original twenty-eight sets of rankings could be reduced to four independent orderings. Therefore, there were four different accounts of therapeutic boundaries reported by the participants in this research study. These accounts will be discussed further in the following sections of this chapter. Once extracted, these factors were rotated to simple structure (varimax rotation, eigenvalue 1.00 or over), in order to provide the 'best fit' with the data, and each factor was given a descriptive title. This means that four factors had eigenvalues greater than 1.00 and were defined by more than one participant so were deemed interpretable. These four factors accounted for seventy-three percent of the variance in the data and Table 4 displays a breakdown of these values.

Table 4. Eigenvalues Associated with the Four Factors

	Eigenvalues	Percentage	Cumulative Percentage
Factor A	10.8112	38.6113 %	38.6113 %
Factor B	5.3441	19.0862 %	57.6975 %
Factor C	2.8510	10.1823 %	67.8799 %
Factor D	1.4338	5.1206 %	73.0004 %

The four factors accounted for seventy-three percent of the total variance in the Q sorts. Although this is statistically distinct, the factors are not fully independent of each other as demonstrated by the table of factor loadings (Table 3) above. The relationship between factors is shown in Table 5.and reveals that factors A and D are most highly correlated (R=0.6875). Factor B has the lowest correlation with other factors, the lowest being between factors B and D. This suggests that there is more overlap between factors A and D, compared to other factors, but that factor B represents a more distinctive, and separate, discourse. These relationships will be discussed further in the next sections and in the Discussion chapter of this thesis.

Table 5. Factor Correlations

Factor	A	B	C	D
A	1.0000	-0.0068	-0.0962	0.6875
B	-0.0068	1.0000	0.1261	-0.2780
C	-0.0962	0.1261	1.0000	-0.1825
D	0.6875	-0.2780	-0.1825	1.0000

4.3.1.1 Interpretation of Factors

The software package PQMethod produces a table of Z scores but it is more useful to present the results in terms of factor scores. This is because a table of the factor scores allows for quick comparison of the rankings of each statement on the factors. For each of the four interpretable factors a weighted average

array was calculated from the Q sorts that significantly loaded on that factor. Table 6 shows the ranking assigned to each of the sixty statements in each 'factor exemplifying' Q sort. Therefore, columns A, B, C and D display the comparative rankings of statements which characterise each factor. For example, reading row one, it can be observed that factors C and D strongly disagreed (-6 = strong disagreement and +6 = strong agreement) with the statement "I would not be bothered if my therapist had chatted about me with others (e.g. friends/family)." See Table 6 for full details of factor scores for each statement.

Table 6. Item Concourse and By-Factor Ratings of the Merged Q-Sorts

Concourse Statements n = 60	**Factors n = 4**			
	A	**B**	**C**	**D**
1. I would not be bothered if my therapist had chatted about me with others (e.g. friends/family).	**-1**	**0**	**-6**	**-6**
2. My therapist should never contact me by telephone, text message, email etc, outside of our therapy sessions.	**0**	**-3**	**-6**	**-1**
3. It is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy.	**5**	**1**	**-5**	**3**
4. I could not work with a therapist who showed no emotion at all.	**5**	**5**	**-4**	**1**
5. The rules of therapy must be spoken about during the first session and then must never change.	**-1**	**-3**	**-2**	**-1**
6. If I bumped into my therapist in the street I would want them to ignore me.	**-3**	**-5**	**-1**	**3**
7. It would never be acceptable for my therapist to drive me home.	**1**	**-3**	**0**	**0**
8. I think it would be great if my therapist told me lots of personal information about themself.	**-2**	**2**	**1**	**-5**

9. I think it would really improve the therapeutic relationship if my therapist did not have boundaries. **-6 1 5 -3**

10. I think it is good for a therapist to say that they care about their client and this feels ok for me. **6 4 5 -4**

11. It would be great to have a sexual relationship with my therapist. **-6 0 4 -6**

12. My therapist has rung/emailed me a few times over the years when I have been going through crisis times. It felt nice to know s/he was thinking of me. **2 6 6 3**

13. If a therapist doesn't get yelled at, during their career, they probably aren't having a 'close' relationship with their client. However, that does not mean therapists are immune so it is important to be able to apologise when appropriate. **1 5 6 1**

14. Boundaries must be identical for every single client that a therapist sees. **-1 -4 5 2**

15. I would not mind if my therapist swore and used obscene language, towards me, during our sessions. **-5 -2 4 -4**

16. I would be happy to meet my therapist in the local coffee shop for my next session. **-2 2 3 -4**

17. I want my therapist to come to all of my birthday parties and other social events. **-2 2 2 -2**

18. Once some level of comfort is reached in therapy, I think it's good to have the flexibility to bend the rules as necessity or compassion dictates. **5 1 1 2**

19. On one occasion my therapist cried during my session which felt acceptable. This made me realise that we are all human and can feel hurt or moved by what others say. **1 5 0 -2**

20. Every client has different needs in relation to therapeutic boundaries. **5 -1 -1 1**

21. It is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions. **2 -6 -4 5**

22. I need to entirely decide what the rules are in my therapy sessions.

-1 1 -4 -1

23. My therapist has shared bits about her (his) life outside work and I am not comfortable with this. **0 -5 -5 0**

24. I think it is fine for therapists to wear what they are most comfortable in, but it is not right for them to wear jeans or provocative clothes. **2 -1 -6 2**

25. I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person. **2 2 -5 6**

26. If I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat. **-1 3 -2 -5**

27. I think my therapist would 'burn out' and not be able to continue seeing me if there weren't some boundaries. **4 -1 -2 6**

28. I think it would be fine never knowing how long my therapy sessions are going to last. (e.g. anything between 10 minutes and three hours).
-4 -2 -1 -3

29. I just find rigid boundaries a little too 'official' and 'professional' but I guess they are there for a reason. I believe there should be a degree of flexibility even if it is small. **3 3 0 1**

30. I would not be able to continue therapy if my therapist could not guarantee my confidentiality. **6 0 1 4**

31. I am comfortable with my therapist hugging me every time I feel upset.
-4 3 3 -3

32. I would never feel comfortable inviting my therapist to a social event, even if it were a special occasion e.g. wedding. **3 -3 4 -2**

33. It would be ok for my therapist to give me a ride home if I were walking home in a thunderstorm and s/he drove past me. **3 2 5 -1**

34. There should not be any boundaries in therapy because I have problems being told, by someone else, what I can do. **-5 -3 6 -5**

35. If my therapist returned my sexual flirtation they would immediately lose all credibility to me. **6 -4 4 6**

36. I do like to push time boundaries a little with my therapist and add a couple of extra minutes to my session. If it works then I feel like they care more and they are more sincere. **0 6 1 0**

37. I want my therapist to address me as "Ms/Mr (Surname)" rather than calling me by my first name. **-5 -5 2 -1**

38. It is important to negotiate what is and is not acceptable in therapy. However, I believe my therapist has the ultimate responsibility when I have my 'moments.' **3 -1 0 5**

39. If my therapist showed lots of emotion, during every session (e.g. crying), I would really like this. **-5 4 0 -3**

40. It feels empowering that I can be responsible for taking care of myself, through negotiating boundaries, after much of my past had felt out of my control. **4 4 0 3**

41. Every therapy session should be exactly the same length of time e.g. 50 minutes. **1 -4 -2 2**

42. If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended. **-3 6 -5 -2**

43. Maintaining boundaries is totally down to the therapist. **-1 0 -4 0**

44. I like firm boundaries because when I know where I stand with my therapist I have less stress and anxiety. **4 -6 -3 5**

45. I have been told that other clients have exchanged small gifts with their therapists. I feel that this is wholly inappropriate. **0 -2 -3 0**

46. I would be really pleased if my therapist accepted expensive gifts from me as it would prove that we had a special relationship. **-4 1 -1 -2**

47. I think having a little bit of information about my therapist's life has made me feel more at ease during sessions. **3 5 -3 4**

48. I think it could be really dangerous if a therapist does not have very firm boundaries. **4 -6 1 5**

49. It would be acceptable for my therapist to give me a ride home after every session. **-4 3 2 -5**

50. Once a line is crossed, where I feel vulnerable, I usually disappear from therapy. I cancel, or don't set up another appointment, and never look back.

	1	**-2**	**2**	**3**
51. My last therapist let me come in once without paying for the session. That meant a lot to me because I felt she actually did care.	**0**	**1**	**3**	**2**
52. I would only be comfortable inviting my therapist to very special and significant personal event like my own wedding.	**0**	**0**	**3**	**1**
53. It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt.	**-3**	**3**	**3**	**-1**
54. I want my therapist to be inconsistent with me as it keeps me 'on my toes.'	**-3**	**-1**	**2**	**-4**
55. If I saw my therapist in town I would want them to acknowledge me, but would like to keep a distance.	**2**	**-2**	**1**	**4**
56. I don't think anyone should have to pay for therapy (including NHS covering therapy costs) as the therapist should morally want to be there rather than seeking payment.	**-2**	**-1**	**-1**	**0**
57. I would feel safe with a therapist who had no boundaries.	**-6**	**0**	**-3**	**-6**
58. I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed.	**-2**	**-4**	**-2**	**4**
59. I would hate it if my therapist cried in front of me and would never go back to see them.	**1**	**-5**	**-2**	**1**
60. I welcome my therapist contacting me, by phone or email, as much as possible between sessions.	**-3**	**4**	**-3**	**-3**

4.4 Extraction of Factors

The following sections outline and describe the four factors that were extracted through Q sort analysis. These factors will be interpreted using the distinguishing statements, emerging from each factor, alongside comments made by participants whose Q sorts are most highly correlated with each discourse (both in the focus groups and as recorded on their Q sort feedback forms).

4.4.1 Factor A – "HEDGE"

Factor A was found to have the largest number of participants' Q sorts loading on it. Fourteen participants' Q sorts defined this factor (Glass, Wood, Rock, Block, Cement, Timber, Terracotta, Oak, Plywood, Foam, Aluminium, Pine, Steel, Plastic). The discourse that emerged from Factor A will most closely resemble the understandings, and experiences, of participants whose Q sorts gained high loadings on Factor A. The statements which distinguished Factor A from the other three factors are listed in Table 7 below. The statements which received the most positive and the most negative scores for Factor A are of particular interest. For example, participants loading onto Factor A were in highest agreement with the three statements "It is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy", "Every client has different needs in relation to therapeutic boundaries" and "Once some level of comfort is reached in therapy, I think it's good to have the flexibility to bend the rules as necessity or compassion dictates." However, these participants strongly disagreed with the statements "I think it would really improve the therapeutic relationship if my therapist did not have boundaries" and "It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt."

Table 7. Distinguishing Statements for Factor A (P ≤.05 ; Asterisk (*) Indicates Significance at P ≤.01). Both the Factor Q-Sort Value and the Normalised Score are Shown).

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3. It is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy. (Rank = 5) **1.43***

20. Every client has different needs in relation to therapeutic boundaries. (Rank = 5) **1.40***

18. Once some level of comfort is reached in therapy, I think it's good to have the flexibility to bend the rules as necessity or compassion dictates. (Rank = 5) **1.37***

21. It is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions. (Rank = 2) **0.73***

14. Boundaries must be identical for every single client that a therapist sees. (Rank = -1) **- 0.34***

8. I think it would be great if my therapist told me lots of personal information about themself. (Rank = -2) **- 0.71***

53. It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt. (Rank = -3) **- 0.87**

9. I think it would really improve the therapeutic relationship if my therapist did not have boundaries. (Rank = -6) **-1.85**

4.4.1.1 Interpretation of Discourse A – "HEDGE"

Firstly, I will explain my reasoning for giving Factor A the title of '"HEDGE".' A "HEDGE" normally marks the boundary of a person's land. "HEDGE"s are made up of living, growing, and evolving plants which can, for example, be left to grow wild, cut back excessively and/or trimmed, depending upon the needs of an individual. Despite the manner in which a "HEDGE" is maintained there will always be growth, flexibility, adaptability and change unless the "HEDGE" is so poorly maintained that it dies. Also, a "HEDGE" is not an impenetrable barrier, and may allow crossings of its boundary. However, additional branches may be nurtured, and grown, if the "HEDGE" becomes too sparse and/or ill-containing, or the "HEDGE" may be trimmed as time passes. Overall, this metaphor seems to encapsulate the meanings, understandings and experiences of participants who have identified with this factor and their beliefs, about therapeutic boundaries. This will be further explored in this section of the chapter.

Interpretation of each factor is achieved by paying particular attention to the distinguishing statements, and to statements with extreme scores, in order to interpret the discourse that the factor represents. This process highlights how Factor A differs from the discourse of the other factors. Therefore, discourse A

can be interpreted as displaying participants' agreement with a firm but fair approach to therapeutic boundaries, which is perhaps a compromise position between 'thick' and 'thin' boundaries. In accordance with this, statement 21 (Rank = 2, 0.73*), "it is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions" can be interpreted as clients viewing firm, and clearly articulated, professional boundaries as fundamental to healthy therapeutic relationships.

A degree of flexibility in therapeutic relationships seems important for participants associated with Factor A. For example, the three statements that most clearly define the beliefs of individuals, with borderline personality disorder, who load onto this factor are "it is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy" (3, Rank = 5, 1.43*), "every client has different needs in relation to therapeutic boundaries." (20, Rank = 5, 1.40*) and "once some level of comfort is reached in therapy, I think it's good to have the flexibility to bend the rules as necessity or compassion dictates" (18, Rank = 5, 1.37*). All three of these statements suggest that participants identifying with this factor understand that professional boundaries are necessary, but that there may be times when a degree of flexibility feels appropriate. The first statement reveals that gift-giving, limited to marking the ending of therapy, is seen as acceptable. The second statement suggests that clients believe that boundaries do not need to be rigid and identical for each client, but that boundaries should be flexibly adapted according to clients' needs. This is corroborated by participants' disagreement with the statement "boundaries must be identical for every single client that a therapist sees" (14, Rank = -1, - 0.34). Finally, the third statement explicitly agrees that it would feel acceptable to "bend the rules." This statement appears to reveal that participants think this flexibility is necessary because clients and therapists engage in human relationships, where it may be appropriate for "necessity or compassion" to be attended to.

It is important to interpret the statements that participants, loading onto Factor A, did not agree with, as this allows further insights into clients' understanding and experience of boundaries. Two of the statements can be interpreted as clients believing that the therapeutic relationship requires boundaries that differentiate it from other everyday relationships. For example, participants disagreed with the statements "I think it would be great if my therapist told me lots of personal information about themselves" (8, Rank = -2, - 0.71*) which suggests that substantial personal self-disclosure from therapists is not expected by clients and that this demarcates the professional relationship. Also, participants disagreed with "It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt" (53, Rank = -3, - 0.87) and this also seems to reflect that clients, associated with Factor A, believe that visual indicators (clothing) of professional boundaries are important.

This section has explored and interpreted the distinguishing statements for ""HEDGE"" and further enquiry will be undertaken in the Discussion chapter. The following section will examine the qualitative data generated by participants.

4.4.1.2 Discourse A – "HEDGE" - Qualitative Comments

The additional comments, made by participants whose Q sorts are most highly correlated with each discourse (both in the focus groups and as recorded on their Q sort feedback form), can be used to corroborate the interpretation of each discourse. An examination of the comments made by the participants, whose sorting pattern exemplifies Factor A, provides additional support for ""HEDGE"". These comments have been gathered from participants' feedback after Q sort completion and from the focus groups. Therefore, participants' perspectives have been gathered from the Q sort feedback, and from the focus groups, in order to offer further evidence for ""HEDGE"."

The following viewpoint was shared during the focus group stage of this study. The participant demonstrated her flexible beliefs regarding therapist self-disclosure as detailed below:

> "I don't like to know too much about them (therapist) because it turns the relationship slightly more personal than professional. My last therapist shared little titbits about her kids sometimes and that was okay. But too much of it wouldn't be good, in my opinion. To know a little bit about them would help my problem with idolizing though. I need to realize they aren't perfect and do have a life beyond the office." (Oak, Group 3, line 92, p. 275)

Importantly, these flexible beliefs are also revealed by the following participant's feedback about Q sort statement forty-one. This statement reads: "every therapy session should be exactly the same length of time e.g. 50 minutes." In response, the participant commented:

> "I work shifts which I have to fit appointments round so if e.g. I had shorter session one week I would have a compensatory longer one another week." (Plastic, email feedback comment)

The next excerpt demonstrates more flexible thinking, regarding therapeutic boundaries, through this client's belief that different people have varying needs in therapy. However, it was clear, from her perspective, that this flexibility in thinking about therapeutic boundaries, could be extended to clients' personal development. This participant believed that she had progressed during the first year and a half of therapy and that her difficulties with 'rules' had lessened.

> "Boundaries are difficult to have in this type of relationship, as every client has different needs/different schemas. I had a lot of issues with boundaries in the first year and a half of therapy. It was difficult to

> stick to the rules. I would feel jealousy if I would see a patient come when I was leaving. It was all very weird as I had not experienced that sort of thing before." (Glass, Group 1, line 100, p.246)

The following viewpoint was expressed by a participant during the focus groups and shows that Rock collaboratively negotiated with her therapist what would be said if they were questioned at work. This demonstrates flexibility towards, and negotiation about, a dual relationship. This therapy client felt that:

> "I've been in a situation where a therapist worked in the same organisation as me so she told me so I wouldn't be taken by surprise if I saw her, but also we agreed what we'd say if someone with us asked 'where do you know them from'." (Rock, Group 2, line 68, p.269)

The next excerpt is taken from the focus groups and reflects the viewpoint of Plastic who felt that the boundaried, yet human relationship, with her doctor was positive. Therefore, Plastic was not wanting an all-or-nothing approach to boundary management but was seeking a small amount of expressed compassion:

> "...it has to be solid boundaries - actually my doctor has got it sorted as far as boundaries - a bit of a laugh and banter at beginning of session, and always gets the final word to me as I walk out the door and down the corridor - something like be careful or hope you have a better week - makes me feel cared for." (Plastic, Group 1, line 396, p.255)

Statement 19 of the Q sort reads: "On one occasion my therapist cried during my session which felt acceptable. This made me realise that we are all human and can feel hurt or moved by what others say." One participant chose to feedback,

about this statement, after Q sort completion. The comment reveals that the participant believes that the focus needs to be on the client's wellbeing but that empathy, demonstrated through a therapist's tears, can be perceived as beneficial to the client. However, there is a clear message from this participant that uncontrolled crying from therapists crosses the line of what s/he thinks is appropriate. It is important to understand that the following participant works in an area allied to therapy and s/he has also attracted the diagnosis of borderline personality disorder.

> "I know I've had tears in my eyes when dealing with bereaved families/patients in my own job and it can show understanding so long as it doesn't interfere with providing what they (client) need at the time. If I need to 'really cry' at work, that has to wait until after." (Laminate, feedback email comment)

A participant gave further feedback on statement fifty-eight of the Q sort, which reads: "I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed." This feedback offered further support for the viewpoint advocating flexible thinking, in relation to individual's needs, and the value of collaboratively negotiating boundaries through stating:

> "It should be agreed in the rules what is acceptable e.g. if ok to touch hand/put arm around shoulder if upset – that would be fine with me (from female therapist) as I'm a 'hugs' person but I know I'd be uncomfortable with the same from a man." (Timber, feedback email comment)

The following perspective was shared by a participant during the focus groups. It reveals that in this participants' opinion both clients and therapists hold responsibilities regarding sexual flirtation. There is additional flexibility in this

participant's beliefs as she expresses that it feels fine for a therapist to tell a client that they care about him or her:

> "I would not flirt with a therapist as they would immediately not feel a safe person for me to be alone with and I certainly don't expect any sort of sexual "come-on" from a therapist - how could I talk about my problems if the therapist crossed boundaries that are meant to be there to protect me? However, I do think it is good for a therapist to say that they care about their client. I have certainly experienced this and it feels ok for me." (Plastic, Group 1, line 193, p.249)

Finally, one focus group participant did not hold rigid beliefs regarding what therapists choose to wear and this provides further evidence for ""HEDGE"."

> "I feel less intimidated by therapists wearing what they are most comfortable in, be that casual or smartly dressed. It shows that they themselves are confident in their own ability and don't need to dress up to look professional." (Oak Group 3, line 20, p.272)

To summarise, this discourse represents the 'middle ground' between 'thick' and 'thin' boundaries. A degree of flexibility, in relation to boundary management, is valued by participants identifying with Factor A alongside firm but fair boundary enforcement by the therapist.

4.4.2 Factor B – "CHICKEN MESH"

Factor B was found to have the second largest number of participants' Q sorts loading on it. Five participants' Q sorts defined this factor (Stone, Metal, Plaster, Rubber, Vinyl). The discourse that emerged from Factor B, will most closely resemble the understandings, and experiences, of participants whose Q sorts gained high loadings on Factor B. The statements which distinguished Factor B

from the other three factors are listed in Table 8 below. The statements that received the most positive and the most negative scores for Factor B are of particular interest. Participants loading onto Factor B were in highest agreement with the statements "If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended" and "I do like to push time boundaries a little with my therapist and add a couple of extra minutes to my session. If it works then I feel like they care more and they are more sincere." However, these participants strongly disagreed with the statements "I think it could be really dangerous if a therapist does not have very firm boundaries" and "If I bumped into my therapist in the street I would want them to ignore me."

Table 8. Distinguishing Statements for Factor B (P ≤ .05; Asterisk (*) Indicates Significance at P ≤ .01). Both the Factor Q-Sort Value and the Normalised Score are Shown).

42.	If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended.	(Rank = 6) **1.60***
36.	I do like to push time boundaries a little with my therapist and add a couple of extra minutes to my session. If it works then I feel like they care more and they are more sincere.	(Rank = 6) **1.50***
19.	On one occasion my therapist cried during my session which felt acceptable. This made me realise that we are all human and can feel hurt or moved by what others say.	(Rank = 5) **1.24***
39.	If my therapist showed lots of emotion, during every session (e.g. crying), I would really like this.	(Rank = 4) **1.17***
60.	I welcome my therapist contacting me, by phone or email, as much as possible between sessions.	(Rank = 4) **1.08***
26.	If I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat.	(Rank = 3) **1.00***
9.	I think it would really improve the therapeutic relationship if my therapist did not have boundaries.	(Rank = 1) **0.58***

46. I would be really pleased if my therapist accepted expensive gifts from me as it would prove that we had a special relationship. (Rank = 1) **0.49***

57. I would feel safe with a therapist who had no boundaries. (Rank = 0) **0.11***

11. It would be great to have a sexual relationship with my therapist (Rank = 0) **- 0.04***

54. I want my therapist to be inconsistent with me as it keeps me 'on my toes. (Rank = -1) **-0.22**

24. I think it is fine for therapists to wear what they are most comfortable in, but it is not right for them to wear jeans or provocative clothes. (Rank = -1) **-0.28***

55. If I saw my therapist in town I would want them to acknowledge me, but would like to keep a distance. (Rank = -2) **-0.43**

50. Once a line is crossed, where I feel vulnerable, I usually disappear from therapy. I cancel, or don't set up another appointment, and never look back. (Rank = -2) **-0.48***

7. It would never be acceptable for my therapist to drive me home. (Rank = -3) **-1.13***

14. Boundaries must be identical for every single client that a therapist sees. (Rank = - 4) **-1.29***

35. If my therapist returned my sexual flirtation they would immediately lose all credibility to me. (Rank = - 4) **-1.40***

59. I would hate it if my therapist cried in front of me and would never go back to see them. (Rank = - 5) **-1.44***

6. If I bumped into my therapist in the street I would want them to ignore me. (Rank = -5) **-1.54***

48. I think it could be really dangerous if a therapist does not have very firm boundaries. (Rank = -6) **-1.57***

4.4.2.1 Interpretation of Discourse B – "CHICKEN MESH"

Factor B has been given the descriptive title '"CHICKEN MESH"' as this form of boundary enforcement seems most relevant for depicting the perspectives of participants' who are associated with this factor. Chicken wire has large holes in

its structure which means that it is not a rigid or impenetrable barrier. The wire mesh generally keeps chickens safe as it offers a good enough barrier to stop the chickens crossing their boundary. Also, chicken wire stops anything large and significant penetrating the wire boundary from the outside. However, the large holes do allow for small boundary crossings and sometimes the wire may become stretched and/or pushed, from either side. This may leave the chicken wire boundary looking loose and potentially unsafe.

Interpretation of each factor is achieved by paying particular attention to the distinguishing statements, and to statements with extreme scores, in order to interpret the discourse this factor represents. This process highlights how Factor B differs from the discourse of the other factors. Therefore, discourse B can be interpreted as displaying participants' desire to push therapeutic boundaries and for 'thin,' loose and flexible boundaries between client and therapist. The statement that is particularly in accordance with this, is statement 36 (Rank = 6, 1.50*); "I do like to push time boundaries a little with my therapist and add a couple of extra minutes to my session. If it works then I feel like they care more and they are more sincere." It seems likely that borderline personality disordered clients who are associated with Factor B want their therapist to "care more" about them and desire their therapist to also push professional therapeutic boundaries.

The concept of 'thin' boundaries appears particularly relevant for this factor as many of the significant statements reveal participants desire for an emotional and/or physical closeness with their therapist. For example, there was strong agreement with the following: "if my therapist showed lots of emotion, during every session (e.g. crying), I would really like this" (39, Rank = 4, 1.17*), "I welcome my therapist contacting me, by phone or email, as much as possible between sessions" (60, Rank = 4, 1.08*) and "If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended" (42, Rank = 6, 1.60*). Adding further weight to this position

is that participants loading highly on Factor B, firmly disagreed with the statements: "If I bumped into my therapist in the street I would want them to ignore me" (6, Rank = -5, -1.54*) and "If my therapist returned my sexual flirtation they would immediately lose all credibility to me" (35, Rank = -4, -1.40*). It appears that clients identifying with Factor B wish to feel cared for by their therapists and want to break down traditional professional boundaries. Clients' desire to break down traditional therapeutic boundaries is further shown by participants' agreement with: "if I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat" (26, Rank = 3, 1.00*) and their disagreement with: "It would never be acceptable for my therapist to drive me home" (7, Rank = -3, -1.13*).

The participants who significantly contributed to this factor seem to have strong beliefs about the connection between therapeutic boundaries and safety. In particular, it was demonstrated that they would not feel unsafe with a therapist who did not have firm boundaries: "I think it could be really dangerous if a therapist does not have very firm boundaries" (48, Rank = -6, -1.57*). Therefore, it is assumed that these participants would feel safe with therapists who push boundaries. It would be interesting to question what 'safety' actually means to these clients, as they seem to welcome sexual flirtation from therapists as demonstrated in their disagreement with the following statement: "If my therapist returned my sexual flirtation they would immediately lose all credibility to me" (35, Rank = -4, -1.40*). However, participants loading onto this factor seemed a little more uncertain about therapists with no boundaries or who actually physically crossed sexual boundaries. This suggests that these clients only wished to push therapeutic boundaries without completely violating them. For example, participants did not commit to a positive or negative viewpoint about these boundary examples: "I would feel safe with a therapist who had no boundaries," (57, Rank = 0, 0.11*) and "it would be great to have a sexual relationship with my therapist" (11, Rank = 0, - 0.04*).

This section has explored and interpreted the distinguishing statements for ""CHICKEN MESH"" and further enquiry will be undertaken in the Discussion chapter. The following section will examine the qualitative data generated by participants.

4.4.2.2 Discourse B – "CHICKEN MESH" - Qualitative Comments

The additional comments made by participants whose Q sorts are most highly correlated with the discourse from Factor B (both in the focus groups and as recorded on their Q sort feedback form) will be used to corroborate the interpretation of this discourse. An examination of the comments made by the participants, whose sorting pattern exemplifies Factor B, provides additional support for ""CHICKEN MESH"". Therefore, participants' perspectives have been gathered from the Q sort feedback, and from the focus groups, in order to offer further evidence for ""CHICKEN MESH"."

For example, one participant commented during the focus groups that they desired more contact with their Community Psychiatric Nurse, as the participant felt that s/he was the only person that they felt connected to:

> "If so I find that overall my CPN is very good, but a bit sergeant major. I don't like her phoning me and talking to me like I'm a piece of rubbish, but I also find it difficult that I cant fone (sic) her all the time. I want her to contact me as much as possible between sessions. I know that it's not appropriate but I sometimes feel she is the only one I can talk to." (Rubber, Group 1, line 80, p.245)

The next excerpt highlights that this participant did not like that she felt strongly about her relationship with the therapist, but resented the fact that she believed it was one-sided. Importantly, this participant desired her therapist to also have feelings for and/or about her:

"...often very strong feelings are felt for your therapist. My experience was that I had never confided or shared or felt so accepted by another human being. I resented at times the fact that I knew those feelings were one-sided." (Stone, Group 1, line 117, p. 246)

The three viewpoints expressed below are regarding participants resisting time limits and reveal their difficulties with these rigid time limits:

> "I have to admit I do find strict boundaries very hard to deal with. My current psychologist is very strict on contact and time limits. Other than our weekly one hour meeting I am allowed two ten minute sessions with her on the phone at set times and if I miss those then I miss our contact." (Vinyl, Group 1, line 148, p. 247)

> "I know that time boundaries are necessary, especially because of their schedule with other patients. I do like to push these boundaries a little sometimes and add a couple extra minutes to my session... and if it works than I feel like they care more and they are more sincere. Like, I'm not just a patient they collect money from." (Plaster, Group 2, line 17, p. 267)

> "The main problem I have with boundaries is no matter how emotional everything gets time keeping is very strict so you can be left in tatters when everything finishes." (Vinyl, Group 1, line 177, p. 248)

Participants repeatedly alluded to the desire that they wished to feel cared for by their therapists. The two perspectives below demonstrate these beliefs regarding pushing emotional boundaries in therapy:

"My Freudian psychotherapist had such strict boundaries that it was hard for me to engage with her as she hardly showed any emotion at all; I desperately needed to know that she cared for me but, even after eleven and a half years of therapy with her, I never felt that I knew." (Stone, Group 1, line 261, p.251)

"My last therapist let me come in once without billing my insurance. I had been in and out of the hospital for a month and she knew I wanted to see her and give her an update on how I was doing. She said I could come in and we could talk and she wouldn't bill my insurance. That meant a lot to me, because I knew she actually did care. .....It makes you realize they are not just in it for them and helps build a trust." (Plaster, Group 2, line 92, p. 269)

To summarise, the discourse of ""CHICKEN MESH"" represents clients' desire for 'thin' boundaries in therapeutic relationships. There seems to be a theme that participants, associated with Factor B, wish to push traditional therapeutic boundaries and feel safe doing so, and with therapists who push boundaries. However, there appear to be boundary limits for these clients and they do not seem to want to totally violate all therapeutic boundaries. Overall, the data suggests that participants loading onto Factor B want to feel connected and cared for by their therapists.

4.4.3 Factor C – "BARBED WIRE"

Four participants' Q sorts defined Factor C (Thatch, Mortar, Wattle, Polystyrene). The discourse that emerged from Factor C, will most closely resemble the understandings, and experiences, of participants whose Q sorts gained high loadings on Factor C. The statements that distinguished Factor C from the other three factors are listed in Table 9 below. The statements that received the most positive and the most negative scores for Factor C are of particular interest.

Participants loading onto Factor C were in highest agreement with the statements: "There should not be any boundaries in therapy because I have problems being told, by someone else, what I can do," "Boundaries must be identical for every single client that a therapist sees" and "It would be great to have a sexual relationship with my therapist." However, these participants strongly disagreed with the statements: "I think it is fine for therapists to wear what they are most comfortable in, but it is not right for them to wear jeans or provocative clothes" and "it is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy."

Table 9. Distinguishing Statements for Factor C (P ≤ .05 ; Asterisk (*) Indicates Significance at P ≤ .01). Both the Factor Q-Sort Value and the Normalised Score are Shown).

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34. There should not be any boundaries in therapy because I have problems being told, by someone else, what I can do. (Rank = 6) **1.71***

14. Boundaries must be identical for every single client that a therapist sees. (Rank = 5) **1.56***

9. I think it would really improve the therapeutic relationship if my therapist did not have boundaries. (Rank = 5) **1.50***

11. It would be great to have a sexual relationship with my therapist. (Rank = 4) **1.30***

15. I would not mind if my therapist swore and used obscene language, towards me, during our sessions. (Rank = 4) **1.23***

51. My last therapist let me come in once without paying for the session. That meant a lot to me because I felt she actually did care. (Rank = 3) **1.15**

54. I want my therapist to be inconsistent with me as it keeps me 'on my toes. (Rank = 2) **0.56**

48. I think it could be really dangerous if a therapist does not have very firm boundaries. (Rank = 1) **0.16***

39. If my therapist showed lots of emotion, during every session (e.g. crying), I would really like this. (Rank = 0) **- 0.06**

40. It feels empowering that I can be responsible for taking care of myself, through negotiating boundaries, after much of my past had felt out of my control. (Rank = 0) **-0.16***

59. I would hate it if my therapist cried in front of me and would never go back to see them. (Rank = -2) **-0.53**

57. I would feel safe with a therapist who had no boundaries. (Rank = -3) **-0.84**

47. I think having a little bit of information about my therapist's life has made me feel more at ease during sessions. (Rank = -3) **-1.05***

4. I could not work with a therapist who showed no emotion at all. (Rank = -4) **-1.15***

22. I need to entirely decide what the rules are in my therapy sessions. (Rank = -4) **-1.18**

43. Maintaining boundaries is totally down to the therapist. (Rank = -4) **-1.20**

25. I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person. (Rank = -5) **-1.23***

42. If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended. (Rank = -5 **-1.41**

3. It is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy. (Rank = -5) **-1.49***

24. I think it is fine for therapists to wear what they are most comfortable in, but it is not right for them to wear jeans or provocative clothes. (Rank = -6) **-1.50***

4.4.3.1 Interpretation of Discourse C – "BARBED WIRE"

Factor C has been given the descriptive title of '"BARBED WIRE".' This description is consistent with the other three factor titles in that a method of land boundary enforcement has been adopted, which seems most appropriate for the content of participants' experiences and understandings of therapeutic boundaries in this study. "BARBED WIRE" is often used around the boundaries of high security institutions, such as prisons, and may portray an authoritarian

image. If a person chooses to excessively challenge "BARBED WIRE" they will, potentially, get hurt and/or damaged. However, if they do not challenge the "BARBED WIRE" at all it is likely that the individual may become totally disempowered leading to complete passive submission. Therefore, "BARBED WIRE" has the potential to provoke very extreme reactions to its presence. Discourse C can be interpreted as displaying participants' rebelling against, or being submissive to, perceived authoritarian therapeutic boundaries. This is explicitly displayed by participants strong agreement with the statements "there should not be any boundaries in therapy because I have problems being told, by someone else, what I can do" (34, Rank = 6, 1.71*) and "I would not mind if my therapist swore and used obscene language, towards me, during our sessions" (15, Rank = 4, 1.23*).

Clients associated with Factor C seem to desire 'thin' boundaries between themselves and their therapists, but due to their extreme beliefs and/or behaviours may inadvertently place themselves in potentially damaging victim roles. For example, participants loading highly on Factor C firmly agreed with: "it would be great to have a sexual relationship with my therapist" (11, Rank = 4, 1.30*) and "I would not mind if my therapist swore and used obscene language, towards me, during our sessions" (15, Rank = 4, 1.23*). These viewpoints on boundaries may portray that these clients are most comfortable in therapeutic relationships that perhaps (re)create dysfunctional dynamics.

Additionally, discourse C can be viewed as being full of contradictions, as participants loading onto this factor seemed to switch between holding flexible beliefs about boundaries, and having very rigid viewpoints. For example, their rigidity regarding what they believe to be appropriate is demonstrated through the high agreement with "boundaries must be identical for every single client that a therapist sees" (14, Rank = 5, 1.56*) but extreme disagreement with "I think it is fine for therapists to wear what they are most comfortable in, but it is not right for them to wear jeans or provocative clothes" (24, Rank = -6, -1.50*). However,

participants associated with Factor C appeared to evidence some flexibility in their attitudes about boundaries, as they significantly disagreed with "I need to entirely decide what the rules are in my therapy sessions" (22, Rank = -4, -1.18). Overall, these contradictions may reflect that these participants' experiences, of being treated in a confusing manner by others, have become what they are used to and expect. This assumption is partly supported by participants' agreement with the statement "I want my therapist to be inconsistent with me as it keeps me 'on my toes'." (54, Rank = 2, 0.56).

Analysing the content of these statements, it seems likely that participants loading onto Factor C have understandable difficulties with power and control. This is possibly due to difficult past experiences, regarding power and control, such as emotional abuse from a caregiver during childhood. Participants loading onto this factor seem to hold quite contradictory viewpoints about therapeutic boundaries. Interestingly, these clients express that they would not feel safe with a therapist who did not have boundaries (57, Rank = -3, -0.84) but at the same time do not want therapeutic boundaries because "...I have problems being told, by someone else, what I can do" (34, Rank = 6, 1.71*). Overall, most of the significant viewpoints that these participants hold about boundaries are extreme, in terms of being either very rigid/thick or very flexible/thin perspectives.

This section has explored and interpreted the distinguishing statements for ""BARBED WIRE"" and further enquiry will be undertaken in the Discussion chapter. The following section will examine the qualitative data generated by participants.

4.4.3.2 Discourse C – "BARBED WIRE" - Qualitative Comments

The additional comments made by participants whose Q sorts are most highly correlated with the discourse from Factor C (both in the focus groups and as recorded on their Q sort feedback form) will be used to corroborate the

interpretation of this discourse. An examination of the comments made by the participants, whose sorting pattern exemplifies Factor C provides additional support for ""BARBED WIRE"". Therefore, participants' perspectives have been gathered from the Q sort feedback, and from the focus groups, in order to offer further evidence for ""BARBED WIRE"."

For example, one participant commented during a focus group, that she had felt 'rage' in response to NHS boundaries. This extreme response evokes a sense of the participant potentially harming him/herself through this 'rage' reaction:

> "I have had treatment it has been with the NHS and there has always been a real focus on boundaries, something that has caused me to rage many many times." (Wattle, Group 1, line 376, p.255)

The following two excerpts below demonstrate the all-or-nothing, contradictory, and potentially damaging behaviours of participants holding ""BARBED WIRE"" type attitudes.

> "I have had a tendency to become overly dependent on those that help me, in fact with one person, who was actually my health visitor, she became such an integral part of my life, when it came time for her to move on I was affected very badly, resulting in extreme OD [overdose] & SH [self-harm]." (Polystyrene, Group 1, line 156, p. 248)

> "I fell out with my therapist whilst in the day unit on a Friday with the whole weekend looming and no therapy and I decided that the obvious solution was to kill myself as my therapist was the only person I trusted and had got close to and if she had abandoned me as it appeared to me, then death was the only way out." (Thatch, Group 1, line 536, p. 260)

The following four perspectives are from participants talking about sexual contact with therapists and demonstrate that some clients desire a sexual relationship with their therapists. These desires seem inextricably linked to participants' difficulties with power and control and according to participants' views below are linked to clients wanting to feel powerful through having sexual power. These excerpts provide strong evidence for ""BARBED WIRE"" :

> "I've always had issues with boundaries. I see a new therapist on Tuesday. Problem is (or is it) he is a male. I've never seen a male therapist before and am nervous, just because of my personality. I am a flirtatious person. I've been told that I lack sexual boundaries." (Thatch, Group 1, line 31, p. 244)

> "I know my sexual boundaries are not too good and I get quite upset if men don't respond when I flirt. I feel quite powerful when I am flirting with men! I talk about this a lot with my therapist." (Polystyrene, Group 1, line 67, p. 245)

> "Well, I would like him to act sexually toward me... I too feel powerful when I flirt with men. It's like a sense of being in control. I always thought it would like be hot to have sexual relationship with your therapist. It would ensure a type of closeness that you don't get with other therapists. I really do hope he reciprocates. And just FYI [for your information], I am really good at getting what I want, sexually I mean." (Thatch, Group 1, line 71, p. 245)

> "I tend to want my therapist to find me the most interesting, intelligent, amusing, patient in his practice, I guess, I want him to be in love with me (not lust)....this, I would assume, is also a form of control." (Thatch, Group 1, line 306, p. 252)

To summarise, this discourse represents clients' understanding of therapeutic boundaries in very extreme and contradictory terms. Participants representative of Factor C seem to rebel against authority and perhaps feel most comfortable in relationships that are critical (e.g. being sworn at), and/or potentially harmful (e.g. wanting a sexual relationship with their therapist). The theme of power and control appears particularly relevant for this factor and it seems probable, from the data, that clients may inadvertently seek to (re)create damaging therapeutic relationships.

4.4.4 Factor D – "BRICK WALL"

In Factor D there were four participants whose Q sorts defined this factor (Clay, Laminate, Iron, Ceramic). The discourse that emerged from Factor D, will most closely resemble the understandings, and experiences, of participants whose Q sorts gained high loadings on Factor D. The statements that distinguished Factor D from the other three factors are listed in Table 10 below. The statements that received the most positive and the most negative scores for Factor D are of particular interest. Participants loading onto Factor D were in highest agreement with the statements: "I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person", "It is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions" and "I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed." However, these participants strongly disagreed with the statements: "I think it would be great if my therapist told me lots of personal information about themself" and "If I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat."

Table 10. Distinguishing Statements for Factor D (P ≤ .05 ; Asterisk (*) Indicates Significance at P ≤ .01). Both the Factor Q-Sort Value and the Normalised Score are Shown).

25. I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person. (Rank = 6) **1.81***

21. It is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions. (Rank = 5) **1.62***

58. I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed. (Rank = 4) **1.01***

6. If I bumped into my therapist in the street I would want them to ignore me. (Rank = 3) **0.78***

14. Boundaries must be identical for every single client that a therapist sees. (Rank = 2) **0.63***

4. I could not work with a therapist who showed no emotion at all. (Rank = 1) **0.21***

33. It would be ok for my therapist to give me a ride home if I were walking home in a thunderstorm and s/he drove past me. (Rank = -1) **- 0.16***

53. It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt. (Rank = -1) **- 0.23**

9. I think it would really improve the therapeutic relationship if my therapist did not have boundaries. (Rank = -3) **-1.15**

10. I think it is good for a therapist to say that they care about their client and this feels ok for me. (Rank = - 4) **-1.17***

26. If I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat. (Rank = -5) **-1.39**

8. I think it would be great if my therapist told me lots of personal information about themself. (Rank = -5) **-1.62***

4.4.4.1 Interpretation of Discourse D – "BRICK WALL"

The descriptive title of '"BRICK WALL"' will be used for Factor D. This term seems most appropriate for the content of participants' experiences and understandings of therapeutic boundaries in this study. "BRICK WALL"s are rigid

constructions and can offer a firm barrier. These walls can be perceived to protect and/or defend, for example, a person's home. However, an imposing "BRICK WALL" may scare visitors away, resulting in loneliness, isolation, and little room for personal growth for the individual hiding in their home. Discourse D can be interpreted as participants aspiring for 'thick' boundaries, between therapists and clients. These clients seem to understand, and experience, rigid boundaries as the most acceptable. This is explicitly demonstrated in many of the significant statements, which include: "boundaries must be identical for every single client that a therapist sees" (14, Rank = 2, 0.63*) and "I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed" (58, Rank = 4, 1.01*).

Participants who load onto Factor D seem to desire both emotional, and physical, distance between themselves and therapists through rigid, professional, boundaries. This is corroborated by the firmly held beliefs: "it is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions" (21, Rank = 5, 1.62*), "If I bumped into my therapist in the street I would want them to ignore me" (6, Rank = 3, 0.78*) and disagreement with the following statements: "I think it is good for a therapist to say that they care about their client and this feels ok for me" (10, Rank = -4, -1.17*), "if I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat" (26, Rank = -5, -1.39) and "I think it would be great if my therapist told me lots of personal information about themselves" (8, Rank = -5, -1.62*).

Themes surrounding risk, protection and safety may be particularly relevant for participants who load onto Factor D. The statement with the highest agreement for this factor is "I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person" (25, Rank = 6, 1.81*). This may suggest that these clients may be fearful of therapeutic relationships, so may test boundaries as a way to protect themselves. Also, participants associated with

Factor D agreed with the following statement: "I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed" (58, Rank = 4, 1.01*), which again suggests these clients prefer to adopt a defensive, and rigid, position.

The participants who contributed to Factor D seem to desire an authoritarian style therapist as suggested by the statement regarding therapists dressing in a more casual manner. This is demonstrated by the significant disagreement with the statement: "It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt" (53, Rank = -1, - 0.23). Also, these participants displayed that they think that rules are important for therapeutic relationships, shown by their disagreement with "I think it would really improve the therapeutic relationship if my therapist did not have boundaries" (9, Rank = -3, -1.15).

This section has explored and interpreted the distinguishing statements for ""BRICK WALL"" and further enquiry will be undertaken in the Discussion chapter. The following section will examine the qualitative data generated by participants.

4.4.4.2 Discourse D – "BRICK WALL" - Qualitative Comments

The additional comments made by participants whose Q sorts are most highly correlated with the discourse from Factor D (both in the focus groups and as recorded on their Q sort feedback form) will be used to corroborate the interpretation of this discourse. An examination of the comments made by the participants, whose sorting pattern exemplifies Factor D provides additional support for ""BRICK WALL"". Therefore, participants' perspectives have been gathered from the Q sort feedback, and from the focus groups, in order to offer further evidence for ""BRICK WALL"."

For example, the following four participants' comments, reported during the focus groups, provide strong support for ""BRICK WALL"." These participants strongly

stated that they wished for physical distance between themselves and their therapists. Also, references were made to them needing to keep safe through being physically distant from their therapists and sometimes 'testing' their therapists:

> "I actually don't think anything over a handshake should take place, there is too much risk of a sexual boundary being crossed - in therapy it's commonplace for the client to fall in love with the therapist." (Laminate, Group 1, line 132, p.247)

> "I have really rigid boundaries - the thought of any kind of physical contact with a therapist revulses (sic) me - maybe that's a bit strong, but how I FEEL - they have to be separate from me - I mean we used to have social groups every week when I was in treatment, and days out once a year, which were great at sort of normalising staff, but in my therapy time, it has to be solid boundaries." (Plastic, Group 1, line 392, p.255)

> "I know on a personal level I try and test certain boundaries with therapists to see how far I can push it and part of this is because I have problems being told what I can and cannot do...As for the no physical contact in therapy it has always been something I have asked therapists to include in boundaries, and found not all are willing for this to happen." (Ceramic, Group 1, line 183, p.248)

> "I made a commitment to my current therapist and she wanted to shake on it... I was uncomfortable with this. It makes the therapy too personal, for me...but I just think it would do more harm than good... especially knowing that therapy doesn't last forever. So remaining at a certain distance is helpful in the long run." (Clay, Group 3, line 101, p. 275)

The theme of physical distance is further alluded to by the next participant who is most comfortable sitting as far away from her therapist as possible:

> "In the office where we meet, I always have to be in the chair across from her (therapist), furthest away. Just my comfort level." (Laminate, Group 1, line 277, p. 252)

Participants, who evidence beliefs consistent with ""BRICK WALL"" seem to prefer emotional distance from therapists. For example, the following two excerpts were taken from focus groups and reflect the participants' fears regarding vulnerability :

> "I would hate it if my therapist cried in front of me and I would never go back to see them - that would make them weak and pathetic - I need to see strong people who are robust to ignore my rants." (Clay, Group 3, line 126, p. 276)

> "Once some imaginary line is crossed where I feel vulnerable, I usually disappear from therapy. I cancel or never set up another appointment, change my number and never look back....I have talked about this with my therapist since this happened and I have decided to continue with therapy and am learning to trust her." (Laminate, Group 1, line 281, p. 252)

The final participant perspective, offered below, provides further evidence for ""BRICK WALL"." Overall, this client has a firm belief regarding appropriate therapist clothing and believes that therapists' dress should be reflective of their professional status, thereby, marking the client and therapist roles visually and, potentially distancing the two roles:

"My therapists have always been professionally dressed... suit pants [trousers] and a blouse of some type. I like this formality. Where I currently go, I have seen a therapist that wears jeans with a dressy top... I would not like that. It is too informal and I don't believe appropriate....at the end of the day... they are my therapist and I am their client... so the appropriate clothing should reflect that." (Iron, Group 3, line 14, p. 272)

In summary, this discourse represents that these clients understand, and experience, therapeutic boundaries in very rigid terms. Participants representative of Factor D seem to desire a firm, professional, emotionally and/or physically distant relationship with therapists perhaps as a defensive strategy.

4.4.5 Areas of Consensus

The discourses revealed in this study explore the complexity of borderline personality disordered individuals' attitudes about therapeutic boundaries. Four distinct discourses are represented by the findings of this study but there are important areas of consensus between them. As summarised in table 11, there are three consensus statements (statements 5, 28 and 56). The four discourses, identified through the labels of '"HEDGE",' '"CHICKEN MESH",' '"BARBED WIRE"' and '"BRICK WALL",' although statistically distinct, have areas of similarity as well as distinguishing features. There are important areas of consensus between the four factors ""HEDGE"," ""CHICKEN MESH"", ""BARBED WIRE"" and ""BRICK WALL"." Overall, the three consensus statements outlined below did not distinguish between any pairs of factors. The three consensus statements which emerged from this study are displayed below.

Table 11. Consensus Statements

Consensus Statements (Those that do not distinguish between any pair of factors) All Listed Statements are Non-Significant at P>.01, and Those Flagged With an * are also Non-Significant at P>.05.			
1 **RANK SCORE**	**2** **RANK SCORE**	**3** **RANK SCORE**	**4** **RANK SCORE**
5. The rules of therapy must be spoken about during the first session and then must never change.			
-1, -0.34	**-3, -0.77**	**-2, -0.67**	**-1, -0.07**
28. I think it would be fine never knowing how long my therapy sessions are going to last. (e.g. anything between 10 minutes and three hours).			
-4, -0.90	**-2, -0.72**	**-1, -0.41**	**-3, -1.12**
56.* I don't think anyone should have to pay for therapy (including NHS covering therapy costs) as the therapist should morally want to be there rather than seeking payment.			
-2, -0.58	**-1, -0.18**	**-1, -0.16**	**0, -0.05**

It is interesting to note that all four factors are negatively associated with the three consensus statements. This means that participants, who loaded onto the four factors, generally disagreed with the three consensus statements and this will be further explored in the following paragraphs.

The topic of therapeutic boundaries encompasses so many aspects, which means that people have many and varying opinions. Q methodology is based on the assumption that underlying these many opinions there is a small number of factors or discourses which explains the attitudes that exist. Therefore, using Q methodology to determine attitudes about therapeutic boundaries, and the areas of agreement that exist between them, provides much needed information.

It seems that the most important area of consensus is shown by the shared disagreement to statement 28. The following rankings are displayed in order of the discourses A, B, C and D. Statement 28 "I think it would be fine never knowing how long my therapy sessions are going to last. (e.g. anything between 10 minutes and three hours)" resulted in mutual disagreement from all four discourses (-4, -2, -1, -3), Therefore, all discourses agree that it is important to know the length of therapy sessions. Discourse A ("HEDGE") is most concerned to know the length of sessions, followed by Discourse D ("BRICK WALL") and Discourse B ("CHICKEN MESH"). Discourse C ("BARBED WIRE") is least concerned with knowing how long therapy sessions will last, but this discourse still mildly disagrees with the statement.

Another area of agreement between discourses is in respect of the shared disagreement with statement 5 (-1, -3, -2, -1), "The rules of therapy must be spoken about during the first session and then must never change." All four discourses disagreed with this statement. However, Discourse B ("CHICKEN MESH") disagreed most strongly with this statement. This means that participants identifying with this discourse believed that the rules of therapy should be changeable. Proponents of Discourse C ("BARBED WIRE") were the next strongest to disagree with statement 5, thus, advocating that the rules of therapy could change over time. Both Discourse A ("HEDGE") and Discourse D ("BRICK WALL") mildly disagreed with the consensus statement as demonstrated by the ranking of -1. Perhaps participants representing this viewpoint felt that small boundary changes were acceptable after the first session of therapy.

The final area of agreement, between discourses, is demonstrated through the shared disagreement with, and apparent indifference to, statement 56 (-2, -1, -1, 0), "I don't think anyone should have to pay for therapy (including NHS covering therapy costs) as the therapist should morally want to be there rather than seeking payment." Participants representing Discourse A ("HEDGE") most

strongly disagreed with this statement. This finding could be interpreted as participants, representative of '"HEDGE",' believing that therapists should be financially recompensed for their work rather than working for purely altruistic or moral reasons. Both discourse B ("CHICKEN MESH") and discourse C ("BARBED WIRE") mildly disagreed with statement 56 which is concurrent with the previous interpretation. However, discourse D ("BRICK WALL") seems to demonstrate apparent indifference to this statement. This may reveal that participants were not overly concerned about the moral motivations for therapists' work or whether therapists gained financial reward.

4.4.6 Areas of Divergence

As discussed above, all discourses have some similarities, alongside varying attitudes, towards therapeutic boundaries. For example, the boundary of time, where all participants wished to know how long therapy sessions would be, was found to have shared importance. Additionally, there are significant differences between factors relating to participants' views about therapeutic boundaries and this will be discussed below.

Discourse C ("BARBED WIRE") demonstrated the greatest number of areas of divergence compared to the other three discourses. This is indicated in the rankings for the following statements. Discourse C ("BARBED WIRE") agrees with statement 15 "I would not mind if my therapist swore and used obscene language, towards me, during our sessions" (-5, -2, 4, -4). In contrast, Discourse A ("HEDGE") and Discourse D ("BRICK WALL") strongly disagree with this statement. Discourse C ("BARBED WIRE") agrees with statement 34 "There should not be any boundaries in therapy because I have problems being told, by someone else, what I can do" (-5, -3, 6, -5) but all other discourses firmly disagree with this viewpoint. Interestingly, participants loading onto '"BARBED WIRE"' agreed with statement 37 "I want my therapist to address me as "Ms/Mr (Surname)" rather than calling me by my first name" (-5, -5, 2, -1). This belief

appears very formal and seemingly contradicts Discourse C's ("BARBED WIRE") agreement with statement 15 about therapists using obscene language. However, contradictory beliefs seem to be one of the identifying themes for '"BARBED WIRE".' This viewpoint is articulated through statement 54: "I want my therapist to be inconsistent with me as it keeps me 'on my toes'" (-3, -1, 2, -4).

It has been demonstrated, in the previous paragraph, that participants who identify with '"BARBED WIRE"' display contradictory attitudes about therapeutic boundaries. This is further displayed through Discourse C's disagreement with the following statements, which are contrary to the beliefs portrayed by the alterative discourses. Participants identifying with '"BARBED WIRE"' disagreed with statement 3: "It is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy" (5, 1, -5, 3) and statement 4: "I could not work with a therapist who showed no emotion at all" (5, 5, -4, 1). These participants also disagreed with statement 25: "I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person" (2, 2, -5, 6), and statement 47: "I think having a little bit of information about my therapist's life has made me feel more at ease during sessions" (3, 5, -3, 4).

Discourse B ("CHICKEN MESH") demonstrated the second greatest number of areas of divergence compared to the other three discourses. This is indicated in the rankings for the following statements: 42, "If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended" (-3, 6, -5, -2), 46, "I would be really pleased if my therapist accepted expensive gifts from me as it would prove that we had a special relationship" (-4, 1, -1, -2) and 60, "I welcome my therapist contacting me, by phone or email, as much as possible between sessions" (-3, 4, -3, -3).

Discourse D ("BRICK WALL") only had one statement that was clearly divergent. This was statement 58, "I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed" (-2, -4, -2, 4). It seems that Discourse A ("HEDGE") did not have any clear areas of divergence. However, this could be explained by the fact that '"HEDGE"' and '"BRICK WALL"' shared some similar beliefs, but that the degree to which these beliefs were held differed. For example, participants loading on to '"HEDGE"' disagreed strongly with the viewpoint of statement 31 that "I am comfortable with my therapist hugging me every time I feel upset" (-4, 3, 3, -3) and Discourse D ("BRICK WALL") also disagreed with this statement. This was in contrast to the beliefs of participants who significantly loaded onto Discourse B ("CHICKEN MESH") and C ("BARBED WIRE").

In summary, the differences between the discourses reflect the differences in understandings, and experiences, about therapeutic boundaries. The next section of this thesis offers some observations regarding socio-demographic characteristics and participants viewpoints about therapeutic boundaries.

4.5 Significance of Socio-demographic Characteristics

It is important to acknowledge that the focus of any Q methodological study is on the discourses identified, as opposed to the participants who were involved in their identification. Willig (2001) clarifies that "qualitative research explores a particular, possibly unique, phenomenon or experience in great detail. It does not aim to measure a particular attribute in large numbers of people" (p.17). Therefore, Q is not primarily concerned with the number of the sample, or population, who hold particular beliefs. However, it may be interesting, for the reader, to indicate which participants held particular perspectives.

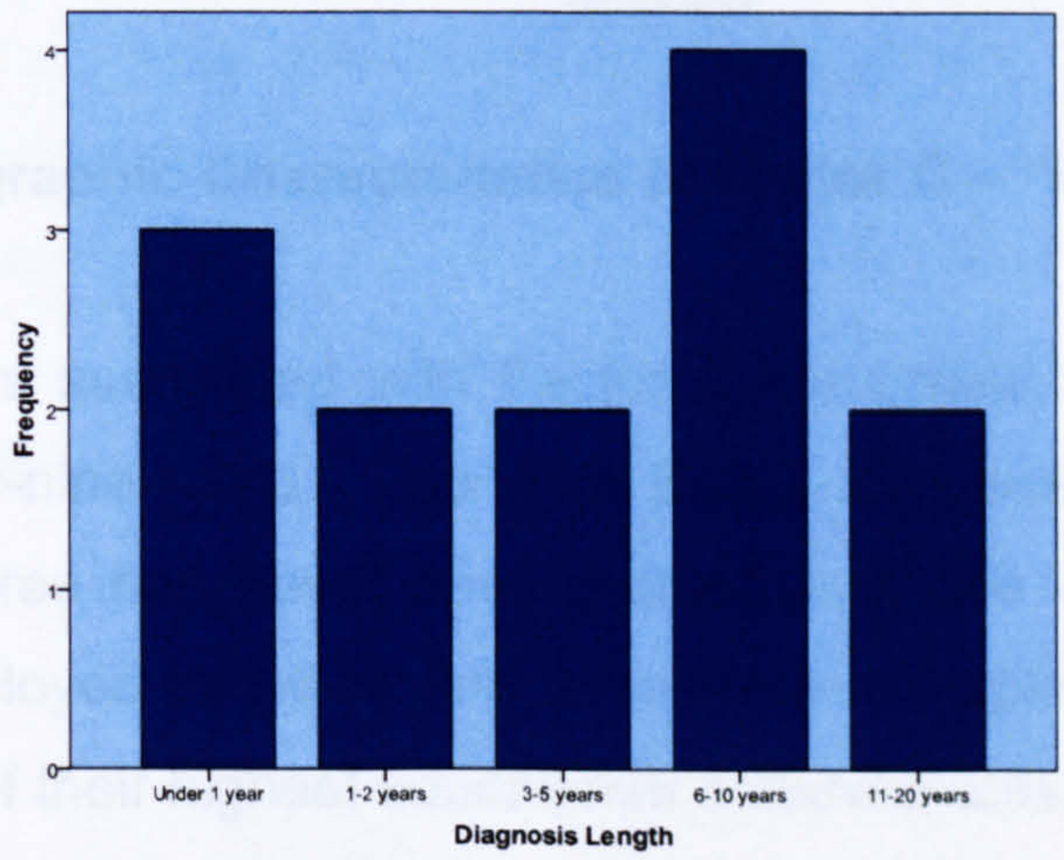
The next section will outline some observations regarding the possible correspondence of the four discourses with sociodemographic factors (e.g. age,

gender and education). Due to the fact that this study strategically selected the sample of participants, it is crucial that the reader recognise that no inferences can reliably be made

4.5.1 Socio-demographic Characteristics of Factor A - "HEDGE"

The fourteen participants associated with Factor A comprised thirteen females and one male, with a mean age of thirty-eight years. The cultural backgrounds were diverse, as eight participants were British, five were American and one was Canadian. Nine of the participants had never been married, three were currently married, one was separated and one divorced. Six of these participants were employed full time, three worked part-time and five were unemployed and not looking for work. In terms of educational backgrounds six had a university undergraduate degree, four had a postgraduate qualification, three had completed an apprenticeship and/or trade certificate and one had completed secondary school. In relation to current education, eleven were not studying, two were studying part-time and one was studying full-time. The length of time that participants had been diagnosed with borderline personality disorder is displayed in Figure 2.

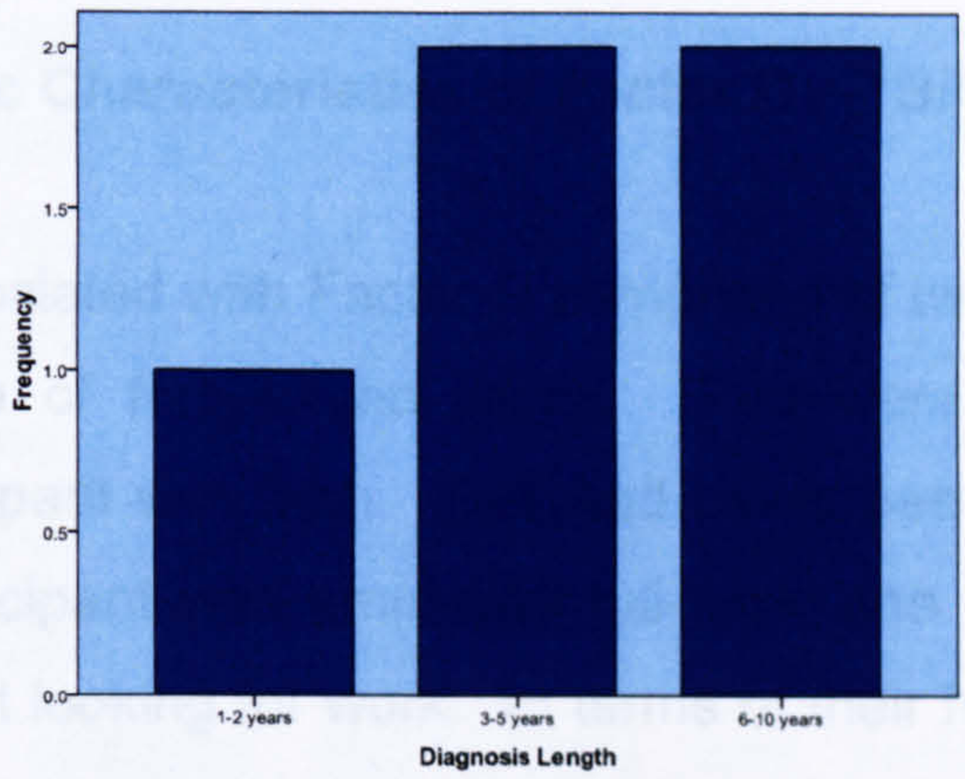
Figure 2. Factor A: Length of Time Diagnosed with BPD



4.5.2 Socio-demographic Characteristics of Factor B – "CHICKEN MESH"

The five participants associated with Factor B comprised of five females with a mean age of twenty-eight and a half years. Three were British and two were American. Four had never been married and one was divorced. Two were employed full-time and three were unemployed and not looking for work. In terms of their highest educational achievements, three had completed apprenticeship and/or trade certificates, one had completed secondary school and one had a university degree. Currently, one person was studying part-time and the remaining four were not studying. The length of time that participants had been diagnosed with borderline personality disorder is displayed in Figure 3.

Figure 3. Factor B: Length of Time Diagnosed with BPD

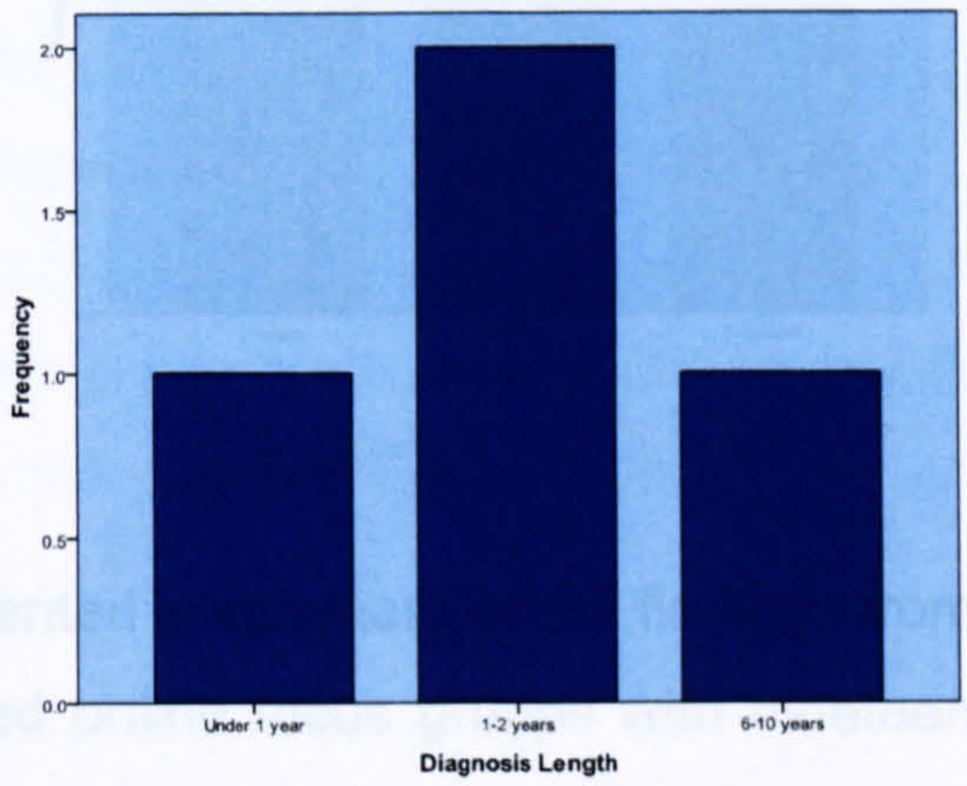


4.5.3 Socio-demographic Characteristics of Factor C – "BARBED WIRE"

The four participants associated with Factor C comprised four females with a mean age of twenty-nine years. Two were British, one was American and one was Canadian. Three had never been married and one was divorced. One participant was employed part-time and three were unemployed and not looking for work. In terms of their highest educational achievements, two had completed apprenticeship and/or trade certificates, one had completed secondary school and one had a university degree. Currently, one person was studying part-time

and the remaining three were not studying. The length of time that participants had been diagnosed with borderline personality disorder is displayed in Figure 4.

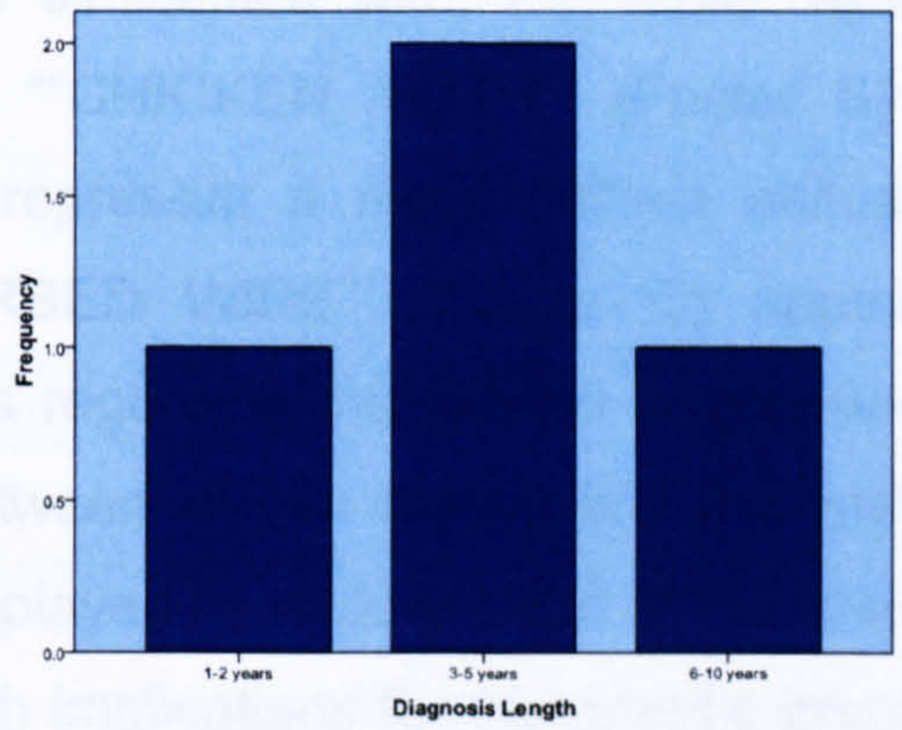
Figure 4. Factor C: Length of Time Diagnosed with BPD



4.5.4 Socio-demographic Characteristics of Factor D – "BRICK WALL"

The four participants associated with Factor D comprised of two females and two males with a mean age of forty-seven years. Two were British, one was American and one participant was Irish. Two had never been married and two were married. One participant was employed full-time, one part-time, and two were unemployed and not looking for work. In terms of their highest educational achievements, one had completed an apprenticeship and/or trade certificate, two had completed secondary school and one had a university degree. Currently, one person was studying part-time and another was studying full-time and the remaining two were not studying. The length of time that participants had been diagnosed with borderline personality disorder is displayed in Figure 5.

Figure 5. Factor D: Length of Time Diagnosed with BPD



4.6 Summary

This chapter has presented a summary of the findings from this two-stage study. The first stage involved online focus groups with nineteen clients attracting the diagnosis of borderline personality disorder. Rich qualitative data was generated through these focus groups and reflected an extreme variety of perspectives regarding clients' understandings and experiences of therapeutic boundaries. Thematic analysis of the focus groups revealed that participants reported both positive and negative examples regarding therapeutic boundaries. The second stage of this study, involved an online Q sort procedure, and was partly informed by participants' views that were generated during the preceding stage. Analysis of the second stage focussed upon interpretation of four separate factors which represented underlying attitudes, experiences and understandings about therapeutic boundaries, of the twenty-eight borderline personality disordered participants in this study. The discourses, of these four factors, can be simplistically summarized as the following:

Discourse A: **"HEDGE"**

Discourse B: **"CHICKEN MESH"**

Discourse C: **"BARBED WIRE"**

Discourse D: **"BRICK WALL"**

""HEDGE"" (Factor A) is the discourse that is most statistically significantly loaded and has some similarities with, the most highly correlated, ""BRICK WALL"" (Factor D). ""CHICKEN MESH"" (Factor B) is the discourse that statistically seems to represent a more distinct attitude towards therapeutic boundaries and ""BARBED WIRE"" (Factor C) appears to offer the most contradictory messages regarding therapeutic boundaries. However, there are areas of consensus between all four factors and the relationship between these four discourses was displayed towards the end of this chapter. The findings from this thesis, together with implications for therapeutic practice, are discussed and explored further in the next chapter: Discussion.

Chapter 5

Discussion

"the conditions of the boundary determine whether or not the organism inside will thrive. If its boundary is too rigid and impermeable, the organism can't feed or breathe or excrete wastes – can't communicate effectively with the rest of the universe. If its boundary is too porous, it can't sufficiently isolate itself from the rest of the universe to function – it loses its identity. With amoebas and human beings, with stars and nation-states, boundary conditions are crucial" (p.571).

Lechtman (1994) quoting Cyril Stanley Smith

5.1 Introduction

The previous chapter has presented an interpretation of each of the four discourses identified in this study. This chapter will discuss the significance and meaning of the findings outlined in the previous chapter. It will be used to review the findings of the work in relation to the aforementioned literature in chapter 2. The Discussion chapter will also explore the importance of participants' socio-demographic characteristics, consider the implications for clinical practice and will include a discussion of the theoretical and methodological approach adopted in this study. Also, some limitations of the current research study are detailed, providing opportunities for learning, and thoughts about future research possibilities are shared. The discussion is thorough in content but others may identify alternative areas of significance. The acknowledgment of these inevitable limits to this chapter show that it is in keeping with a research study with a constructivist base

5.2 Summary of Findings

The current research study set out to explore how clients attracting the diagnosis of borderline personality disorder experienced and understood therapeutic boundaries. The findings from the participants demonstrated how variable the

attitudes of this client group can be. Four themes emerged from the data, which highlights the importance of clients' attitudes for creating and maintaining successful therapeutic alliances.

The Q methodological analysis resulted in the interpretation of four statistically distinct factors which represent the underlying viewpoints, about therapeutic boundaries, of the participants in this study. The discourses revealed in this thesis explore the complexity of beliefs about therapeutic boundaries. As discussed in the previous chapter: Research Findings, the distinctive features suggest that Discourse A ("HEDGE") represents the 'middle ground' between 'thick' and 'thin' boundaries. A degree of flexibility, in relation to boundary management, is valued by participants identifying with Factor A alongside firm-but-fair boundary enforcement by the therapist. Discourse B ("CHICKEN MESH") represents clients' desire for 'thin' boundaries in therapeutic relationships. There seems to be a theme that participants, associated with Factor B, wish to push traditional therapeutic boundaries and feel safe doing so, and with therapists who push boundaries. However, there appear to be boundary limits for these clients and they do not seem to want to totally violate all therapeutic boundaries. Overall, the data suggests that participants loading onto Factor B want to feel connected and cared for by their therapists.

Discourse C ("BARBED WIRE") represents a more distinct viewpoint, from the other three discourses, and can be seen as demonstrating clients' understanding of therapeutic boundaries in very extreme and contradictory terms. Participants representative of Factor C seem to rebel against authority and perhaps feel most comfortable in relationships that are critical (e.g. being sworn at), and/or potentially harmful (e.g. wanting a sexual relationship with their therapist). The theme of power and control appears particularly relevant for this factor and it seems probable, from the data, that clients may, inadvertently, seek to (re)create damaging therapeutic relationships. Finally, Discourse D ("BRICK WALL") represents that some clients understand, and experience, therapeutic boundaries

in very rigid terms. Participants representative of Factor D seem to desire a firm, professional, emotionally and/or physically distant relationship with a therapist. This could be conceptualised as a defensive strategy. Having described the detail of the findings of the focus groups and Q sorting in the previous chapter, the following sections will summarise and discuss these findings in relation to prior literature.

There has been much debate over whether a literature review should be carried out before or after a qualitative research study (e.g. Willig, 2001). Willig (2001) advocated a brief awareness of the literature to confirm that there was scope for further research and that the topic is not already fully developed and understood. For the current study, a review of the literature was conducted for the purposes of justifying the research proposal and ethics applications and further discussed in Chapter 2: Literature Review. This initial literature review covered the practical aspects of the therapeutic engagement process such as clients' perspectives regarding therapy, attitudes towards therapeutic boundaries and borderline personality disordered clients' experiences of therapy. It was not until after the data collection and analysis were complete that the literature was revisited and critically explored in relation to the four themes that emerged from this study. Aspects of the four themes that emerged from the data were mirrored in the published literature and this will be discussed further in the following paragraphs.

5.2.1 Discourse A: "HEDGE"

- a flexible, evolving and 'firm-but-fair' viewpoint. A balance between thick and thin boundaries.

""HEDGE"" represents the viewpoints of participants who loaded onto this factor. This finding will now be discussed and interpreted in relation to the literature already presented in the Literature Review chapter (Chapter 2) and new literature as relevant. Tentative conclusions will be drawn about what this finding might

mean in the context of this literature and what has been explored in previous research.

The therapeutic utility of adopting a boundary management style, consistent with the flexible and evolving nature of ""HEDGE"," is corroborated by the work of Vygotsky (1978). Vygotsky proposed that effective learning in childhood requires a secure, but responsive, framework in order for children to explore and develop. Therefore, Vygotsky's framework asserted that boundaries should not be too rigid but should adapt to a child's stage of development. It should be noted that Vygotsky's work focussed primarily upon child development rather than adult development and this may limit generalisability. However, clinically it could be important for therapists to adapt boundary management according to their clients' stage of personal and therapeutic development. This will be explored further in section 5.4: Implications for Clinical Practice. Also, there seems to have been a re-conceptualisation of personality disorders over the last decade, so that the prognosis of people labelled with the disorder has improved over their lifespan. For example, longitudinal studies (e.g. Paris and Zweig-Frank, 2001), have found that only a small number of borderline personality disordered clients still meet the diagnostic criteria, after a number of years. This adds further weight to the flexible and evolving nature of ""HEDGE"" style boundary management by both clinicians and clients as clients develop over time.

Inconsistency and unreliability are recurrent themes in the childhoods, and attachment experiences, of many clients with borderline personality disorder. Therefore, maintenance of boundaries could be seen to be basic to the development of a safe therapeutic environment in which a trusting relationship can be developed, *(*Briere, 1996; Dalenberg, 2000*)* and could be likened to Bowlby's (1969) 'secure base.' Therefore, if the therapeutic boundaries are unclear, the therapeutic space is likely to be experienced as unsafe by the client. This 'insecure base' of therapy may recreate an insecure early environment base and hence make therapeutic interventions difficult or impossible. Winnicott

(1955), argued that the more fragile the client's sense of self, the more central frame (boundary) management becomes, compared to other therapeutic techniques. Therefore, maintenance of boundaries may become the therapeutic priority with borderline personality disordered clients. However, because boundaries emerge from interactions, they are unique to each therapeutic relationship and rigid maintenance is not always possible or helpful. Thus, a flexible and evolving approach to successful boundary management, supported by the ""HEDGE"" discourse, provides further evidence for these relationship based attachment theories.

A growing number of professionals advocate for flexible boundaries as it is believed that they can aid clinical interventions when applied ethically (e.g. Knapp and VandeCreek, 2006) and this supports the "HEDGE" discourse. Most Humanistic therapists would support the position that self-disclosure is expected and desirable as a way to exhibit congruence (Rogers, 1961) and transparency (Jourard, 1971). In addition, Feminist therapy values self-disclosure as a way to reduce the power imbalance between therapist and client (Mahalik, van Ormer and Simi, 2000) and enhance therapeutic interventions. Previous research, such as Knox et al (1997), conducted a qualitative analysis of client perceptions of therapist self-disclosure in therapy and further display the therapeutic utility of ""HEDGE"" style boundary management. Knox et al found that many clients perceived limited therapist self-disclosure as a valued aspect of therapy. This is consistent with Hill, Helms, Tichenor, Spiegel, O'Grady and Perry (1988) who conducted a rare study on actual therapy and found that therapist self-disclosure occurred only one percent of the time, but received the highest client helpfulness ratings. Audet and Everall's (2003) research about disclosure further supports this viewpoint by concluding that this finding emphasised the importance of a flexible and responsive approach towards therapeutic interactions. Harper (2006), writing about working with survivors of child abuse, stated that it can be therapeutically beneficial to flexibly negotiate therapeutic boundaries with clients and to facilitate clients' understanding about therapeutic boundaries. This

research and literature will be further discussed in section 5.4 in order to explore the clinical implications.

5.2.2 Discourse B: "CHICKEN MESH"

- a perspective where clients push boundaries by attempting to cross them rather than violating them. Thin boundaries.

""CHICKEN MESH"" was the discourse that represented the statistically distinct viewpoints of participants who loaded onto this factor. This viewpoint will now be discussed, and interpreted, in relation to the literature and tentative conclusions will be drawn.

The diagnostic criteria for borderline personality disorder highlights the distress and difficulties that can result from emotions and behaviour. The DSM-IV-TR (APA, 2000, p.710), states that the essential feature of borderline personality disorder is "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood. Therefore, pushing the limits, of what is generally considered to be acceptable, is a core feature of the diagnosis of borderline personality disorder. Bender (2005), recommended exercising great care to avoid crossing inappropriate lines in a quest to build an alliance with clients with personality disorders. It has been stated that borderline personality disordered clients are more likely than other clients to file complaints and initiate legal actions against their therapists due to alleged boundary transgressions (Zur, 2008; p.1). In relation to clinical implications, it seemed pertinent to gain an understanding, from clients with borderline personality disorder, of these boundary limits, in order to ethically enhance the success of therapeutic alliances and this will be further explored in section 5.4.

Manthei (2007) found that having a constructive working relationship was important but that clients tended to depict therapists who met the clients' perceived needs, or demonstrated similarity to them, as reasons for good therapeutic alliances However, it has been stated that personality disordered clients have often not been able to develop appropriate boundaries, for themselves, as they have learned to get their needs met through interactions based on ill-defined and ever-changing boundaries (Harper and Steadman, 2003). Therefore, when borderline personality disordered clients are with a therapist, they may expect to be let down, harmed and/or exploited in some way and perhaps they are alert to signs that they are about to be abused or rejected. While in this defensive mode clients may 'test' fidelity and loyalty within the relationship that they are establishing and this is consistent with the ""CHICKEN MESH"" discourse.

Melia, Moran and Mason (1999) argue that personality disorders are associated with clients denying any responsibility for their actions and developing complex rationalisations about how the cause of any of their problems always lies with others. Melia at al (1999), go on to state that personality disordered clients are "...most strongly drawn to those staff who are less challenging and more accepting" (p.17), which could have clear implications for therapists managing boundaries within therapy with these clients adopting a ""CHICKEN MESH"" attitude towards boundaries. Perhaps clinicians need to be aware that personality disordered clients may push against boundaries and that clinicians need to remain boundaried and consistent in their approach to boundaries.

Gabbard and Lester (1995), distinguished between boundary violations and boundary crossings in therapy. Boundary crossing refers to any move away from traditional 'only in the office' therapy, or deviation from rigid risk-management protocols. Boundary crossing includes therapist self-disclosure, home visits, non-sexual touch and gift giving etc. and supports a ""CHICKEN MESH"" approach to boundary management. Boundary violations occur when therapists cross the

line of appropriate and ethical behaviour, such as violating or exploiting clients e.g. illegal breaches of confidentiality, financial exploitation and engaging in sexual relationships. Overall, it appears that boundary crossings, and violations, exist on a continuum ranging from adaptive (therapeutically useful boundary crossings) to maladaptive (non therapeutic boundary violations). Therefore, ethical considerations by therapists are imperative in order to manage the multitude of dilemmas that may be presented in therapy.

5.2.3 Discourse C: "BARBED WIRE"

- a position of contradictory and extreme viewpoints, which may inadvertently involve clients seeking to (re)create damaging relationships. Fluctuation between thick and thin boundaries.

The DSM-IV-TR (APA, 2000, p.710), states that the essential feature of borderline personality disorder is "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood." This diagnostic pattern of unstable and intense interpersonal relationships, characterized by alternating between extremes of idealization and devaluation, supports the statistically distinct discourse of ""BARBED WIRE"."

The primitive defence of 'splitting' has received a lot of attention in the literature (Neilson, 1991) and this theory appears to corroborate the ""BARBED WIRE"" discourse. This defence is characterised by a polarisation of good feelings and bad feelings such as love and hate or attachment and rejection. Therefore, someone who is seen as all good one day can be perceived as all bad the next. Clients with borderline personality disorder have problems with a sense of continuity and consistency about people, and things, in their lives. An example of splitting would be a client telling a therapist, who is not responding to a boundary request, that other therapists always respond to requests, such as

adding five minutes to the end of a therapeutic session or disclosing personal information. In practice, this exerts a coercive pressure on the therapist, who is attempting to maintain consistent boundaries and communicates that the borderline personality disordered individual believes there is a 'good' therapist and a 'bad' therapist. Splitting is unconsciously, or sometimes consciously, used to make an individual, or group, feel differently (either better or worse) than their peers (Melia, Moran and Mason, 1999). This polarised thinking and fluctuation between positions, depicted by the concept of splitting, corroborates the ""BARBED WIRE"" discourse.

According to Fonagy and Bateman (2005), maladaptive ways of relating may make those with borderline personality disorder attracted to abusive relationships, such as ""BARBED WIRE"," where they can continue to project negative feelings on to others. This may explain the high-rates of 're-victimisation' of female child abuse survivors through rape and domestic violence (Coid et al, 2001). It should be noted that this is only a correlation and causal mechanisms are unknown. For example, vulnerable people could be easily targeted by abusers. It has been well documented that survivors of abuse can equate love and intimacy with abuse. Therefore, these clients may have distorted physical and emotional boundaries, and may dissociate from cues of danger (Kroll, 1993) as shown through the discourse of ""BARBED WIRE"."

Manthei (2007) stated that people tend to depict therapists who meet their perceived needs, or demonstrate similarity to them, as reasons for good therapeutic alliances. Additionally, Pope-Davis et al (2002), expressed that clients' experiences of therapy were dependent upon their self-identified needs and upon how well the therapist met these needs. Therefore, it seems that some personality disordered clients may believe that they need more and more from their therapist, such as establishing a sexual relationship, which could lead to the (re)creation of a damaging relationship. The research literature has primarily focussed upon harmful effects of sexual contact between therapists and clients

(Pope, 1990). This literature supports the ""BARBED WIRE"" discourse and has important clinical implications that will be discussed more in section 5.4.

5.2.4 Discourse D: "BRICK WALL"

- a stance which is rigid, emotionally and/or physically distant. Thick boundaries.

The discourse of ""BRICK WALL"" represented the statistically distinct viewpoints of participants who loaded onto this factor. This viewpoint will now be discussed, and interpreted, in relation to the literature and tentative conclusions will be drawn.

Boundaries are critical to the therapeutic relationship as they protect the client, the therapist and the therapeutic process (Smith and Fitzpatrick, 1995). This theme around safety and boundaries was expressed repeatedly in the literature. Glass and Arnkoff (2000) elaborated upon this by stating that the context of therapy was considered important whereby clients want a protective setting where they could feel safe. A potentially rigid and distant approach to safety and boundary management supports the ""BRICK WALL"" discourse. For example, in the 1980's there was a shift towards 'risk management' in medicine and this had a knock-on effect for therapy. Therefore, according to Pope and Vasquez (1998), crossing boundaries, such as gift giving, touch and dual relationships, was seen as hazardous, from a risk management viewpoint and a first step in the 'slippery slope' towards sexual relationships and causing harm. Also, the most traditional of psychoanalytic positions support the proposal that therapists should be like a mirror to their clients and any deviation, including self-disclosure, is incorrect and unethical (Langs, 1979; Rothstein, 1997).

Some previous research about self-disclosure has offered additional evidence for ""BRICK WALL"." For example, self-disclosure produced negative effects on the therapeutic process in terms of reactions to the disclosure, or feelings about the

therapist, for some clients (Knox et al, 1997). "One client, for instance, was wary about therapy boundaries and questioned what she was supposed to know as a result of the disclosure, and another client feared the closeness engendered by the disclosure and wanted to push it away" (Knox et al, 1997, p.280). Therapist self-disclosure seems to be viewed with caution as some believe it could interfere with professionalism and the therapeutic process (Peterson, 2002). The most common reason for not disclosing is that it might remove the focus from the client, burden or confuse the client, or blur boundaries between therapist and client (Mathews, 1989; Simone et al, 1998). Clinically, this may have implications for therapeutic interventions and will be discussed in greater detail in section 5.4.

It is important to understand the process of 'rejection' in therapeutic relationships with borderline personality disordered individuals, as this could be considered a primitive defence relevant for the ""BRICK WALL"" discourse. Due to the nature of the diagnosis, individuals with personality disorders have often been exploited or abused and let down. Therefore, often, borderline personality disordered clients expect to be rejected, so use rejection as a way to protect themselves. Thus, many borderline personality disordered clients can be difficult to establish a therapeutic relationship with, because they will often reject the therapist before the therapist can reject them by putting up a ""BRICK WALL"" and being rigid or distant. It is interesting to note that previous research generally supports the viewpoint that unhelpful aspects of therapy were therapists being demonstrating a cold, rote, or impersonal manner (Glass and Arnkoff, 2000) but this current research demonstrates that some clients may prefer this interaction style.

Overall, the previous paragraphs have highlighted and discussed the varying perspectives, about therapeutic boundaries, for people attracting the borderline personality disorder diagnosis. The following section will reflect upon the socio-demographic findings for this study.

5.3 Socio-demographic Observations

A significant majority of participants were female (eighty-nine percent). This is consistent with the prevalence rates, for females and males, in borderline personality disorder, as a greater number of females seem to attract this diagnostic category. According to the DSM-IV-TR (APA, 2000) borderline personality disorder "is diagnosed predominantly (about seventy-five percent) in females" (p.708). This suggests a possibility of diagnostic bias by Psychiatrists or biological and/or socio-cultural differences between men and women leading to the development of borderline personality disorder. In clinical samples, women are more likely to be diagnosed with borderline personality disorder and men more likely to have anti-social personality disorders associated with violent conduct (Morey, 2005). Depue and Lenzenweger (2001), argue that different genders may have different genetic personality trends based on serotonin and dopamine systems. Conversely, Torgersen (2005), argues that the social construction of femininity may bias practitioners to view more borderline personality disorder symptoms in women. Social constructions of gender may also legitimise women accessing services. Men are less likely to report mental health conditions to health professionals than women (MacIntyre et al, 1999, O'Brien et al, 2005), and may talk about mental illness as an embarrassing 'feminising' experience (Emslie et al, 2006). Therefore, the literature for borderline personality disorder is primarily a white and westernised perspective (Ndegwa, 2003) and this pattern is repeated in this study with eighty-nine percent of participants being female and one hundred percent were white.

It is interesting to note that the male participants in this study either loaded onto Factor D ("BRICK WALL") or Factor A ("HEDGE"). However, female participants were represented in each of the four discourses. Participants loading onto Factor D ("BRICK WALL") were the oldest group, with a mean age of forty-seven years. These participants were perhaps displaying the most rigid and distant views as a defensive strategy. It is possible that as personality disordered clients

get older their beliefs develop into more rigid views due to gathering biased evidence for experiences that support their beliefs. The respondents identifying with "HEDGE"' were the next oldest and had a mean age of thirty-eight years. Alternatively, is possible that some personality disordered clients' beliefs become more flexible as they mature. This discourse represented the largest number of participants which adds additional support for this hypothesis. Participants identifying with the discourses of "'CHICKEN MESH"' and "'BARBED WIRE"' were, on average, twenty-eight and a half years and twenty-nine years respectively. Another interesting observation is that participants loading onto "'BARBED WIRE"' had held the borderline personality disorder diagnosis for the shortest time period which was, on average, thirty-seven and a half months (the most frequent time bracket was one to two years). Participants loading onto "HEDGE" had held the diagnosis for the longest time with a mean of seventy months (the most frequent time bracket was six to ten years). The socio-demographics, outlined above, display a wide variation in educational backgrounds, marital status and employment. Overall, it is important to observe these statistics with a critical perspective, as no inferences should be made.

5.4 Implications for Clinical Practice

There is very little information regarding clients' perspectives on therapeutic boundaries. Therefore, therapists and policy-makers require acquisition of this knowledge in order for them to be able to formulate effective therapeutic practice. The implications of the use of Q methodology, to research understanding and experience of therapeutic boundaries, are considered in 5.4.1 and implications of the research findings for wider clinical practice in 5.4.2.

5.4.1 Methodological Discussion

This section moves away from reflecting upon the field of therapeutic boundaries to examine the methodological considerations that were made during study.

An aspect of the diagnostic criteria, for borderline personality disorder, is polarised thinking, such as a therapist being potentially perceived as 'all good' or 'all bad.' Therefore, researching a complex topic, such as therapeutic boundaries with this client group, required a research methodology that would not simplify the subject in terms of 'for' or 'against' therapeutic boundaries. Q methodology is able to reveal the complexity of a topic and Gargan and Brown (1993) found that Q methodology facilitates clarification of "the perspectives of decision makers'" (p. 348) and serves to locate elements of consensus if they exist.

This thesis has explored the conceptual differences between Q and R methodologies. Brown, Durning, Selden, Miller and Whicker (1999) propose that "...the differences between Q and R methods are not simply a matter of technique, they reflect very different philosophies of inquiry that encompass competing epistemologies and understanding of what constitutes sound scientific practice" (p.599). In comparison to more traditional R methodologies, Q methodology offered an alternative for studying subjective attitudes. The main strengths of Q methodology were its capacity to reveal differing attitudes and the complexity of these interwoven viewpoints. In addition, Barry and Proops (2000) state that "Q methodology, we feel, is not 'expert' driven, but a form of research methodology in which the researcher is as much a mirror, reflecting the attitudes of those studied, rather than obliging individuals to categorise themselves according to the criteria derived solely from the researcher" (p.105). This understanding of Q methodology is congruent with the philosophical underpinning of the discipline of Counselling Psychology. Counselling Psychologists strive to take a non-expert position in their work and this is based upon the profession's Humanistic foundations. Therefore, it is hoped that this thesis will encourage others to consider applying Q methodology in research areas where subjectivity is deemed to be important.

Q generates information about discourses that subsequently could, with regard to this thesis, facilitate better therapeutic practice and outcomes. This study has identified the ways that therapeutic boundaries are perceived, through identifying some common perspectives in the borderline personality disordered population. Therapists, therapeutic organisations, and policy-makers who take such discourses into account would be more likely to be therapeutically effective and sensitive to potential ethical issues in clinical practice. Also, by showing areas of divergence between discourses and the people who might hold these views, Q offers some information for therapists and policy-makers regarding what types of therapeutic practice are more, or less, likely to receive support from people attracting the borderline personality disorder diagnosis. Therefore, therapeutic ways of working could potentially be reformulated to offer the most acceptable, and appropriate, therapeutic interventions for people with borderline personality disorder.

Overall, Q methodology has the capacity to reveal viewpoints, whilst still offering statistically rigorous results. However, it is a very time-consuming methodology, so there may be occasions when standard R methods may be appropriate. For example, Schlinger (1969) proposes that "Q methodology is not the answer to all research problems, and it should not be used when simpler information-gathering procedures will suffice. However, it is a powerful, sophisticated method that is appropriate whenever there is a need to develop a comprehensive and differentiated picture of consumers, without the sacrifice of quantification" (p.60). Thus, it has been an excellent research methodology for informing clinical practice and this will be explored further in the next section.

5.4.2 Research Findings for Wider Clinical Practice

The current study has highlighted that the therapeutic alliance, and attitudes about therapeutic boundaries, may require a high level of awareness by therapists in order to facilitate clinical effectiveness. This awareness and

intelligent reflection may enable therapists to become more aware of their clients' attitudes towards boundaries. Research into clients' experiences of therapy and attitudes towards boundaries has many clinical implications. Firstly, it can be used to help identify processes and events that clients find helpful or unhelpful in therapy. . All therapeutic orientations make assumptions about processes that are experienced by clients. This study actually gathered clients' perspectives, through research, which allowed previous literature to be challenged and tested. Finally, by asking clients about their views, researchers can attempt to ascertain 'non-professional' perspectives as clients normally do not have a 'therapeutic language' to account for what happens in therapy.

This research demonstrated that clients may hold one of the four emergent themed attitudes about boundaries such as holding a '"BARBED WIRE"' attitude about boundaries. The four discourses were statistically distinct and portrays the wide variety in clients' perspectives. This awareness could inform and enhance therapeutic interventions with clients. This may suggest the importance of developing therapists' skills for establishing and maintaining successful therapeutic relationships with a wide variety of clients. The role of inter-subjective meanings and beliefs, within and between therapist and client, supports the use of interpersonal models of working with clients advocated by the discipline of Counselling Psychology. In particular, clients with borderline personality disorder, who have often experienced negative relationship patterns as part of the development of the disorder, may particularly benefit from therapists attending to these process issues.

Currently, some services for personality disorders attend to these process issues, including services based upon attachment models (e.g. Bowlby, 1969). These services include therapeutic communities for personality disorders. It needs to been stated that therapeutic communities can vary in the approaches utilised. However, most are based upon attachment models where everyone within the community works together. They are normally a living and learning

environment with a programme of group therapy and activity-based groups. All behaviours, interactions and decisions are open for discussion at therapeutic communities and clients give each other feedback confronting them with the impact of their own behaviour. Clients learn through interaction, observation, reflection and clear boundaries. The aim is for people to develop more adaptive attachment styles and improve interpersonal relationships. The current research supports this style of service where process issues and relationship based models of therapy are advocated.

Another clinical implication for this research is that therapists could aim to develop their skills and techniques for learning more about their clients' and their own experiences. The personality, temperament and relationship-building skills of therapists are rarely evaluated. However, these factors partially shape the relationship that a therapist has with the client. Therefore, this research suggests the value of supporting therapists to identify supervision and training requirements for personal and professional development.

The process of receiving regular clinical supervision and ongoing training may encourage and enhance clinicians' reflective skills in relation to therapeutic boundaries. Clinical supervision can contribution to therapists" ability to manage the practical boundary management demands of clients. Also, supervision can provide the support and guidance essential to enable the therapist to work through personally difficult situations and to reflect on their therapeutic practice.
This research clinical implication is supported by Bland and Rossen (2005) who suggested that clients with borderline personality disorder can be among the most challenging. They state that staff who provide for their day to day care should receive regular clinical supervision. The current research identified that some clients' attitudes may be difficult for a clinician to manage. For example, clients identifying with '"BARBED WIRE"' may be contradictory in their attitudes and/or behaviour. Therapists can have an influence on the therapeutic alliance

between the client and their therapist. Clinical supervision for staff may provide an opportunity to encourage their positive support for the therapeutic alliance.

The term 'boundary' is more frequently used in relation to child development compared to adult relationships. For example, appropriate parental 'boundary-setting' is regarded as crucial to children's development (Kerig, 2006). Baumrind's (1967, 1971) classification of parenting styles contributed to the literature on child-parent boundaries, and originally suggested three distinct styles most present in family dynamics. According to these styles, authoritative parenting, is marked by patterns of warmth, non-punitive discipline, and consistency. Authoritarian styles are marked by patterns of low warmth, harsh discipline, and inconsistency, and permissive styles are evident by low levels of supervision (Maccoby and Martin, 1983). Subsequent research has expanded on Baumrind's parenting styles by differentiating between two categories of permissive parenting; indulgent and neglectful (Lamborn, Mounts, Steinberg, and Dornbusch, 1991; Steinberg, Lamborn, Darling, Mounts, and Dornbusch, 1994).

In relation to the literature outlined above on boundaries and parenting styles, Discourse A ("HEDGE") can be perceived as representing an 'authoritative' style, of relating to another person, which can be conceptualised as a middle road between 'authoritarian' and 'permissive' styles. Authoritative parenting has been shown to foster secure attachments between children and their caregiver and to contribute to a greater sense of autonomy and wellbeing (Karavasilis, Doyle, and Markiewicz, 2003). Discourse B ("CHICKEN MESH") can be viewed as representing an 'indulgent-permissive' style and Lamborn et al (1991) found that adolescents with permissive parents have strong self-confidence but that they experience more problems with drug experimentation and misconduct. Children of permissive parents can find it difficult to control their behaviour and expect to always get their way (Diss and Buckley, 2005). Discourse C ("BARBED WIRE") may be seen as a 'neglectfully-permissive' (Maccoby and Martin, 1983) style and children of neglectfully-permissive parents often show poor self-control, and fail

to handle independence well (Diss and Buckley, 2005). Discourse D ("BRICK WALL") could be conceptualised as an 'authoritarian style.' Children of authoritarian parents are often unhappy, fearful, and anxious about comparing themselves with others and have weak communication skills (Santrock, 2007).

The process of "limited re-parenting" is an important aspect of schema therapy (Young, Klosko and Weishaar, 2003) and the findings of this study support the re-parenting process. Limited re-parenting attempts to address the unmet emotional needs of clients in order to heal schemas (Young, 1999). It involves a therapist offering, within appropriate boundaries of a therapeutic relationship, what clients needed from their parents as children, but did not receive. Limited re-parenting, parallels healthy parenting, which partially involves the establishment of a secure attachment through a therapist, within a boundaried relationship. Limited re-parenting comes from schema therapy's assumption that early maladaptive schemas and modes arise when core needs are not met in childhood. Therefore, schema therapy attempts to meet these needs, through helping clients find the experiences that were missed in early childhood, which will serve as an antidote to damaging experiences, that led to maladaptive schemas/modes. Bateman and Fonagy (2004) propose that limited re-parenting is "in marked contradistinction to traditional analytic approaches, in which the 'real relationship' is considered to be on a path towards boundary violation" (p.128). However, it is important to note that other theorists, such as Gabbard and Lester (2003), explore psychoanalytic positions about therapeutic boundaries and propose that different psychoanalytic perspectives may view this less dichotomously. The clinicial implication of re-parenting could be for services to design their therapeutic interventions, based upon this model, for borderline personality disorder.

Overall, this study makes a contribution to both the field of Counselling Psychology's and other professions' understandings of therapeutic boundaries, and adds to a knowledge base that can be used to inform decisions relating to

staff training, treatment of people with a diagnosis of borderline personality disorder and education of both borderline personality disordered clients and the general public. In summary, the research findings suggest that people attracting the diagnosis of borderline personality disorder may primarily understand, and experience, therapeutic boundaries in one of four different ways, as outlined above. This research has highlighted the importance of, and need for, more research and education about therapeutic boundary issues. Education could be aimed at therapists in training, as part of ethical awareness and development programmes. Also, therapists could acquire further knowledge about therapeutic boundaries as part of their continuing professional development in order to improve safe, ethical and effective therapeutic practice. Additionally, borderline personality disordered clients may benefit from learning more about therapeutic boundaries and their own preferences for relating to therapists. Potentially, this could be a therapeutic priority, with this client group, as relationship styles may be 'practised' and developed in a 'safe' therapeutic relationship. Social disruption is part of the diagnostic criteria for borderline personality disorder. Therefore, clients' enhanced awareness about therapeutic boundaries and relationship styles may precipitate positive behavioural and attitude changes which could, potentially, enhance clients' wellbeing.

5.5 Research Questions

This section moves from reflecting broadly about the findings of the current thesis to specifically answering the questions that have been posed. This section develops the general answers presented within the 'findings' chapter by giving a brief answer, alongside the reasoning behind the conclusion, for the questions that were detailed in Chapter 2.

1. **How do borderline personality disordered clients understand therapeutic boundaries?**

Data generated through the focus groups, and literature search, indicated how people attracting the diagnosis of borderline personality disorder may understand therapeutic boundaries. The qualitative data demonstrated an extreme variety of viewpoints regarding therapeutic boundaries. The main themes that emerged from the focus groups were 'safety,' 'power,' and 'boundary thickness.' For example, many focus group participants understood therapeutic boundaries in terms of safety whereby they believed boundaries protected people involved in therapeutic interactions. Participants from the focus groups often expressed that they understood therapeutic boundaries to be disempowering, or empowering, and many had differing understandings of the level of flexibility appropriate within therapeutic relationships.

Completion of a Q sorting task enabled patterns of attitude types to emerge from the data in this study which demonstrated understandings of therapeutic boundaries. The main discourse observed in this study was "HEDGE" whereby many clients understood therapeutic boundaries as being flexible, evolving and 'firm-but-fair.' Alternatively, borderline personality disordered clients may understand boundaries as something that can be pushed with boundary crossings being perceived as acceptable but boundary violations being seen as unacceptable ("CHICKEN MESH"). Some clients attracting the diagnosis of borderline personality disorder may understand therapeutic boundaries in contradictory and/or extreme ways ("BARBED WIRE") while others maintain a very firm and rigid understanding about boundaries ("BRICK WALL").

2. What experiences do borderline personality disordered clients have of therapeutic boundaries?

The focus groups offered insights into clients' personal experiences of therapeutic boundaries due to the in-depth nature of the research procedure. For example, borderline personality disordered participants gave personal examples of their own experiences of boundaries. These experiences included boundaries

around therapeutic encounters (time, space and money) and boundaries within therapeutic encounters (clothing, gifts, language, self-disclosure and touch). The Q sort methodology enabled patterns of clients' attitudes, regarding these experiences of therapeutic boundaries, to be observed. As outlined above, the analysis resulted in the interpretation of four statistically distinct factors, which represent the experience of therapeutic boundaries, for the twenty-eight participants in this study ("HEDGE", "CHICKEN MESH", "BARBED WIRE" and "BRICK WALL").

3. **Do borderline personality disordered clients report positive or negative perspectives about therapeutic boundaries?**

The data, from the focus groups were analysed in order to ascertain whether participants disclosed positive or negative perspectives about therapeutic boundaries. Overall, the participants in this study reported both positive and negative viewpoints about therapeutic boundaries. The aim of a Q methodological study is not to quantify experiences. However, it was informative, for the Q sort, to identify that participants reported both positive and negative experiences and understandings regarding therapeutic boundaries.

5.6 Future Research

On completing this study it is evident that a number of the initial questions remain unanswered or could be explored in alternative ways. This section outlines what are felt to be the areas of primary concern that are in need of further scrutiny.

The scope of the literature review was very broad and covered clients' perspectives about therapy, therapeutic boundaries and personality disorder. The breadth of the coverage was a strength. However, narrowing the focus of the review would have allowed a greater depth of analysis of the literature.

It is important to acknowledge limitations, and difficulties encountered, with the methodology adopted in this thesis and its application. It is hoped that awareness of these limitations may enhance future research. Additionally, after the completion of this thesis it became evident that there are many further research questions, about therapeutic boundaries, that remain unanswered or could be explored through further research. These areas will be focussed upon in the following paragraphs.

It seems important to acknowledge that the nature of the third research question may have set up a dichotomy within the research and this could be seen as a research weakness. The third research question asked : "Do borderline personality disordered clients report positive or negative perspectives about therapeutic boundaries?" The nature of this dichotomous question seemed to parallel the 'black-or-white' rigid thinking style that is indicative of the borderline personality disorder diagnosis. The main researcher may have been unconsciously influenced, by working in the personality disorder field for approximately four years, to limit the research experiences as 'good' or 'bad' perspectives, This dichotomy was quickly acknowledged within the research process and it should be reiterated that the principle aim of the study was not to quantify experiences but to allow qualitative themes to emerge from the data. Ultimately, it appears that this key aim was met through the research and that the dichotomous third question had little influence upon the process of this study. Future research may wish to carefully consider the nature of the research questions, particularly paying close attention to possibly dichotomous questions, in order to attend to the strengthening of the research process and findings.

The online methodology adopted for this research meant that potential participants were not able to take part if they could not access, or were unable to use, a computer. Therefore, this thesis represents the views of individuals with borderline personality disorder who were competent computer users. Also, the

utilisation of computer technology meant that the researcher never met any of the participants face-to-face. Therefore, it is not possible to be certain that the participants were the people that they were claiming to be. This may have influenced the research findings, such as 'competent computer users' perhaps typically representing a younger demographic group. Also, a lot of communication and meaning can be expressed in a non verbal manner and this additional form of communication was lost through the online methodology. .Additionally, people without the personality disorder diagnosis may have participated, whilst claiming to have attracted the diagnosis, as they were perhaps interested in the research and their identity and diagnostic credibility could not be verified online. Future research may wish to utilise an alternative methodology, such as face-to-face focus groups and face-to-face Q sorting tasks, in order to address these concerns.

During the focus groups, a considerable effort was made to include participants who were less articulate compared to others. In these instances probing questions were utilised with the intention of generating further responses. However, it should be acknowledged that some participants were more willing to share their viewpoints compared to others. This means that the findings of this research are more reflective of the viewpoints proposed by the more expressive participants. In addition, some people agreed to participate in the online study and then 'lurked' in the background without contributing to the content of the focus groups. These 'lurkers' may have influenced the findings as it is possible, for example, that 'lurkers' opinions may have differed from those articulated during the focus groups. These people may not have wished to express their own views due to a social desirability bias and desire to be consistent with the norm. Alternatively, some people may have preferred to observe the research process rather than participate and this will have affected the findings as these participants' viewpoints were not able to be ascertained. Future research may wish to overcome some of these potential difficulties through using alternative research techniques, such as by interviewing participants individually, so that

each participant is directly given the opportunity to express their opinion. Also, future research may wish to remove 'lurkers' from closed online focus groups if they have not actively participated within a certain time limit.

It became apparent that completion of the online Q sort task was confusing for some participants and this could be considered a limitation of this research. The The Q sort task required participants to have a relatively good memory, whereby they could remember and compare various statements for long enough, in order to put them into a rank order. Thus, the Q sort task excluded participants who did not have a good enough memory for the task and may have influenced the findings. People with relatively poor memories may have started the task and left it unfinished. The researcher would not know about this as only fully completed Q sort tasks could be forwarded through the online software. Additionally, the author was requested, through email, to offer additional guidance for the Q sort to three participants. It is possible that this indicates that other participants may have found the task too complex to complete but may not have disclosed this. Future research may wish to further consider participants' cognitive capabilities and perhaps utilise a Q sort task consisting of fewer statements. However, this would limit the possibilities for emergent themes. Also, future research may wish to further acknowledge that some participants find Q sorting a complex task and adopt alternative strategies to manage these difficulties, For example, face-to-face completion of the task would mean that the researcher could immediately address any questions or confusion that may arise.

Future researchers may wish to ensure that the size of their focus groups are consistent. The current study incorporated three focus groups of uneven numbers. The first group comprised thirteen participants whereas the second and third groups had much smaller numbers. The second and third groups each consisted of only three participants. This was due to the small number of participants who put themselves forward for the second and third groups and may have influenced the study's findings. For example, participants may have felt

more able to openly express themselves in a smaller focus group compared to a larger group. However, focus groups of differing sizes could be viewed as a strength as this technique enabled a variety of voices, from people with differing personality characteristics, to be heard. For example, the smaller second and third groups may have allowed more socially anxious individuals to express themselves more openly compared to socially anxious individuals participating in a large focus group.

Future research may wish to further limit researcher subjectivity through introducing more objective research methods. For example, the items for the Q sort were generated by the researcher selecting statements and this could be seen as a limitation due to possible subjective biases. It is possible that the researcher may have had biases, such as a biased perception regarding the meaning of therapeutic boundaries. For example, this could have influenced the research through items being potentially omitted, or particularly focussed upon, depending upon the researchers' viewpoint. However, it should be accentuated that the strength of Q sort studies is not from the 'quality' of statements but from the relationship between any of the statements in a Q sort. Also, the researcher used qualitative data from the focus groups to support the Q sort results and this meant that subjective biases may have interfered with the study's findings. It was felt that the benefit of being able to elaborate upon, and give detailed and descriptive examples of the four themes, through utilizing the data from the focus groups, outweighed the possible costs. However, other researchers may wish to adopt more objective research methods in the future.

Overall, Q could be viewed as an abductive approach which may lead to additional questions that could be pursued through both qualitative and quantitative methods. There are numerous areas of future research highlighted by this study. For example, the current thesis could inform the design of a questionnaire, about therapeutic boundaries, which further explores the four discourses identified in this study. Alternatively, the discourses identified in this

research could be used to inform further Q methodological studies about more specific therapeutic boundaries. For example, a research focus could be placed upon one therapeutic boundary such as the boundary of touch. These avenues for future research could incorporate web based, telephone, video conference, face-to-face or paper research methodologies to help understand the nature of therapeutic boundaries.

It would be interesting to repeat the Q sort from this thesis in order to explore how discourses may alter over time. It is important to recognise that the formation and maintenance of viewpoints is reflective of social and cultural contexts. Therefore, new discourses about therapeutic boundaries may emerge, or disappear, over time and further research may be able to offer further insights. Also, the relative stability of the four discourse patterns could be researched. It is noteworthy that participants identifying with the discourse of '"HEDGE" had a mean age of forty seven years compared to twenty-eight and a half years and twenty-nine years for '"CHICKEN MESH"' and '"BARBED WIRE".' It is hypothesised that people identifying with the discourse of '"HEDGE"' may have held other discourse patterns, such as '"BARBED WIRE",' earlier in their lives and this warrants further research. Additionally, the current research did correlate the amount of therapy undertaken by participants with the four identified themes. Thus, the length of time that individuals have engaged in therapy may be associated with the different boundary discourses and this could potentially offer an important avenue for further research.

Further research could be conducted into both the childhood, and adulthood, experiences that may have contributed to the development of different discourses regarding therapeutic boundaries. Finally, and perhaps most significantly for the relational discipline of Counselling Psychology, further exploration of the views of both clients and clinicians, could offer constructive insights into the relationship between boundary discourses and perspectives of the therapeutic alliance. All of this research about boundary styles and

preferences could potentially incorporate both clients' and therapists' viewpoints and it may be useful to compare and contrast perspectives.

5.7 Summary

This chapter reviews the findings of this study in relation to the current literature. The research strategy that has been adopted is felt to have successfully met the aims of this project.

This chapter has highlighted both the areas of agreement, and disagreement, between the discourses identified through Q methodology in this thesis. Overall, the implications for this study suggest that it has the potential to offer borderline personality disordered clients, trainee therapists, therapists and policy-makers, with information that could facilitate more effective and appropriate therapeutic practice.

The analysis resulted in the interpretation of four statistically distinct factors, representing the understanding and experience of therapeutic boundaries, for the 28 participants in this study. The discourses were summarised as follows:

Discourse A: "HEDGE"

- a flexible, evolving and 'firm-but-fair' viewpoint. A balance between thick and thin boundaries.

Discourse B: "CHICKEN MESH"

- a perspective where clients push boundaries by attempting to cross them rather than violating them. Thin boundaries.

Discourse C: "BARBED WIRE"

- a position of contradictory and extreme viewpoints, which may inadvertently involve clients seeking to (re)create damaging relationships. Fluctuation between thick and thin boundaries.

Discourse D: "BRICK WALL"

- a stance which is rigid, emotionally and/or physically distant. Thick boundaries.

This chapter has also presented suggestions for future research. Final conclusions are presented in chapter 6, and reflexive insights about the author's experience of writing this thesis will be articulated.

Chapter 6

Reflection

**"A boundary is not that at which something stops…
the boundary is that from which something begins" (p.154).**

Heidegger (1975)

6.1 Introduction

This Doctoral thesis has offered a detailed account of Q methodology as a technique capable of addressing the complexities regarding borderline personality disordered individuals' experiences, and understandings, of therapeutic boundaries. A two-stage application of Q methodology, involving focus groups and a Q sort task, together with implications for clinical practice has been presented. At the beginning of this thesis, the author's motivations for conducting a study about therapeutic boundaries was outlined. This final chapter draws the thesis to a close so it feels appropriate to offer some thoughts and reflections about the impact that this thesis has had. The following sections are written in first person narrative to accentuate the personal nature of these reflections.

6.2 Reflection Regarding Methodology

There will always be benefits and drawbacks for methodological approaches adopted in any study. However, I perceive that the benefits of Q methodology, focus groups and online research techniques, outweigh the drawbacks. The appropriateness to the aims, objectives and philosophy was considered high for this study. These components have, at times, been difficult to effectively synthesise in a coherent manner for the purposes of this thesis. Also, it was challenging to write a thesis, within the word count allowed, due to the multitude of avenues that could potentially have been explored.

Overall, I have been amazed how stimulating the design aspect of this research project has been and the seemingly boundary-less questions that have been raised in response to acquiring further research knowledge. In therapy the 'good enough mother' (Winnicott, 1953) stands in contrast with the 'perfect mother' who satisfies all of the needs of the infant, immediately, thus preventing him/her from developing. The design of this project has furthered my knowledge of how important it is to formulate a study that is philosophically and technically 'good enough' and does not need to be 'perfect.' The reader is invited to consider whether the previous chapters, detailing research procedures, results and discussion, are 'good enough' to meet the research aim and justify the methodology adopted. I strongly believe that these research 'needs' have been met but I am also acutely aware of the importance of epistemological reflexivity.

Epistemological reflexivity offers an opportunity to examine the way that this study approached the research and what this may mean about the subsequent knowledge that was produced. For example, it is possible that the nature of this study's research question defined and limited what could be found because of the language used. Participants were initially asked during the focus groups: "What is your experience of therapeutic boundaries?" The words used to phrase this question and any subsequent prompts, alongside participants' responses, played a role in constructing the meanings attributed to these experiences. Also, the themes that emerged during the qualitative analysis research process inevitably contributed towards shaping the study's findings. The design of this study may have further limited what could be found due to the reductionistic nature of Q methodology. Participants were made to rank and place statements in categories during the second part of the study and this forced choice may be considered to inhibit what could be found. The research question could have been investigated differently, such as through attitude questionnaires, and it is plausible that this would have given rise to a different understanding of the phenomenon of therapeutic boundaries.

6.3 Research Journal

A commitment to critically reflect upon therapeutic and research practice, is fundamental to the discipline of Counselling Psychology and congruent with my own beliefs about effective, ethical behaviour. In my opinion, an important part of this research journey involved my attempts to record my own reflexive processes through a research journal. Initially, I thought that writing a research journal might create even more work for a project that, at times, seemed 'boundary-less.' However, it proved to be invaluable in raising my awareness of developing beliefs, regarding boundaries, and my own experiences and thought processes that have partly influenced this research. In addition, this journal allowed a safe place to vent my frustrations about the perceived slow progress of this thesis and it enhanced my ability to maintain perspective, when necessary.

6.4 Ethical Concerns

An ethical concern, of which I became aware while writing this thesis, was about using other people's experiences to gain a Professional Doctorate degree. I realise that this parallels the ethical dilemma of any psychologist or therapist who receives financial reward, or some sort of personal gain, including satisfaction, from being with other people in pain. However, I came to realise that participants, who chose to become involved in this research project, were also gaining benefit through the process. Many participants emailed messages with their completed Q sort results. An example of which is "I really hope that this research will help others with borderline personality disorder to get the help they deserve." This type of message implicitly implied that the participant had got personal satisfaction through thinking that their own views had value and that they might be able to help other people. This research thesis was incredibly challenging, but my personal gain was a sense of achievement. My professional reward has been to gain a Doctorate qualification, increase the profile of the

relatively new profession of Counselling Psychology, and enhance my competence at work.

6.5 Catharsis

As outlined in the 'Researcher Statement', at the beginning of this thesis, my interest in professional boundaries stemmed, primarily, from working at a specialist personality disorder service in my early twenties. It seems ironic, but I have come to realise, through writing this thesis, that sometimes violations of boundaries can have some very positive consequences in the longer term. On a personal level, my professional confidentiality was once broken, by a previous senior colleague, through her own lack of insight and awareness, rather than malice. I believe this has heightened my own awareness of the importance of strict confidentiality boundaries with both clients and other professionals.

In this incident, I had given in my notice period due to career progression, after four years of service, and had expressed the ethical importance of negotiating therapeutically sensitive endings with clients, with whom I was working. However, without my knowledge, and contrary to a verbal agreement, this senior colleague chose to inform all clients, that I was working with, that I would be leaving the service. At the time I can remember feeling shocked, as I could not comprehend any therapeutic reason, that would be in the clients' best interests, why this had been done. However, I understand that it is common that, when humans feel rejected, they can potentially become very rejecting, and this reciprocal role is common for people with the diagnosis of borderline personality disorder. It is only through writing this thesis that I have come to realise how angry I actually felt about this senior colleague's, in my opinion, unethical behaviour. Upon reflection, it is clear that this incident was significant to me, as it provided the inspiration to research therapeutic boundaries from clients' viewpoints. I had felt powerless to respond adequately in the situation outlined above, due to the power differential with this senior colleague. Additionally, I

think that my emotional response, which was a reaction to this incident, allowed for a personal connection to the subject matter of boundaries. Consequently, this emotional connection, borne out of a human relationship, contributed to keeping me motivated to complete this Doctorate thesis on therapeutic boundaries, over the last few years. Therefore, I believe that, sometimes, in the long term, crossing, or even the violation of boundaries can potentially offer a significant turning point in a person's professional and personal development and this could, potentially, parallel therapeutic interactions.

In classical Psychoanalysis 'catharsis' is used to describe the relieving effects of expressing deep and previously hidden feelings associated with past events. The assumption is that, as a result of the emotional process of disclosing experiences, energy, that was previously used to suppress this pain, would be released. It is proposed that this enables the person to act, think, and feel more freely. I consider the writing of this thesis to have been a cathartic experience. In contemporary Psychodynamic therapy "the important issue ... is not to vent the anger in the moment but notice the feeling and find some way to use its energy in the service of problem solving" (McWilliams, 1999, p.20). Overall, I believe that I channelled the anger and pain that I felt, in response to an old colleague's perceived unethical behaviour, into the creation and development of this research thesis.

It seems important to be aware that the cathartic processes outlined above may have influenced the research findings. For example, the incident described earlier, regarding a senior colleague's unethical behaviour, acted as a catalyst for my own interest in therapeutic boundaries. This interest, and associated process issues, may have led to biases such as overly attending to information related to the breaking of confidentiality boundaries. It is possible that these biases may have led to less focus being placed upon other possible therapeutic boundaries such as the use of language within therapy e.g. use of culturally diverse words and swear words. Additionally, the fact that I worked in a personality disorder

service for approximately four years may have impacted upon the objectivity of the study. Working in a personality disorder service allowed me to observe examples of attitudes towards therapeutic boundaries. For example, it was common to observe clients displaying very rigid black-or-white attitudes about therapeutic boundaries. These observations may have led to me making some assumptions about the possible themes that could be present and may have biased any interpretations made. However, I do not feel that this was a particular difficulty within the current research as steps were taken to enhance rigour and objectivity, such as through writing a reflective journal and getting other people to read and check possible Q sort statements during the pilot stage.

6.6 Summary

Through writing this thesis, studying the literature, talking with colleagues, reflecting upon my personal and professional relationships, I have learned that there are no black and white answers to questions regarding therapeutic boundaries. The findings of this thesis suggest that there are at least four distinct types of experiences, and understandings, of therapeutic boundaries for people attracting the diagnosis of borderline personality disorder and this thesis makes a contribution to the developing evidence base for working with this client group. Also, I consider that the overall research process and subsequent research findings have influenced my own thoughts about therapeutic boundaries in my ongoing professional practice. While initially working as a Psychologist, I did not have such an awareness regarding other people's vastly differing perspectives regarding therapeutic boundaries. With this current and enhanced awareness, gained through this research process, I now attempt to attend to clients' specific therapeutic boundary needs through careful attention to the ongoing therapeutic relationship. Notably, I consciously think about therapeutic boundaries during therapeutic interventions. I currently work for the National Health Service and am obliged to inform clients about standard boundaries such as the length of sessions and confidentiality arrangements. I am now more explicit about

therapeutic boundaries, such us by giving additional verbal information about boundaries during initial assessment, and where appropriate during ongoing therapy, appointments.

A previous Clinical Supervisor once said to me "for someone who likes to see the bigger picture why are you setting yourself, and others, limits by studying boundaries?" I can remember thinking for a moment before replying "it depends upon what the word boundary means to the individual. For me it doesn't represent a limit, or border, but instead offers infinite possibilities."

"A boundary is not that at which something stops...
the boundary is that from which something begins" (p.154).

Heidegger (1975)

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List of Appendices

Appendix Number		Page(s)
1.	Comparison of DSM and ICD Classifications of Personality Disorders	226
2.	Personality Disorders of DSM-IV-TR	228
3.	Approved Ethics Committee Application	230
4.	Inclusion Criteria from the Research Website – Text and Screen Shot	236
5.	Demographic Questionnaire from the Research Website Full Text and Screen Shot	240
6.	Focus Group Transcripts	243
7.	Q Sort Statements	277
8.	Screen Shot of the Research WebQ	281
9.	Instructions for the Online Q-Sort	282
10.	Q Sort Distribution Template	284
11.	Email Generated After Q-Sort Completion	285
12.	Socio-Demographic Information SPSS Output – All Factors	286
12a.	Socio-Demographic Information SPSS Output – Factor A	289
12b.	Socio-Demographic Information SPSS Output – Factor B	292
12c.	Socio-Demographic Information SPSS Output – Factor C	295
12d.	Socio-Demographic Information SPSS Output – Factor D	298
13.	Screen Shot of Focus Group Boundaries	301

Appendix 1. Comparison of DSM and ICD Classifications of Personality Disorders

	DSM IV TR (APA, 2000)	ICD 10 (WHO, 1992)
Definition Personality Disorder	'An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. This enduring pattern is inflexible and pervasive across a broad range of personal and social situations and leads to clinically significant distress or impairment in social, occupational or other important areas of functioning. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.'	'A severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption.'
Classification Personality Disorder	**Three Clusters, Ten Types**	**Nine Types**
	Cluster A (Odd-eccentric): 5. Paranoid PD 6. Schizoid PD	8. Paranoid PD 9. Schizoid PD

	7. Schizotypal PD	
	Cluster B (Dramatic-emotional): • Anti-Social PD • Borderline PD • Histrionic PD • Narcissistic PD	• Dissocial PD • Emotionally unstable PD – Impulsive type • Emotionally unstable PD – Borderline type • Histrionic PD
	Cluster C (Anxious-fearful): 7. Avoidant PD 8. Dependant PD 9. Obsessive Compulsive PD	10. Anxious (Avoidant PD) 11. Dependant PD 12. Anankastic PD

Appendix 2. Personality Disorders of DSM-IV-TR (adapted from Millon & Davis, 2000)

Cluster A (Odd-eccentric)	
Paranoid PD	Guarded, defensive, distrustful, suspicious. Hypervigilant to the motives of others to undermine or do harm. Always seeking confirmatory evidence of hidden schemes. Feels righteous but persecuted.
Schizoid PD	Apathetic, indifferent, remote, solitary. Neither desires nor needs human attachments. Minimal awareness of feelings of self or others. Few drives or ambitions if any.
Schizotypal PD	Eccentric, self-estranged, bizarre, absent. Exhibits peculiar mannerism & behaviours. Reads thoughts of others. Preoccupied with odd daydreams and beliefs. Blurs line between reality and fantasy.
Cluster B (Dramatic-emotional)	
Histrionic PD	Dramatic, seductive, shallow, stimulus seeking, vain. Overreacts to minor events. Exhibitionist as a means of securing attention & favours. Sees self as attractive and charming.
Narcissistic PD	Egotistical, arrogant, grandiose, insouciant. Preoccupied with fantasies of success, beauty or achievement. See self as admirable & superior and therefore entitled to special treatment.
Borderline PD	Unpredictable, manipulative, unstable. Frantically fears abandonment and isolation. Experiences rapidly fluctuating moods. Shifts between loving and hating. Sees self and others as

	alternately all-good and all-bad.
Antisocial PD	Impulsive, irresponsible, deviant, unruly. Acts without due consideration. Meets social obligations only when self serving. Disrespects societal customs, rules & standards. Sees self as free & independent.
Cluster C (Anxious-fearful)	
Avoidant PD	Hesitant, self conscious, embarrassed, anxious. Tense in social situations due to fear of rejection. Plagued by constant performance anxiety. Sees self as inept, inferior, or unappealing. Feels alone and empty.
Dependant PD	Helpless, incompetent, submissive, immature. Withdraws from adult responsibilities. Sees self as weak or fragile. Seeks constant reassurance from stronger others.
Obsessive Compulsive PD	Restrained, conscientious, respectful, rigid. Maintains a rule bound lifestyle. Adheres closely to social conventions. Sees the world in terms of regulations & hierarchies. Sees self as devoted, reliable, efficient, productive.

Appendix 3. Approved Ethics Committee Application

LONDON METROPOLITAN UNIVERSITY
Department of Psychology
Professional Doctorate in Counselling Psychology

DEPARTMENTAL FORMS FOR THE ETHICAL CLEARANCE

OF RESEARCH PROJECTS

The forms below will be used by your Supervisor, the module co-ordinator and/or the Psychology Department's Research Ethics Review Panel (RERP) to determine the ethical soundness and viability of your proposed research project.

After submitting this form, you must await notification of ethical clearance before commencing any data collection.

Insert additional sheets only if absolutely necessary. Your descriptions of your proposed research must be as explicit and comprehensive as possible. If they are too vague to assess the project's ethical soundness and viability you will be asked to resubmit these forms which, of course, will take up valuable time and delay you proceeding with data collection. Ensure that all relevant parts of the form are complete before submitting.

Student Name ***REBECCA BOYLE***

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CO1 2SY.

Email **RCB0034@LONDONMET.AC.UK**

Telephone No **07890 207779**

PLEASE NOTE: YOUR EMAIL ADDRESS AND TELEPHONE NUMBER ARE IMPORTANT AS THEY WILL BE USED TO INFORM YOU WHEN YOU HAVE

BEEN GIVEN ETHICAL CLEARANCE TO PROCEED WITH DATA COLLECTION.

Professional Doctorate in Counselling Psychology
Study outline and ethics application: Student's Report

Title of study: **Borderline Personality Disorder Clients' Understanding of Therapeutic Boundary Alterations: A Q methodological study**

Student name: Rebecca Boyle Supervisors: Jill Mytton/Charlotte Brownlow ***(later changed to Elaine Kasket due to Jill Mytton leaving London Metropolitan University)***

Student number: 06025605

1. Study outline

Research topic and question. State clearly the topic to be investigated and the research question(s) to be addressed in your study.

The discipline of Counselling Psychology has a firm value-base, which is grounded in the primacy of the therapeutic alliance. Boundaries are essential for establishing and maintaining therapeutic relationships and allow the safety necessary for client self-disclosure (Epstein, 1994). It has been proposed that personality disorders are associated with "pushing the limits" (Bender, 2005; p.73), particularly the borderline personality disorder (BPD) diagnosis, which is predominantly based on a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity (American Psychiatric Association, 1994). Alliance ruptures and premature drop-out, from psychotherapy, are common with clients who have a diagnosis of BPD, limiting the clinical effectiveness of treatment.
This study aims to:
(a) Define boundary alterations from borderline personality disorder clients' perspectives.
(b) Describe different accounts of boundary alterations by:
(I) Reporting the diversity/range of understandings of boundary alterations, by clients.
(II) Demonstrating that these accounts are either positive or negative experiences.
(III) Recognizing the influences that affect boundary changes.
Research Question - How do BPD clients understand and experience alterations made to therapeutic boundaries?

Study design. Outline the proposed design of the study including your methods of data collection and analysis. If an experimental design, state the variables you plan to measure. If a non-experimental design, describe the nature of the study.

Q methodology (Stephenson, 1935), is a pattern analytic technique that has been chosen for this study, as it allows access to individual and collective experiences, without sacrificing scientific rigour. Q methodology is an example of an integrated quantitative and qualitative approach to data analysis. Stephenson, (1935, 1953), was interested in providing a way to reveal the subjectivity involved in situations, which is typically passed over by quantitative procedures. Q methodology "combines the strengths of both qualitative and quantitative research traditions" (Dennis & Goldberg, 1996, p. 104). It is a dynamic method that aims is to identify the way in which language is configured into particular patterns. Therefore, the end result of Q analysis is the definition of a collectively defined account that cannot be traced to a particular individual. Interpretation is based on analysis of statement positions with reference to the available literature. According to Liegeois & Van Audenhove (2005), "The problem is thus evident: policy makers insist that information must be quantifiable, but ethical reflection is ultimately qualitative by nature, and cannot, without difficulty, be reduced to quantifiable data" (p.453).

There are four key aspects to Q methodology, that will be used in this study. The first stage involves developing a "Q concourse" by sampling the area of interest and generating a number of statements (Q set)

that represent a wide range of opinions and ways of understanding therapeutic boundary alterations. Asynchronous online focus groups will be conducted, in order to survey BPD clients' understandings of boundary alterations, thus informing the Q sort. The next step involves asking participants to carry out a Q sort, which requires participants to order the statements along a continuum of "most agree" to "most disagree", according to how the statements reflect their point of view. The participants will be required to place all the statements into a grid, which means the statements are compared with each other during the sorting process, revealing the statements that create the strongest reaction in the participant. Participants will also be asked for demographical data and invited to reflect on how they have completed the Q sort. All of these tasks will be provided to participants in what is commonly known as a Q pack. The third stage will involve entering the completed Q sorts into a database for factor analysis. Finally, results will be taken back to some of the original participants, to check that any interpretations of the results are representative. At this stage, the conclusions forming the data will be revised as necessary.

The data from the focus groups will be summarised and themes developed, by grouping typical responses to the questions. This data will provide statements for the Q sorting, alongside beliefs about boundary alterations from the literature, that are felt to be important, that did not get raised in the focus groups. The data from the focus groups may also provide important material, that could be used to support theories in the Discussion section, of the research study.

The completed Q-sorts will be analysed using factor analysis (principal components), using PQMethod. The whole Q-Sorts will be factoranalysed for intercorrelations, rather than individual items (as in traditional factoranalysis). Hence participants, not sample items will be correlated and, therefore, this procedure does not require data from a large number of people, unlike other factor analytical methods (McKeown and Thomas 1988). Respondents loading on each factor indicates the association between respondents and the expressed point of view. Factor arrays will be constructed by merging high loading Q-sorts. Finally the factors will be interpreted in terms of existing accounts and theories, which appear to be reflected in the patterns of responses. The object of analysis is, firstly, to summarize underlying factors which determine patterns of intercorrelation amongst the data, and, also, to determine which individual Q-sorts are positively correlated with a particular factor. Factor scores will then be displayed in a factor array, from which interpretation will proceed. Interpretation of the accounts will be based on examination of the relative factor weightings in the factor arrays and will be informed by the review of the literature and by reference to the people who defined the factors that were loaded at a significance of more than 0.45.

Participants. Specify the population from which you will draw your participants, how they will be accessed, and how many you will need. Specify any inclusion/ exclusion criteria which will be applied. If you intend to sample from special populations (e.g. School children), indicate what arrangements you have made (or will be making) to gain approved access.

In Q methodology, sampling is different compared to methods used in conventional psychology research. According to Jones, Guy & Ormrod (2003), it is the participants who have the status of variables rather than the sample elements. For the purpose of analysis, the sample is each participant's set of Q-items (McKeown & Thomas, 1988). Therefore, in Q-methodology, the breadth and diversity of the participant sample are considered important (Brown, 1996), in order to investigate the complexities surrounding boundary issues, and participants should be individuals who are likely to have viewpoints on the topic under investigation. Participants will be recruited from a variety of sources, including Personality Disorder Services in the United Kingdom and a BPD internet forum (Borderline UK Yahoo group), in order to sample as many divergent BPD client voices as possible. Tentative expression of research interest has been conveyed to the yahoo group web-master, by email, with positive feedback. Informal discussions with managers of two of the National PD Services has also resulted in positive responses.

Approximately 40 BPD clients will be invited to participate in online asynchronous focus groups, before Q sorting is undertaken, with about 40-60 clients. There will be approximately 5 focus groups, with about 8 BPD clients in each group. The purpose of the asynchronous online focus groups is to inform the content of the Q sorts. The intention is to focus participants on their own therapeutic boundaries, their management of therapeutic boundaries, their experiences of boundary alterations and how they understand boundary alterations. The Q-sort packs will be sent to clients by post or email. Participants, for the online groups, will be invited through a written posting on the Borderline UK Yahoo subgroup called "Borderline UK Managing BPD group." The Borderline UK group is for people resident in the UK who have been diagnosed with BPD. Borderline UK Managing BPD "...is a group for those members of Borderline UK Yahoo group who feel they are moving towards recovery and/or being able to manage their BPD. The aim of this group is to encourage

people to manage their recovery by looking at such things as: our behaviours and reactions; developing boundaries; taking responsibility for our actions; challenging aspects of our own and others behaviour/thinking; developing our self esteem and of course to support each other on this journey." In order for as many clients as possible to complete the Q-sort, additional clients who have not participated in the focus groups, will be invited to participate by letter. This will be sent to every personality disorder service listed on the National Personality Disorder Service website.

Materials. Specify the materials you intend to use in your study. This should include any stimulus materials as well as data collection materials. Say whether these materials are pre-existing (e.g., standard psychometric test) or whether you plan to produce your own.

The main pieces of equipment that will be needed for this piece of research are a computer and data analysis software (PQMethod). One Q sort pack, comprising of statements relating to therapeutic boundaries, will be compiled. Consent forms, information sheets and debriefing forms will be created by myself.

Procedure. Briefly outline the procedure through which you plan to collect your data (excluding access to participants).

Clients will be invited to participate in online focus groups, through posting an invitation on an online BPD forum. After participants have agreed to take part, and given informed consent, they will be granted access to an online forum, controlled by Rebecca Boyle. Clinicians and clients will be asked to identify boundaries that they think are important and to elaborate upon these boundaries. I will purposefully not suggest boundary topics, as I do not wish to lead the participants. Participants will then be asked to identify situations in which a boundary was extended or changed and asked how they experienced this alteration. The data will be summarised and themes developed from the data by grouping typical responses to the questions. Participants will then be asked to review the themes for accuracy.

It is hoped that asynchronous on-line focus groups will reveal participants' perceptions, feelings and understandings of memorable boundary situations. The participants will decide when (eg. time of the day) and where (eg. on a computer at home) this will occur. Statements will be selected, verbatim, from the written transcripts. One Q-sort will be prepared from these statements and statements may be added, from the literature, that are felt to be important, that do not come up in the focus group. This is known as a 'hybrid type' (McKeown and Thomas, 1988). A pilot of five volunteers will be asked to sort the statements into three piles, 'agree' 'disagree' and 'indifferent/don't know' and then complete the Q-sorts and provide feedback to Rebecca Boyle.

Each participant will receive a Q-pack, either in person, or through the post, which will include the Q-sort (statements and response grids), covering letter, instructions for completion of the Q-sorts, marker numbers for the columns, a consent form and a personal information sheet. Where possible, instructions will be given verbally. Participants will be asked to sort the statements, on a scale of most agree to most disagree, using a quasi-normal distribution. Participants will then be asked to return the completed Q-sorts, consent form and information sheet to Rebecca Boyle in the envelopes provided.

Timetable. Provide a timetable for the key stages in your project

November 2007 – January 2008: Preparation/Discussion with supervisors.

23rd January 2008: Submission of proposal and ethical clearance documents.

25th February: Submission of RD1 form.

April 2008 – December 2008: Organisation and completion of the online focus groups. Completion of Q sort methodology. Analysis of results.

January 2009 – September 2009: Dissertation write-up.

4th September 2009 : Submission of completed dissertation.

2. Ethics proposals

Briefing and consent. Specify the content of what you plan to say to participants by way of introducing your planned study. If you intend to omit anything important (beyond explicit specification of your focus), or you plan not to include a consent form, say why. Please provide a copy of your informed consent form. If your questions touch on sensitive issues, please attach questionnaires, interview schedules or examples of questions, unless instruments are well known.

Research information sheets and consent forms will be included with the participants' letters of invitation. The participants will also be fully briefed before the focus groups and/or Q sorting, in order to be able to give informed consent. During this initial stage, a contract of confidentiality will be agreed. Participants will also be told about their right to withdraw from the study, at any time. This research study will not involve any deception and the nature of the research will be very clear to participants. The participant information sheet is particularly detailed, in order to be transparent about the nature of the research and to address potential ethical concerns.

Confidentiality. Are there provisions for informing participants of confidentiality and protecting data from infringements of privacy? If there are no provisions, say why.

A commitment will be given to ensure that confidentiality of participants will be respected. Participants will be informed of confidentiality issues in writing, through the consent form and information sheet. Only Rebecca Boyle, Jill Mytton and Charlotte Brownlow will have direct access to participants' focus group transcripts. Only members of each focus group (approx 8 clients per group) will have online access to their own focus group's asynchronous chat page. Examiners of the research project will have sight of these transcripts, but as much identifying information as possible will be disguised or removed. For example, in all of these instances, participants names will not be included and any identifying information about participants, or other people, will be removed. Participants will be advised not to mention, by name, any professionals or clients, or to include information that could make third parties or institutions easily identifiable. It is stated in the information sheet that participation in this study will not affect therapeutic relationships due to this research being conducted for academic research purposes. It is clear to participants, from reading the information sheet, that participation will not be mentioned by the researcher in front of other people. No staff or clients from any of the Personality Disorder Services will be provided with information about participants, or the results of this study, which are in addition to the final research report. The only time that confidentiality might be compromised would be in fulfilling a professional duty of care. Rebecca Boyle would be required to report a participant to appropriate third-party services (eg. Police/Psychiatric professionals) in the unlikely event that there is a risk of significant harm to the participant, or others, or where serious criminal acts are involved. Research-related paperwork, will be kept in a locked filing cabinet at Rebecca Boyle's home. A lockable bag will be used to transport confidential research items.

Debriefing. Briefly say what you plan to tell participants afterwards. If your study could identify vulnerabilities, what do you plan to do (e.g., plans to give participants details of potential sources of help)?

After the focus groups and/or Q sorting, participants will be provided with a debriefing sheet (online/as an attached file/in person) and will be given the opportunity to ask any questions they wish, that may arise from the research. It is possible that this research may have psychological implications for the participants. The interview questions are intended to provoke thought about personal processes, when there are boundary alterations. However, clients will be invited to participate through a written posting on Borderline UK Managing BPD Yahoo group. This group"...is a group for those members of Borderline UK Yahoo group who feel they are moving towards recovery and/or being able to manage their BPD. The aim of this group is to encourage people to manage their recovery by looking at such things as: our behaviours and reactions; developing boundaries; taking responsibility for our actions; challenging aspects of our own and others behaviour/thinking; developing our self esteem and of course to support each other on this journey." Therefore, these potential participants have chosen to already explicitly discuss reflective issues online. It is hoped that any participants who chose to take part, from the National Personality Disorder Services, will also experience personal therapeutic-value through self-reflection. It is hoped that this research will have a positive psychological impact upon participants. In the unlikely event that participants wish to learn more about boundaries and ethical implications, triggered by this research, I will make some further reading material available. In order to acknowledge the potential impact of this research upon participants, the

following questions will be explored during debriefing; How has taking part in this research affected your view of boundaries, if at all? What has been your experience of taking part in this research study?

Deception. If your study involves intentional deception (other than harmless omissions of aims or focus), give details or write 'none'.

NONE

Special protection of participants. Specify any foreseeable physical or mental harm/ discomfort that your participants could experience as a consequence of participation, and your plan to minimise the risks. If no risk, write 'none'.

It is possible that participants might feel hot emotions (eg. anger, sadness) after talking about boundary alterations that have been emotionally salient. It will be important that participants have a space (online or in person), to be able to vent these feelings, in order to manage them. If any of the clients who chose to participate are aware of Rebecca Boyle's professional role, at one of the National PD Services, this could have environmental implications. Clients might feel alienated by the researcher after their participation, may alienate the researcher, or may become overly 'friendly.' Ironically, this research concerns boundary issues and it is recognised that this study poses its own boundary dilemma, due to the dual role of the main researcher being a "researcher" and possible "clinician." Personal reflection, supervision and awareness of therapeutic dynamics will be maintained in order to manage this dilemma. An assurance will be given that whether or not clients take part, it will not affect their status at work and they will not be treated differently compared to other clients. Participation will not be mentioned by the Rebecca Boyle, in front of other people, and it will be up to participants whether or not they wish the mention it. The focus of this research is upon "process" rather than "judging" behaviour. The intention is not to encourage revelation of ambiguous ethical behaviour but to explore how participants understand and experience boundary alterations and this is stated in the information sheet. I have incorporated questions into my debriefing, that explore the affect participation, in this research, may have on participants.

Any other ethical issues. Specify any other ethical issues raised by your proposed study (e.g., use of vulnerable population) and say how you plan to address these.

With regard to ethical considerations, BPS guidelines and London Metropolitan University ethics policies have been consulted. It is acknowledged that I am currently employed by one of the National PD services, alongside my Doctorate Training in Counselling Psychology. Therefore, this dual-role as a researcher and as a Project Worker/Trainee Counselling Psychologist may not be seen as an ideal situation. However, the potential for adding to the evidence-base of knowledge for working with clients with PD, in my opinion, counteracts my dual-role. Also, I have explored the ethical implications of this study extensively and have attempted to address these issues. For example, I have incorporated questions, in my debriefing, that explore the affect participation in this research may have on participants and any potential professional relationship with myself. It must be emphasised that I will maintain ethical awareness and will not coerce any clients to participate. The information and debriefing sheets request that participants inform my research supervisor if they feel ethical boundaries have been crossed. Clients who may decline to participate will not be disadvantaged in any way. Likewise, those who may choose to participate will not be advantaged, in any way.

I have read, understood, and agree to abide by the Ethical Principles for Conducting Research with Human Participants set out by the British Psychological Society.

Student's Signature: **Date: 22/01/08**

Rebecca Boyle

Appendix 4. Inclusion Criteria from the Research Website – Text and Screen Shot

► ***Who is carrying out the research?***

This research study is led by Rebecca Boyle, at the Psychology Department, London Metropolitan University. Dr Charlotte Brownlow and Dr Elaine Kasket are on the supervisory team for this research project. This research fulfils a partial requirement for a Professional Doctorate in Counselling Psychology and has been approved by the Psychology Department's Research Ethics Review Panel, London Metropolitan University. This study is being conducted in accordance with British Psychological Society and London Metropolitan University Psychology Department ethics guidelines.

Thank you for your interest in our study. If you would like to take part in this research, please read the following information and then click "I accept" at the bottom of the page.

► ***Who is being invited to participate in this research?***

You have been approached to take part in this study because you have used an online-chat forum associated with the Borderline Personality Disorder (BPD) diagnosis.

Therefore, if you -

- are diagnosed with Borderline Personality Disorder or associate yourself with this diagnosis.
- would be prepared to participate in an online-chat forum in order to discuss therapeutic boundaries.
- are prepared not to mention, by name, any colleagues or service users, or to include information that could make third parties or institutions easily identifiable.

- we would really like you to take part in our study.

► ***What is the purpose of this study?***

This study aims to research BPD clients' experiences of therapeutic boundaries. This gives you an opportunity to contribute to research, which will help clients and professionals, better understand therapeutic work with BPD clients. Alliance ruptures and premature drop-out, from therapy, are common and limit its effectiveness.

Boundaries are essential for establishing and maintaining therapeutic relationships to allow the safety necessary for client self-disclosure (Epstein, 1994). For the purposes of this research, therapeutic boundaries are the very edge of appropriate conduct. Therefore, boundary dilemmas may emerge from role issues, time, place and space, money, gifts and services, clothing, language, and physical or sexual contact (Gutheil & Gabbard, 1993).

► ***When is this study running?***

The online-chat forum will run from August 2008 and will continue until mid October 2008.

► ***What do you have to do now?***

It is important that you know enough about this study, so you can choose whether to take part. You can contact Rebecca Boyle, the principal researcher, if you have any questions or concerns about the research. This can be done by email: rcb0034@londonmet.ac.uk. This study is supervised by Dr Charlotte Brownlow: c.brownlow@londonmet.ac.uk and Dr Elaine Kasket: e.kasket@londonmet.ac.uk .

If you wish to take part, your consent to participate in this study will be assumed by clicking on the "I ACCEPT" web-link, to the chat forum, at the bottom of this page..

■ ***Study results***

If you wish, you can request to receive full feedback about the study, once it is complete.

■ ***As an informed participant of this research:***

- I have read the information on this web-page.
- I understand that my participation will involve taking part in an online chat forum discussing therapeutic boundaries.
- I understand that I will be asked to complete a brief questionnaire of demographic information (eg. age, ethnicity etc).
- I understand what my role will be in this research, and all my questions have been answered to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw at any time, for any reason, and without prejudice.
- I understand that the confidentiality of the information I provide will be safeguarded and that no identifying information will be collected.
- I understand that some of the discussion surrounding therapeutic boundaries may make me feel uncomfortable. If this occurs, I may email Rebecca Boyle regarding further sources of assistance.

- I understand that I am free to ask any questions, at any time, before and during the research study.
- I understand that this study is being conducted purely for research purposes, for a Doctoral dissertation, conducted by Rebecca Boyle.
- I agree to take part in the above research study.

• I understand that by selecting *"I accept"* below, I am giving my consent to participate in this research study. I have read this web-page and understand what is says. I am 18 years of age, or older, and voluntarily agree to participate in this research project.

► **I ACCEPT** ◄

Please print a copy of this page for your records

Thank you for your interest in this research study.
It is greatly appreciated.

Psychology research - Mozilla Firefox

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► **Who is being invited to participate in this research?**

You have been approached to take part in this study because you have used an online-chat forum associated with the Borderline Personality Disorder (BPD) diagnosis.

Therefore, if you -

- are diagnosed with Borderline Personality Disorder or associate yourself with this diagnosis.
- would be prepared to participate in an online chat forum in order to discuss therapeutic boundaries.
- are prepared not to mention, by name, any colleagues or service users, or to include information that could make third parties or institutions easily identifiable.

- we would really like you to take part in our study.

► **What is the purpose of this study?**

This study aims to research BPD clients' experiences of therapeutic boundaries. This gives you an opportunity to contribute to research, which will help clients and professionals, better understand therapeutic work with BPD clients. Alliance ruptures and premature drop-out, from therapy, are common and limit its effectiveness.

Boundaries are essential for establishing and maintaining therapeutic relationships to allow the safety necessary for client self-disclosure (Epstein, 1994). For the purposes of this research, therapeutic boundaries are the very edge of appropriate conduct. Therefore, boundary dilemmas may emerge from role issues, time, place and space, money, gifts and services, clothing, language and physical or sexual contact (Gutheil & Gabbard, 1993).

► **When is this study running?**

The online chat forum will run from August 2008 and will continue until mid October 2008.

► **What do you have to do now?**

Done

Start Doctorate THESIS FULL DRAFT BEX... Appendix DSM PD Criter... Psychology research... 15:13

Appendix 5. Demographic Questionnaire from the Research Website – Full text and Screen Shot

1. What is your gender?
   - ○ Male
   - ○ Female

---

2. What is your age (in years)?

   I am [ ] years old.

---

3. What is your nationality?
   - ○ British
   - ○ Other

   please specify [ ]

---

4. What is your current marital status?
   - ○ Never married
   - ○ Widowed
   - ○ Divorced
   - ○ Separated
   - ○ Married

---

5. What is your current employment status?
   - ○ Employed - full time
   - ○ Employed - part time
   - ○ Unemployed - looking for work
   - ○ Not employed - not looking for work

---

6. What is your highest level of educational achievement?
   - ( ) Completed primary school
   - ( ) Completed secondary school
   - ( ) Completed apprenticeship or trade certificate
   - ( ) Completed university bachelor degree
   - ( ) Completed postgraduate education (eg Masters, PhD)

---

7. Are you currently studying for a qualification?
   - ( ) Studying - full time
   - ( ) Studying - part time
   - ( ) Not currently studying for any course

---

8. Have you ever been diagnosed with Borderline Personality Disorder (BPD)?
   - ( ) Yes

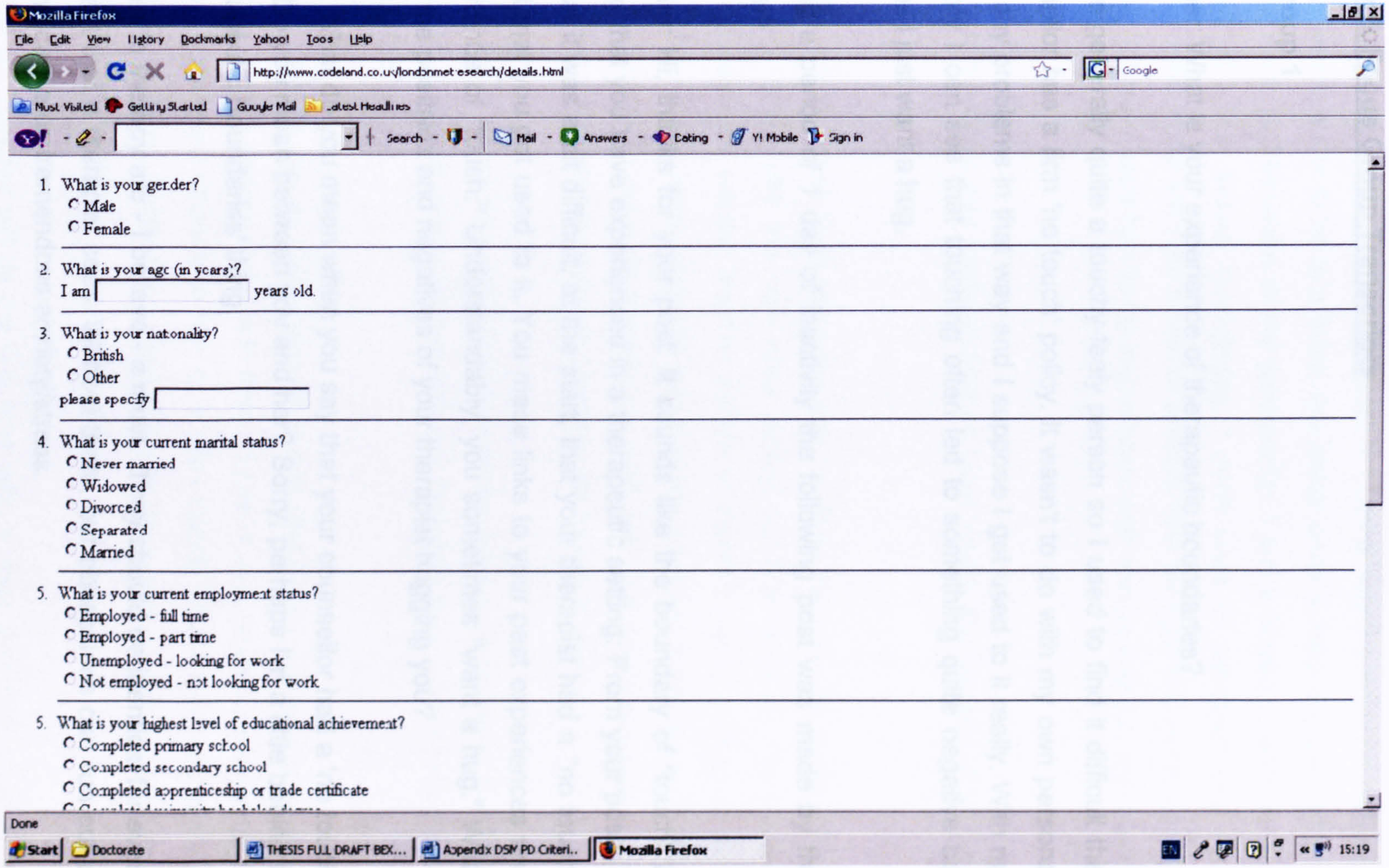
   - If yes, how many years have you had the BPD diagnosis?

   - ( ) No

   - If no, how do you identify with the BPD diagnosis?

---

9. What is your email address (in order for us to invite you to join our "closed" online chat group)?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http://www.codeland.co.uk/londonmetresearch/details.html
Google
Most Visited Getting Started Google Mail Latest Headlines
Search Mail Answers Dating Y! Mobile Sign in
1. What is your gender?
Male
Female
2. What is your age (in years)?
I am years old.
3. What is your nationality?
British
Other
please specify
4. What is your current marital status?
Never married
Widowed
Divorced
Separated
Married
5. What is your current employment status?
Employed - full time
Employed - part time
Unemployed - looking for work
Not employed - not looking for work
5. What is your highest level of educational achievement?
Completed primary school
Completed secondary school
Completed apprenticeship or trade certificate
Done
Start
Doctorate
THESIS FULL DRAFT BEX...
Appendix DSM PD Criteri..
Mozilla Firefox
15:19

Appendix 6. Focus Group Transcripts

Focus Group 1

Researcher: What is your experience of therapeutic boundaries?

Tree: I am generally quite a touchy-feely person so I used to find it difficult that my counsellor has a firm 'no touch' policy. It wasn't to do with my own personal space or any problems in that way and I suppose I got used to it really. With my past history I can see that touching often led to something quite negative but sometimes I just want a hug.

<Following a period of 1 day of inactivity the following post was made by the researcher>

Researcher: Hi, thanks for your post. It sounds like the boundary of "touch" is something that you have experienced in a therapeutic setting. From your post - it seems that it was a bit difficult, at the start, that your therapist had a "no touch" policy but that you got used to it. You made links to your past experiences and the importance of "touch." Understandably, you sometimes "want a hug." What would be the positives and negatives of your therapist hugging you?

Wire: Hi. What do you mean when you say that your counsellor had a 'no touch' policy? - Do you mean between you and her? Sorry, perhaps I'm a little behind in this 'Therapeutic Boundaries' thing.

Boundaries in therapy are - I believe - a must. They should be identical for every single client that a therapist sees. Without them, our obsessions can run out of control and cause us tremendous anxiety/stress.

Mortar: I've always had issues with boundaries. I see a new therapist on Tuesday (16th). Problem is (or is it) he is a male. I've never seen a male therapist before and am nervous, just because of my personality. I am a flirtatious person. I've been told that I lack sexual boundaries. I don't want to sabotage this new therapeutic relationship but I am a sexual person, how do I get this under control by Tuesday? Also, I want him to be inconsistent with me as it keeps me 'on my toes.'

Tree: My last message was really unclear as I just read it and thought WHAT! 😐 😕

I meant that my therapist does not allow any touching between us (me=patient, her=therapist). She made this very clear during our first meeting. I found this tough as I sometimes wanted another person to comfort me by putting an arm round me. Over time I have begun to see that my therapist is not there to take away my pain but help me work through my stuff. I think it would not help me in the longer term if she were to hug me. I have to do this stuff myself.

I agree with Kevin about how important boundaries are so 'obsessions' don't get out of control. If I know where I stand with my therapist then I have less stress and anxiety too.

Wire: I really feel for you as I have also been told that I am quite sexual towards other people (I don't always agree with this). I haven't ever seen a male therapist but maybe it's a great chance to talk to a man openly about how you behave (without fear of being belittled by him). Do you feel able to talk to your new therapist about your fears?

Mortar: Well on Tuesday will be my first time with a male therapist. I just know how I am around males. I think I will attempt to talk to him about this area in my life because it is effecting me greatly. I'm just afraid he is gonna be so cute and

I'm immediately gonna be hitting on him. I can't help it. I think it would really improve the therapeutic relationship if my therapist did not have boundaries. I suck at this therapeutic boundaries thing.

Polystyrene: Hey if your therapist is cute and you did hit on him how would you like him to act? I know my sexual boundaries are not too good and I get quite upset if men don't respond when I flirt. I feel quite powerful when I am flirting with men! I talk about this a lot with my therapist.

Thatch: Well, I would like him to act sexually toward me... I too feel powerful when I flirt with men. It would be great to have a sexual relationship with my therapist. It's like a sense of being in control. I always thought it would like of be hot to have sexual relationship with your therapist. It would ensure a type of closeness that you don't get with other therapists. I really do hope he reciprocates. And just FYI, I am really good at getting what I want, sexually I mean.

Rubber: Do u mean, experience of rules in the relationship with your therapist? If so I find that overall my CPN <Community Psychiatric Nurse> is very good, but a bit sergeant major. I don't like her phoning me and talking to me like I'm a piece of rubbish, but I also find it difficult that I cant fone her all the time. I want her to contact me as much as possible between sessions. I know that it's not appropriate but I sometimes feel she is the only one I can talk to.

<Following a period of 2 days of inactivity the following post was made by the researcher>

Researcher: Dear participants,

All of your posts have been really interesting and valuable! Do you have any further examples of therapeutic boundary experiences?

Glass: If I was able to flirt or have sex with a therapist - they would immediately lose all credibility to me.

The therapeutic relationship is so much deeper than that - it is about that person playing the role of every significant person in your life.

Boundaries are difficult to have in this type of relationship, as every client has different needs /different schema's... I had a lot of issues with boundaries in the first year and a half of therapy. It was difficult to stick to the rules. I would feel jealousy if I would see a patient come when I was leaving. It was all very weird as I had not experienced that sort of thing before....

Rubber: I have just completed an 18 month therapy within a community. Boundaries were a big issue. Some boundaries were keeping within the law, keeping within the time limits, staying in the room or therapy, staying within the ever moving guidelines of the TC <therapeutic community> or rules of TC. Maintaining the structure of day to day running of the community was an issue discussed and re-evaluated almost every day. I tolerated the discussions and arguments, so I guess that was my boundary, not to rear up and say GET ON WITH IT.

Stone: I think one of the hardest things about boundaries in therapy is that in order for therapy to be effective - I believe - tranference needs to occur. Therefore often very strong feelings are felt for your therapist. My experience was that I had never confided or shared or felt so accepted by another human being. I resented at times the fact that I knew those feelings were one-sided. And I questioned the whole I am paying you to tell me good things about myself to make me feel worthwhile. Now I have my emotions more under control (most of the time) I can see how important it was for my therapist to let me know always that there was never any possibility of a friendship outside of sessions.

My life was changed by my therapist in so many good ways....

Laminate: Hello, I remember when I first saw a therapist. I wondered if when leaving we should shake hands, and asked. She said no. I even recall her not even saying "hello" to me, which apparently is something strict Freudians do, which seems over the top to me. In another context I had group counselling where the counsellor would hug us, and we would hug each other. That stopped however when she saw me individually. I actually don't think anything over a handshake should take place, there is too much risk of a sexual boundary being crossed - in therapy it's commonplace for the client to fall in love with the therapist. I started seeing her individually as the group decided, in my absence, that they didn't want me in it anymore. No-one said a word about it while I was there. I oughtn't to have stood for that, I ought to have demanded a right to talk about it with the group as a whole.

That group was quite dysfunctional. It originally had had two counsellors who fell out with each other but nevertheless both continued to run the group together. when someone commented on the atmosphere one of them opened up about it, but the other still refused to talk about it.

MY faith in therapists has really taken a knock over the years for this and other reasons.

Vinyl: Hey, I've had several counsellors/therapists now! I have to admit I do find strict boundaries very hard to deal with as I think I would feel safe enough with a therapist who had no boundaries. My current psychologist is very strict on contact and time limits. Other than our weekly one hour meeting I am allowed 2 10 minute sessions with her on the phone at set times and if I miss those then I miss our contact. I guess I can understand why these boundaries are in place because

Polystyrene: I have had a tendency to become overly dependent on those that help me, in fact with one person, who was actually my health visitor, she became such an integral part of my life, when it came time for her to move on I was affected very badly, resulting in extreme OD <overdose> and SH <self-harm>.

Vinyl: I just find rigid boundaries a little too 'official' and 'professional' but I guess they are there for a reason, I just think there should be a degree of flexibility, even if small!!

Wire: I think though that there has to be boundaries for the relationship to work.

I must admit I found it very difficult at the beginning of relationship I thought that she had the answers to everything and that she had to do everything for me but now i have realised that it all down to me but with a little help from her to get better.

Vinyl: Hi, my experience varies from individual therapy where it was always very formal to the current group therapy. I am now a member of a therapeutic community where you are a member for a year-over half way through already. Formal boundaries exist between client and therapist but you do feel the concern even if there is no touching. The main problem I have with boundaries is no matter how emotional everything gets time keeping is very strict so you can be left in tatters when everything finishes at 4pm.

Ceramic: I would like to say that boundaries in therapy are a must but my problem has been when the therapist has over stepped the boundary that has been set. especially where physical contact is concerned. I know on a personal level I try and test certain boundaries with therapists to see how far I can push it. I think I am testing whether I can trust that person. However, part of this is because I have problems being told what I can and cannot do and also to try and

destroy the relationship before it has started. as for the no physical contact in therapy it has always been something I have asked therapists to include in boundaries, and found not all are willing for this to happen.

Plastic: I really prefer boundaries in therapy but when my last therapist left (male) he gave me a hug and my new therapist (female) has hugged me if I have been particularly distressed in a session. I would not flirt with a therapist as they would immediately not feel a safe person for me to be alone with and I certainly don't expect any sort of sexual "come -on" from a therapist - how could I talk about my problems if the therapist crossed boundaries that are meant to be there to protect me? However, I do think it is good for a therapist to say that they care about their client and have certainly experienced and it feels ok for me.

<Following a period of inactivity the following post was made by the researcher – reflections and probing questions were added under individuals' posts>

Researcher: Hi,

Welcome to new forum members and thanks for all of your posts.

You linked boundaries with a therapist's "credibility" and perhaps integrity. You also expressed your beliefs about how difficult boundaries can be and how people's needs very. It appears that you stuck "to the rules" of therapy and I was wondering what this was like for you? What motivated you to "stick to the rules?" You also drew attention to how important you believed it was for your therapist to let you know that there was never any possibility of a friendship outside of sessions.

You seem to have many insights into boundary issues through your stay at a therapeutic community. You mentioned legal, time, space and organisational boundaries. Negotiation of these boundaries through discussion appeared

important as did your ability to "tolerate" discussions/arguments! I wondered what the pros and cons of "tolerating" these boundary issues are?

You discussed the uncertainties surrounding behaviour during initial meetings with therapists eg. Shaking hands and saying hello. The boundary of touch was also referred to and you mentioned the risk of sexual boundaries being crossed. The boundary of 'information' sharing sounded important to you ie. "No-one said a word about it while I was there." You stated that you faith in therapists has been knocked and I was wondering if you have any thoughts about how this could be re-built?

Your post described how clear and firm your psychologist has been regarding time boundaries. The comment about therapists needing to have a degree of flexibility seemed interesting and I wondered if you have any examples of this?

You acknowledged boundary differences between individual and group therapy (ie context). The boundary of 'time' and time-keeping appears to be difficult for you and I was wondering what you think are the positives/negatives of therapists sticking to time?

You described your therapist over stepping boundaries that had been set. Have you got any examples of this that you feel able to share? It sounds like you have openly discussed boundaries with your therapists "I have asked therapists to include in boundaries, and found not all are willing..." Why do you think this "is a must" and what was it like to discuss this with your therapists?

You spoke about "safety" and "protection" in relation to boundaries. However, 'appropriate' hugging (eg. sessions ending or when you were particularly distressed) appears to have felt ok for you. The boundary of language/information (eg. being told your therapist cared) was also mentioned. I was wondering why you think it's ok for your therapist to say this?

All of your posts have been great and really valuable!

Stone: In the past, I have been really hurtful to my therapists and it was only when this was pointed out to me, by another therapist, that I gave any thought to it and, actually, it was really helpful. Therapists are only human, after all, and it has helped me to feel valued as a person to be told that a therapist cares about me. I think to have an honest and open therapeutic relationship requires openness from both the client and the therapist. I have found that psychologists who are therapists, and my experience is of 3 different people, are more willing to break boundaries or not to have such clearly defined boundaries, and they have shared bits about their lives outside work, which has helped me to see them as people and not just my therapist. Whereas my Freudian psychotherapist had such strict boundaries that it was hard for me to engage with her as she hardly showed any emotion at all; I could not work with a therapist who showed no emotion at all. I desperately needed to know that she cared for me but, even after 11 and a half years of therapy with her, I never felt that I knew.

Laminate: What are the boundaries I look for in therapy?

My boundaries are mostly emotional but I do have physical boundaries too. I have made some recent breakthroughs.

A couple weeks ago I was really depressed and just wanted to go home and die. I didn't want to be in my therapy session at all. My therapist said we could take a walk around the building so I could calm down and have a change of scenery. My therapist was walking right next to me which at first made me very uncomfortable but I kept walking and I was okay with it by the end. In the office where we meet, I always have to be in the chair across from her, furthest away. Just my comfort level.

Emotional boundaries are a lot more complicated. It is very complex and hard to describe accurately. Once some imaginary line is crossed where I feel vulnerable, I usually disappear from therapy. I cancel or never set up another appointment, change my number and never look back. With my current therapist, I almost did this. The DBT skills I am using helped me listen to my wise mind and not disappear. I have talked about this with my therapist since this happened and I have decided to continue with therapy and am learning to trust her.

You wrote that - 'The boundary of 'information' sharing sounded important to you ie. "No-one said a word about it while I was there." You stated that you faith in therapists has been knocked and I was wondering if you have any thoughts about how this could be re-built?'

There's been a little bit of rebuilding recently but now I think my eyes have been opened. So much just depends on the individual therapist.

Plastic: I would not respect a therapist who physically touched me, nor would I ever make an attempt to physically touch a therapist. Having said this, I do feel as if there has always been a kind of protector/protectee relationship between my therapists and myself over the years.

I've always chosen male therapists over female. I just seem to get along better with them. With them, eventually, I feel this overtone, not a sexual overtone, but a kind of "white knight protecting a princess", overtone. Don't know if this makes any sense, but I can sense when it's there and when its not there.

Mortar: I tend to want my therapist to find me the most interesting, intelligent, amusing, patient in his practice and would want my therapist to come to birthday parties and other social events. I guess, I want him to be in love with me (not

lust), although I don't choose to reciprocate. This, I would assume, is also a form of control.

Glass: I've got hardly any experience of therapy as I just don't seem to be able to strike up a rapport with the few psychs I've spoken to. The last time I managed two out of a possible 4 appointments, the first of which was mostly taken up with her explaining her boundaries (about 40 minutes worth).By the end of that lot I was feeling pretty mixed up as to what she was actually there for! The boundary I was most put off by was her going into great detail about the things I might say that she would have to pass on to my doctor. I had recently been sectioned and was still a bit scared of said doctor If I felt things were a bit more confidential I might have been able to open up to her a bit more.

Mortar: Even though I have been told to call my psychologist outside of our regular sessions under certain circumstances, I cannot think of even one occasion on which I have done so, even though these certain circumstances have existed.

I have a very difficult time asking for help from anyone, even my psychologist. However, I think I'd be flattered if he's talked about me with other people. I won't do anything to 'cause my therapist to dislike me, such as take up more than my alotted time. Once, however, my therapist took a phone call from one of his teenagers during our session, and they discussed what kind and where they would order their pizza for dinner. This very much annoyed me, and I almost wondered if the therapist were testing me to see if I would say anything about it, which I did not. He's usually a very nice guy, but I thought this was quite rude, especially since it was on my time.

I'm in the US, and I don't understand what "sectioned" means. However, even though my psychologist and psychiatrist do share some information, nothing is

passed on to my general practitioner. It is my belief that in this country, my consent would be required in order for that to occur.

For me, not having full confidentiality would definitely inhibit my ability to take advantage of therapy. In fact, I might not be able to continue therapy, since not being completely open would make therapy useless.

Tree: Just wanted to let you know that sectioned is an order to detain you in hospital under the mental health act, usually when you're not in a position to make judgements for yourself and really don't want to go!! Don't know what the term in your country is for this. Here, everything covered in therapy sessions is written down with copies sent to just about everyone, psychiatrist, doctor, mental health team and to me. I really hated seeing what I'd said written down, felt foolish!

Plastic: This is one of my boundaries I have. I normally have a strict no call, no exceptions rule. One therapist I had in the past told me to call her if I wanted to self harm, even if it were 1am... I said no. Sincere of her to offer but that is not a boundary I cross... even if it were business hours during the day, I wouldn't.

With my recent therapist I have messed up and called her. I feel that is totally unacceptable on my part so this next appointment I am going to redefine the boundaries.

I've always chosen male therapists over female. I just seem to get along better with them. With them, eventually, I feel this overtone, not a sexual overtone, but a kind of "white knight protecting a princess", overtone. Don't know if this makes any sense, but I can sense when it's there and when it's not there.

The above is me totally, so so relate.

I think its terrible that your last therapist put that kind of pressure on you to call her if you wanted to - clearly she had no boundaries and it is so dangerous for people like us without firm boundaries - it makes me so so angry-why do people have to always focus on it-like if your not doing it your doing ok, and if your doing it your not.

Wattle: It makes me so angry too! Wherever I have had treatment it has been with the NHS and there has always been a real focus on boundaries, something that has caused me to rage many times when I haven't been very well and I have been trying to push them, get time out of hospital, see the Dr when it wasn't my time etc.

Plastic: I guess I really came to understand and respect boundaries when I went into long term specialist help for over 2years - it was terrible to begin with when therapists used to walk out of group suddenly at end of time - but after I had been there a while I grew to rely on the boundaries - it felt like it was all that was keeping me safe - when everything else in my life was such a muddle and all over the place - it was good to have some rules in place which I could rely on and I used to get really mad if some inexperienced therapist would come along and break a boundary by seeing someone outside a group session or talk to us about therapy outside a group etc.

I think I'm the opposite extreme and have really rigid boundaries - the thought of any kind of physical contact with a therapist revulses me - maybe that's a bit strong, but how I FEEL - they have to be separate from me - I mean we used to have social groups every week when I was in treatment, and days out once a year, which were great at sort of normalising staff, but in my therapy time, it has to be solid boundaries - actually my doctor has got it sorted as far as boundaries, a bit of a laugh and banter at begin of session, and always gets the final word to me as I walk out the door and down the corridor - something like be careful or

399 hope you have a better week-makes me feel cared for - I am so grateful all the
400 staff who have helped me, have had really solid boundaries and kept me safe.
401
402 <Following a period of 2 days of inactivity the following post was made by a
403 participant>
404
405 Wattle: That was a total waste of time replying to this piece of research seeing as
406 no-one bothered to even look at it, extremely rude and if you had finished your
407 research you should have not advertised it on our message board.
408
409 <Researcher responded to the above comment the same day>
410
411 Researcher:
412
413 Hi,
414
415 Thanks very much for your posts. I appreciate that you may feel annoyed as I
416 have neglected this message board recently. However, what you wrote is great
417 and seems really useful. This online research will not finish until Sunday 30th
418 November 2008 and I will msg all participants as I agree that things have been a
419 bit quiet on here recently. Please feel free to email me on
420 rcb0034@londonmet.ac.uk if you have any further queries/concerns/thoughts. I
421 hope you can see how valuable your contribution has been.
422
423 Best Wishes,
424
425 Becky
426
427 Researcher: Hi P's,
428

<The following posts were written by the researcher – reflections and probing questions were added under individual participants' posts>

You mentioned being hurtful to therapists and I was wondering if you might be able to give an example of this? What was it like for you to 'realise' that therapists are only human too? Thanks for your observations of boundaries with the different types of therapists that you have seen. I think you also expressed wanting to feel cared for by your therapist in order to feel valued. If possible, could you give an example of when a therapist has shown care – and how that felt for you?

Thanks for your example of your therapist walking around the building with you. It seems that this made you feel uncomfortable, to begin with, but you tolerated this and it was ok – and maybe was beneficial? You also drew attention to the complexity of emotional boundaries and how your usual pattern is to avoid or withdraw from therapy if an "imaginary line" is crossed. However, through using mindfulness skills and open communication with your therapist you appear to be trying to do things differently now. How does it feel, in the moment, to tolerate that "imaginary line" being crossed? You gave the example of phonecalls outside session time and that you intend to "re-define" the boundaries. How do you intend to do this?

Individual therapists qualities/skills seem important from what you said in your post? Could you tell me what helps the "rebuilding" you mentioned?

The boundary of 'no touch' is important in your therapeutic relationships. You mentioned always choosing male rather than female therapists and feeling "protected." "....I want him to be in love with me (not lust), although I don't choose to reciprocate..." - how do you think you would react and feel if your male therapist did reciprocate? You also spoke about wanting to people-please and

wanting your therapist to like you. Has this stopped you saying certain things to your therapist?

You raised a good point about therapists spending time explaining about boundaries and, in your opinion, this took up a lot of time and left you feeling confused? With regard to confidentiality you said that this uncertainty meant you weren't so open about things? How did this affect your therapeutic relationship? How did it feel to hang onto some of your thoughts and be more 'closed.'

You appear to relate and identify with what another forum member wrote about choosing male therapists and wanting to be considered "...interesting, intelligent, amusing..." You described feeling "angry" after reading another member's post "as she (therapist) had no boundaries and it is so dangerous..." Why do you see the situation as "dangerous?" What is the worst thing that could happen? Do you have any personal examples of feeling angry with a therapist, about boundaries, and how you re-established the relationship? You spoke about "rigid" boundaries making you "rage" but also about the "safety" side.

Thanks for everyone's contributions. Just to clarify - this research forum will be open, for further discussion, until Sunday 30th November 2008. I'm very happy to stay in touch with people about the research. Please feel free to email me - rcb0034@londonmet.ac.uk

Best Wishes,

Becky

Rubber: Wot about boundaries re language and wot is said/is not said by patients and therapists? is that a boundary? wot is appropriate? very relevant example above me thinks .

Polystyrene: Hi Rebecca, I often feel fragmented in my life and so after a therapy session can feel that the therapist has not understood what it is like to be me. this can make me feel very angry and want to lash out and so, in the past, have written angry letters to the therapists pointing out their shortcomings and being very blunt and hurtful in what I have said. This has upset a number of therapists but they continued to work with me despite the venom that I spat out at them. I was never able to properly understand that as I expected to be rejected and sent away.

On one occasion my therapist cried during my session and I felt moved to comfort her and realised that we are all human and can feel hurt or moved by what others say. But this is hard for me as I want my therapist to have all the answers for me and take away all my pain but I have come to realise that I am the only one who can do that and the therapist is there to help and guide me on my journey, wherever that may lead. Not always easy to hold onto that as I tend to idealise therapy relationships.

Thatch: Recently, my therapist had to take time off work due to being unwell. I was going through a particularly difficult time in therapy and my therapist gave me her home email address and kept in contact with me during that time. But it put me in an incredibly difficult position. I wanted contact with her but was also angry with her for taking time off sick when I felt so vulnerable. But it is almost impossible to have therapy through email as there is no body language to help interpret what is happening in that exchange, and if she did not answer my email I would feel that I had overloaded her with my problems, or that something had happened to her, or that she did not want me as a patient anymore as I was so demanding, or that I had destroyed her. So it was a double-edged sword but I was so desperate for therapy that I clung onto that contact with her. I also worry about the health of my therapist and what would happen to me if she were to die.

Polystyrene: I can't believe that you said something that I thought was only me. I worry about something terrible happening to my therapist to. It's a double-edged relationship as I wouldn't talk to someone I didn't trust. I think it would be great if my therapist told me lots of personal information about herself. But I feel attached to my therapist now I do trust her. Maybe more than is healthy?

Thatch: I think it can be really dangerous for us when therapists don't have boundaries as we are generally very needy demanding people who need a lot of support so that the more someone will give us, the more we will take and nurture but then therapists burn out, cant cope and drop us or cant be there when we need them, don't answer our emails etc-I have see this happen to quite a few of my on line friends in USA. And the worst and very possible scenario resulting from this is obviously suicide-Once I fell out with my therapist whilst in the day unit, on a Friday with the whole weekend looming and no therapy and I decided that the obvious solution was to kill myself as my therapist was the only person I trusted and had got close to and if She had abandoned me as it appeared to me, then death was the only way out-anyways after spending the day concocting a plan, something in me went back to the unit to speak to another therapist about it, and she basically saved my life if it is the norm that for them to take a couple of days to get back to me is fine but if they usually do then don't - it can feel like the end of the world - like my psychiatrist will always answer my calls or my emails quite quickly so if he didn't at some point - I would be distraught imagining he had abandoned me like everyone does-but then I understand about boundaries and so know that if I send him stroppy messages-he probably wont reply, or if I call him 2 days in a row he probably wont call me back the second time, and get his secretary to call me back so that I don't get dependant on him There was one therapist on the unit I couldn't stand as she had no boundaries, there was a girl on the unit who was always crying in front of therapist but would often be fine the rest of the time - I just found her pathetic and she would really wind me up, as she never talked just cried pitifully - well this therapist would often go up to this girl and try to help her, comfort her with words - well that was not

how the unit was run or how the other therapists worked, and this wouldn't have helped this girl as it just made her more needy, and need more comfort-well normally they wouldn't do this except to people maybe when they first started going to the unit, but then it was about each of taking responsibility and asking for help if we needed it, or else letting other members help each other out - it used to make me so angry as that was showing favouritism by this therapist, as somehow this girl was getting extra attention - got to all be consistent.

Polystyrene: I knew my last therapist cared about me as a couple of times she changed my appointments as I couldn't come at the arranged time - them doing something extra which isn't the norm makes me feel cared about, my psychiatrist always says something nice as I leave his room, like hope you have a better week etc-makes me feel cared about.

Tree: Again I recognise a lot of myself in what you said 😀 Am really impressed though that you vented your frustration (above!) and then came back to the board. Responsibility (personal) has been so important for my recovery and I guess it's important when it comes to boundaries too. Being open about what is and isn't acceptable but realising that the therapist has the ultimate responsibility when I have my 'moments.' I have learnt a lot along the way.

<The following was written by the researcher after a two day absence of posts – reflections and probing questions were added under individual participants' posts>

Researcher: Hi: you referred to appropriate use of language and appropriate topics of conversation by both patients and clients. Could you give a personal example of this?

You described a pattern of feeling misunderstood and expecting to be rejected then verbally attacking your therapists to defend yourself. However, you

highlighted the importance of your therapist continuing to work with you. The humanity (ie. being human) of therapeutic relationships was mentioned and you also spoke about realising that it is you who has the power and control in your recovery. What did that feel like when you first realised the power and control, in recovery, was yours? How does it feel now? Thanks for describing the example of your therapist sharing her home email address - can you see any positives that occurred as a result? eg. you survived and are perhaps stronger as a result?

It appears that attaching to your therapist is a balancing act due to you needing to trust your therapist, before opening up, but that attachment can become 'unhealthy.' Could you give an example of this and what it was like emotionally? Taking personal responsibility for boundaries was also mentioned but that you consider the therapist to have ultimate responsibility. Being "open" was acknowledged and I wonder if you could share an example of being open about boundaries with your therapist?

You highlighted the safety aspect of boundaries for both clients and staff eg. "...it can be really dangerous for us when therapists don't have boundaries..." and "...therapists burn out, cant cope and drop us..." Thanks for sharing your example about the therapist "abandoning" you and your subsequent decision to make a suicide plan. You stated that the other therapist you spoke to "basically saved my life" but I wonder if you are giving yourself enough credit here as you 'chose' to speak to another therapist? Therefore, perhaps responsibility is both yours and the therapists? Your statement that "...I understand about boundaries..." shows that it seems important for you to be aware of underlying reasons for boundaries? Consistency of staff members also appears important and you mentioned some strong emotions when this hasn't happened eg. anger. However, a degree of flexibility seems important "...as doing something extra which isn't the norm makes me feel cared about..." Why do you think it's important for you to feel cared about by your therapist? You also mentioned needing "...strong people who are robust..." and would consider a therapist who

cried “weak” and “pathetic.” Can you think of any examples of therapists crying that seem acceptable to you? Possible loss of your therapist appears to be on your mind eg. “...worried about my therapist getting ill...” and I wonder if you can identify any emotions when you think about this?

Thanks again for your contributions,

Becky

Wattle: I have massive abandonment problems so am always looking out for signs that any therapist etc sees me is fed up with me, bored, planning to give up, I expect it as that is what my experience, my default- so any signs in their voice, their mannerisms - changing appointments, not seeing me as planned feed into this. I need to feel cared about by my therapist or psychiatrist as I have built up a relationship with them and grown to trust them, which I have needed to do to get well - a closer relationship to them than anyone else in my life, so I need them to care and not let me down (or even make me feel like they have let me down.

As for crying, its ok if they are saying goodbye to me but other than that I don't think I can think of any other situation it would be acceptable - if they aren't robust enough to stand me yelling at them, then they shouldn't have been working with people like me - this is a really serious illness and very powerful, and evokes very strong emotions when having to build a close relationship with someone for the first time - if a therapist doesn't get yelled at any time then they probably aren't getting that close and honest relationship with the client - but that does not mean therapists are immune - there is no reason for name calling and basic name calling.

Tree: Hi Rebecca,

Actually it felt really scary that my future was in my hands when so much of my past had felt out of control for me but, after a while, it also felt empowering that I could "thumb my nose" at those people in my past who had caused me so much pain and anguish, and that they would no longer have power over me and that I could negotiate boundaries and be responsible for taking care of myself. There are still times when I would like there to be a "magic answer", that I did not have to go through the pain of therapy, but therapy is also a journey of self-discovery and I am finding that I am much stronger than I had ever believed and that I can achieve, but it is hard for me to see these qualities in myself and to believe them when other people point them out. With regards to my therapist giving me her home email address, it shows that she trusts me not to abuse it. She really supports me and, most of the time, I do feel that support but, sometimes, I feel that she expects more of me than I can give. I would never abuse her trust in me because trust has to be two way for it to work. Having her home email address means that I can keep myself safe in between sessions as I know that she will get my message as soon as she logs on, even if it is the weekend. Although I would like an instant reply, I realise that she does not spend her life in front of her computer and has a family and a life of her own but, when I feel really needy, I can constantly check my messages for a reply and can get very disappointed until she replies. Sometimes I can feel that having access in this way could cultivate dependency but I also think that people with BPD have a heightened sense of neediness to be able to find the right path to a sense of recovery. I am getting stronger and more able to cope knowing that my therapist is there with me, with appropriate boundaries, to help and guide me, has helped me to progress in ways that I never thought would be possible. Recovery? who knows what that will look or feel like but I do know that what I have now is so much better and safer than in the past.

Best wishes

Thatch: Hi Rebecca, I often feel fragmented in my life and so after a therapy session can feel that the therapist has not understood what it is like to be me.

I have just reread what you have written and I feel really sad for you, cos more than anything it has been really important that my therapist or psychiatrist as it is only now they understand what I'm saying and what I'm going through and I'm afraid to say if they didn't understand then I wouldn't stick with them. Don't know why its so important to me but it is take care and good luck.

Researcher: Hi, thank you for your additional comments about therapeutic boundaries.

To everyone who has written anything - thanks for your thoughts and contribution to this research study.

I will leave this forum unlocked (so that people can post goodbye messages if they wish to) for the next 48 hours. I am very happy for participants to email me - rcb0034@londonmet.ac.uk if you would like to be kept updated regarding this research.

Warmest regards,

Becky

Wattle: I don't know if anyone will read this now but just want to say goodbye. To everyone who shared in this research, I would like to say thank you and that it has left me feeling less alone out there.

Thatch: Thank you for your last message, however, I do think it can be so hard for therapists to know what it is like to be sitting in the therapy chair unless they have had therapy in their training. At the end of the day I don't think anyone can

really understand what goes on in another person's head - it is a unique experience.

Focus Group 2

Researcher: What is your experience of therapeutic boundaries?

Rock: Hi I think boundaries in therapeutic relationships are the limits that allow a safe connection between the therapist and the client/patient and are based on the client's best interests. I spent ages surfing the web and thinking about this question - and that is all I came up with!!! What does anyone else think?

Timber: Yep I'd agree with that, in particular the safety side. the edge of what is right and wrong in therapy! the safety is for both service user and counsellor but the service user is the vulnerable one who needs protecting. hope that's of some help?

Researcher: What is your understanding and experience of time boundaries?

Plaster: I know the time boundaries are necessary, especially because of their schedule with other patients. I do like to push these boundaries a little sometimes and add a couple extra minutes to my session... and if it works than I feel like they care more and they are more sincere. Like, I'm not just a patient they collect money from.

Timber: Whilst in hospital I had a preliminary appointment with a therapist. Time wasn't mentioned at all. Don't know if this had any bearing on the fact I found it really easy to talk. When I had a scheduled appointment with a certain time limit I was aware of the therapist glancing at the clock which was behind me and occasionally at her watch. So, I think it would be fine never knowing how long my therapy sessions are going to last. Not wanting to be a bother or to go over my time I think it made me feel uneasy.

Rock: When I first started having therapy I hated it, cos the session just seemed to suddenly end I WOULD BE MILES AWAY WITH THINGS SO I GOT MY THERAPIST TO LET ME KNOW WHEN THER WAS ONLY 5-10 mins left so i could collect my self. Now I think every therapy session should be exactly the same length of time as I got used to it and have to say I'm glad for it overall, as otherwise I would always be worrying about taking up too much time.

Researcher: What is your experience of therapeutic encounters involving technology (eg. emailing, phoning, texting)?

Rock: My therapist should never contact me by telephone, text message, email etc, outside of our therapy sessions. If it were an emergency I think it would be ok but I like to keep things separate.

Timber: My psychiatrist has rung me a couple of times over the years unexpectedly when I have been having a tough time, which was very nice although I wasn't able to answer him but it was just really nice to get the message from him, knowing he had been thinking about me.

Plaster: Haven't heard of or experienced this.

Researcher: What is your experience of therapeutic encounters outside the 'office?'

Rock: I didn't know this was a possibility until my current therapist suggested we go for a walk. At first I wasn't sure about it but I wasn't going to say no to this new experience. In a way, it was good because I definitely felt like she actually cared about my life instead of me just being her job... but at the same time... I have a problem with the idolization symptom of BPD so I idolize her even more now. I don't know which is better... not to have crossed that boundary and think she didn't care... or cross it and idolize her more... I think I would only be comfortable

inviting my therapist to very special and significant personal event like my own wedding.

I have met my CPN in town and would be happy to meet my therapist in the local coffee shop for my next session - if it were quiet.

Rock: I've been in a situation where a therapist worked in the same organisation as me so she told me so I wouldn't be taken by surprise if I saw her, but also we agreed what we'd say if someone with us asked 'where do you know them from?'

Timber: Have no experience of this but it would be easier to chat whilst walking! However, If I bumped into my therapist in the street I would want them to ignore me.

Researcher: What is your experience of therapists' seeing clients from their own homes?

Rock: I have never heard of this. I would like that but that would cross too many boundaries so I would never allow that for me.

Timber: Have never heard of this either but don't believe it would be ethical. Don't think therapists would like it,they would lose their privacy.

Researcher: What is your experience of monetary boundaries?

Rock: I agree, money is what defines that the relationship is mostly business. It's a constant reminder... and always makes me wonder how much they truly want to help. Or how much they care. Do they want to help and they love their job, or do they just seem to and are just in it for the money?

Plaster: My last therapist let me come in once without billing my insurance. I had

been in and out of the hospital for a month and she knew I wanted to see her and give her an update on how I was doing. She said I could come in and we could talk and she wouldn't bill my insurance. That meant a lot to me, because I knew she actually did care.

My current therapist was going to make a similar offer when I thought I was going to lose my insurance and have to stop seeing her. She said she would extend it for another visit and I wouldn't have to pay. That meant a lot to me because I felt she actually did care. It makes you realize they are not just in it for them and helps build a trust.

Timber: Guess this doesn't apply to the NHS. However, I wish I could afford to go private, would feel like less of a nuisance if I was paying. It would make you wonder though, if the therapist was only doing that job cos of the pay. I'm not sure anyone should have to pay for therapy as the therapist should morally want to be there.

Researcher: What is your experience of other boundaries, around therapy, that have not been covered by the forum?

Timber: Only what I mentioned before about the requirement of the therapist to put the whole session in writing and send it to other people. Not sure if this is classed as a boundary!

Rock: I have never heard of this happening, I have never had my therapy sessions written down and passed on to others-it should be confidential. I would not be able to continue therapy if my therapist could not guarantee my confidentiality.

Researcher: Thanks for everyone's contributions. Just to clarify - this research forum will be open, for further discussion, until Sunday 30th November 2008. I'm

very happy to stay in touch with people about the research. Please feel free to email me - rcb0034@londonmet.ac.uk

Best Wishes,

Becky

Focus Group 3

Researcher: What is your experience of therapeutic boundaries?

Iron: In my experience boundaries are very important to protect me. The rules of therapy must be spoken about during the first session and then must never change. If they can change then I would not trust the other person.

Oak: I think it's good to have the flexibility to bend the rules as necessity or compassion dictates so I'm not sure about this one. It's quite confusing actually.

Researcher: What is your experience of 'clothing' within therapy?

Iron: My therapists have always been professionally dressed... suit pants [trousers] and a blouse of some type. I like this formality. Where I currently go, I have seen a therapist that wears jeans with a dressy top... I would not like that. It is too informal and I don't believe appropriate....at the end of the day... they are my therapist and I am their client... so the appropriate clothing should reflect that.

Oak: I feel less intimidated by therapists wearing what they are most comfortable in, be that casual or smartly dressed so I think it's ok for a therapist to wear ripped jeans and a t-shirt. It shows that they themselves are confident in their own ability and don't need to dress up to look professional.

Clay: I see them as professional, and so should dress appropriate to that.

Researcher: What is your experience of language within therapy?

Clay: I wouldn't have a therapist if there were a language barrier. They would have to speak English fluently. All of mine in the past have not allowed silence for

too long, which I appreciate. I like it if there is silence and they try to figure out what is going on in my mind... because oftentimes I am trying to figure out the same thing. My last therapist was awesome at this... my current one is okay... my thoughts will be racing everywhere and I can't find the words to match the confusion but they will somehow find the exact wording I am looking for. It makes me feel a little more sane to know they understand. Their tone of voice and choice of words are key... it gives insight into how they are feeling and how well they are understanding you. If they say something completely off the wall then you know they are not getting you at all. Also, I can understand an occasional swearing but too much is not good. If they did not call me by my first name... but called me Ms... then I wouldn't like that. Too formal.

Oak: I don't like formality either! I would not mind if my therapist swore or used obscene language during our sessions. I think it is good for a therapist to say that they care about their client and this feels ok for me. However, I Don't like long silences unless they say it's ok to take your time. It is easier to talk to people who speak the same language even roughly the same accent so there's no confusion with words.

Iron: I cant bare people who give you the silent approach or sit there po faced whilst you talk-in fact I wont go and see them again if they have been like this-one therapist I saw was like this, and when I asked her why she wasn't saying anything, she said she wanted to listen to what I had to say, well she looked like she was falling asleep so I never went back.

I guess I watch people's faces intently to see their reaction to what I am saying, to see if they are listening, to see if they looked bored-if the therapist isn't actively engaged with what I'm saying I go into deep shame or anger that I am taking up their time. The tone, the strength of their voice, their face is all so important for me.

Researcher: What is your experience of gift giving within therapy?

Clay: I have read where other people have gotten small gifts from their therapist and I have to admit, it makes me jealous. I would love to receive a gift from my therapist. But I do understand the boundaries about that. I have never given a gift to a therapist, but I was considering it when the holiday comes around. Nothing big, just a simple card or something along those lines. I wouldn't give a Christmas gift, because Christmas is too personal I think....

Iron: It is ok to exchange very small gifts/cards at the end of therapy. Would have to be seeing same therapist for a long time and build up a real rapport before thinking this would be appropriate.

Oak: I have given a few different health professional presents and have agonised what to buy them sometimes, it has usually been round Xmas or when I have stopped seeing them. . I would be really pleased if my therapist accepted an expensive gift from me as it would prove that we had a special relationship. It felt so important to me to show how much I appreciated them - if they are good, they are very very good, but if they are bad, they are very very bad and I stay far away from them.

I was once given a present from my therapist when I was in rehab which everyone got, it was nice at the time but soon became pretty meaningless.

The best present my last therapist gave me was telling me that the best present I had given her was letting her see into my mind and see how it works - oh how pathetic am I.

Researcher: What is your experience of therapists' self-disclosure?

Oak: I don't like to know too much about them because it turns the relationship slightly more personal than professional. My last therapist shared little tidbits about her kids sometimes and that was okay. But too much of it wouldn't be good, IMO. To know a little bit about them would help the problem with idolizing though. Realize they aren't perfect and do have a life beyond the office. I think a little bit of info about their lives makes you feel more at ease.

Researcher: What is your experience of touch in therapy?

Clay: I made a commitment to my current therapist and she wanted to shake on it... *I was uncomfortable* with this. It makes the therapy too personal, for me. Not that I don't want to be touched, necessarily, *because if it were a* hug or something, I would want that... but I just think it would do more harm than good... especially knowing that therapy doesn't last forever. So remaining at a certain distance is helpful in the long run.

Iron: Have no experience of this.Yikes, what does that say about me 🙂

Researcher: What is your experience of personal space within therapy?

Iron: I do like my personal space in therapy. My past therapist had a fairly decent sized room and I liked how she sat across from me (you could fit a coffee table in between us) With my current therapist, the room is much smaller. At first I was very uncomfortable. I have gotten use to it but I do like to be across from her as well. I went with a walk with her before and she was right next to me, at first it was a bit uncomfortable but by the time the walk was over, it was fine. I still like my space in the office though.

Clay: I do like a bit of distance but would prefer a table or something in between that I could lean on. Usually there's just 2 chairs facing each other.

Researcher: What is your experience of other boundaries, within therapy, that have not been covered by the forum?

Clay: I would hate it if my therapist cried in front of me and I would never go back to see them - that would make them weak and pathetic - I need to see strong people who are robust to ignore my rants in the past - Have known it was the illness talking and be pleased that I have felt enough with them to get angry at them - that's why I guess it has always been that I have be under a team of people rather than one person-so they have good debriefing.

I have also always worried about my therapist getting ill and always examine them every time I see them, to look for signs of tiredness etc.

Thanks for everyone's contributions. Just to clarify - this research forum will be open, for further discussion, until Sunday 30th November 2008. I'm very happy to stay in touch with people about the research. Please feel free to email me - rcb0034@londonmet.ac.uk. Best Wishes,

Becky

Appendix 7: Q Sort Statements

1. I would not be bothered if my therapist had chatted about me with others (eg. friends/family).
2. My therapist should never contact me by telephone, text message, email etc, outside of our therapy sessions.
3. It is ok for therapists and clients to exchange very small gifts/cards at the end of a course of therapy.
4. I could not work with a therapist who showed no emotion at all.
5. The rules of therapy must be spoken about during the first session and then must never change.
6. If I bumped into my therapist in the street I would want them to ignore me.
7. It would never be acceptable for my therapist to drive me home.
8. I think it would be great if my therapist told me lots of personal information about themself.
9. I think it would really improve the therapeutic relationship if my therapist did not have boundaries.
10. I think it is good for a therapist to say that they care about their client and this feels ok for me.
11. It would be great to have a sexual relationship with my therapist.
12. My therapist has rung/emailed me a few times over the years when I have been going through crisis times. It felt nice to know s/he was thinking of me.
13. If a therapist doesn't get yelled at, during their career, they probably aren't having a 'close' relationship with their client. However, that does not mean therapists are immune so it is important to be able to apologise when appropriate.
14. Boundaries must be identical for every single client that a therapist sees.
15. I would not mind if my therapist swore and used obscene language, towards me, during our sessions.
16. I would be happy to meet my therapist in the local coffee shop for my next session.

17. I want my therapist to come to all of my birthday parties and other social events.
18. Once some level of comfort is reached in therapy, I think it's good to have the flexibility to bend the rules as necessity or compassion dictates.
19. On one occasion my therapist cried during my session which felt acceptable. This made me realise that we are all human and can feel hurt or moved by what others say.
20. Every client has different needs in relation to therapeutic boundaries.
21. It is important for my therapist to be clear that there is never any possibility of a friendship outside of sessions.
22. I need to entirely decide what the rules are in my therapy sessions.
23. My therapist has shared bits about her (his) life outside work and I am not comfortable with this.
24. I think it is fine for therapists to wear what they are most comfortable in, but it is not right for them to wear jeans or provocative clothes.
25. I try to test certain boundaries with my therapist to see how far I can push it so it's important for my therapist to have some tolerance. I think I am testing whether I can trust that person.
26. If I encountered my therapist in the street I would be happy to be introduced to their family and stop for a long chat.
27. I think my therapist would 'burn out' and not be able to continue seeing me if there weren't some boundaries.
28. I think it would be fine never knowing how long my therapy sessions are going to last. (eg. anything between 10 minutes and three hours).
29. I just find rigid boundaries a little too 'official' and 'professional' but I guess they are there for a reason. I believe there should be a degree of flexibility even if it is small.
30. I would not be able to continue therapy if my therapist could not guarantee my confidentiality.
31. I am comfortable with my therapist hugging me every time I feel upset.

32. I would never feel comfortable inviting my therapist to a social event, even if it were a special occasion eg. wedding.
33. It would be ok for my therapist to give me a ride home if I were walking home in a thunderstorm and s/he drove past me.
34. There should not be any boundaries in therapy because I have problems being told, by someone else, what I can do.
35. If my therapist returned my sexual flirtation they would immediately lose all credibility to me.
36. I do like to push time boundaries a little with my therapist and add a couple of extra minutes to my session. If it works then I feel like they care more and they are more sincere.
37. I want my therapist to address me as "Ms/Mr (Surname)" rather than calling me by my first name.
38. It is important to negotiate what is and is not acceptable in therapy. However, I believe my therapist has the ultimate responsibility when I have my 'moments.'
39. If my therapist showed lots of emotion, during every session (eg. crying), I would really like this.
40. It feels empowering that I can be responsible for taking care of myself, through negotiating boundaries, after much of my past had felt out of my control.
41. Every therapy session should be exactly the same length of time eg. 50 minutes.
42. If I got on really well with a therapist I would want them to let me know that we could be friends after sessions had ended.
43. Maintaining boundaries is totally down to the therapist.
44. I like firm boundaries because when I know where I stand with my therapist I have less stress and anxiety.
45. I have been told that other clients have exchanged small gifts with their therapists. I feel that this is wholly inappropriate.
46. I would be really pleased if my therapist accepted expensive gifts from me as it would prove that we had a special relationship.

47. I think having a little bit of information about my therapist's life has made me feel more at ease during sessions.

48. I think it could be really dangerous if a therapist does not have very firm boundaries.

49. It would be acceptable for my therapist to give me a ride home after every session.

50. Once a line is crossed, where I feel vulnerable, I usually disappear from therapy. I cancel, or don't set up another appointment, and never look back.

51. My last therapist let me come in once without paying for the session. That meant a lot to me because I felt she actually did care.

52. I would only be comfortable inviting my therapist to very special and significant personal event like my own wedding.

53. It would be perfectly acceptable for a therapist to wear ripped jeans and a t-shirt.

54. I want my therapist to be inconsistent with me as it keeps me 'on my toes.'

55. If I saw my therapist in town I would want them to acknowledge me, but would like to keep a distance.

56. I don't think anyone should have to pay for therapy (including NHS covering therapy costs) as the therapist should morally want to be there rather than seeking payment.

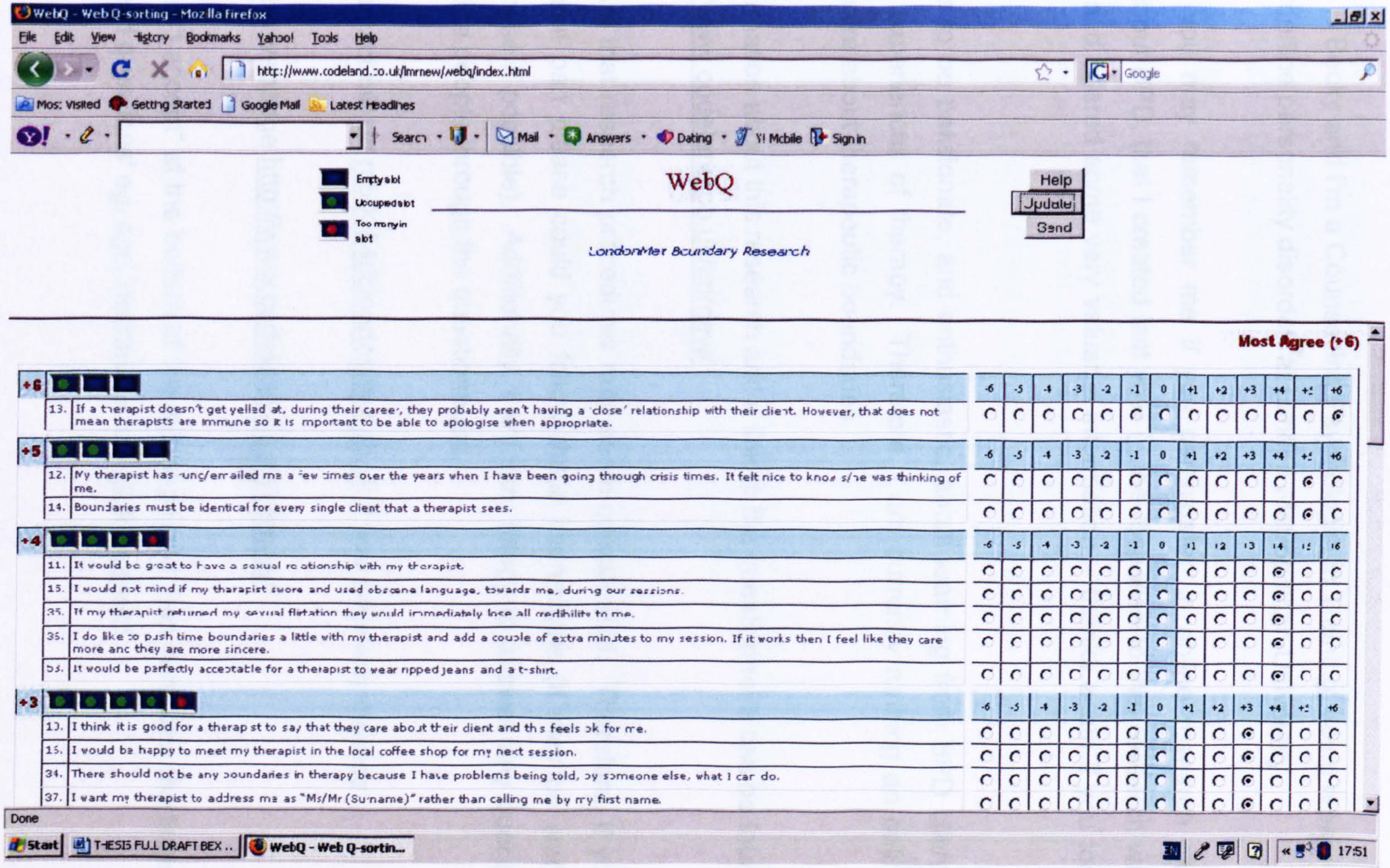
57. I would feel safe with a therapist who had no boundaries.

58. I do not think anything over a handshake should take place in therapy as there is too much risk of a sexual boundary being crossed.

59. I would hate it if my therapist cried in front of me and would never go back to see them.

60. I welcome my therapist contacting me, by phone or email, as much as possible between sessions.

Appendix 8. Screen Shot of the Research WebQ



Appendix 9. Instructions for the Online Q-Sort

"Dear members,

My name is Becky and I'm a Counselling Psychologist in Training, doing research about borderline personality disorder, at London Metropolitan University.

Some of you may remember me if you participated in online research chat forums, about BPD, that I created last year (...the response to that research was amazing and offered some very valuable information – thanks again if you took part!).

I continue to be passionate, and enthusiastic, about learning from BPD clients' and their experiences of therapy. Therefore, I am currently running an online questionnaire about therapeutic boundaries.

More information about this research and a link to the questionnaire can be found at - http://www.codeland.co.uk/lmrnew/

I am aware that research procedures may seem complicated. Therefore, if you wish to take part please could you follow these instructions (it may be worth printing these if possible). Additionally, I am very happy to answer any queries and/or guide people through the questionnaire.

Please contact me on rcb0034@londonmet.ac.uk if you have any queries -

1. Read the webpage http://www.codeland.co.uk/lmrnew/

2. Click on "I accept" at the bottom of the webpage and then complete the linked 'background questions' eg. age, nationality and click "submit"

3. You will then be directed to click on "Questionnaire." Please click questionnaire which will take you to the main research

4. Please then click on "Help" at the top right as I believe that this type of 'forced choice' questionnaire can be confusing and there is extra information here. If you click on "WebQ Tutor" in the top right corner you will be guided through an example questionnaire

5. Overall, there are 60 statements in this research. Please could you rate how much you agree or disagree with each statement by clicking the relevant box. If possible it may be worth printing this questionnaire before you fill it in online.

6. Once you have rated all of the statements online please click "Send" at the top right and enter "research" as the code word in the grey box

7. This will create an email with your coded results in the body of the email. You can also include any comments you may have in this email.

Many thanks for you interest in this research and please let me know if you would like to be kept informed of research progress.

Best wishes,

Becky"

Appendix 10. Q-Sort Distribution Template

The layout for a 60 item Q sort

Most Disagree **Most Agree**

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6

Appendix 11. Email Generated after Q Sort Completion

To: rcb0034@londonmet.ac.uk
Subject: LondonMet Boundary Research

Browser: Mozilla/5.0 (Windows; U; Windows NT 6.0; en-GB; rv:1.9.1.16) Gecko/20101130 Firefox/3.5.16 (.NET CLR 3.5.30729)
Q-Sort response array (DO NOT CHANGE!!):
> -6-6-6 6 6 6 0-5-5-5 5 5 5 5-5-4-4-4-4 0 0 0 1 4 0-3-3-3-3-3-1-1 3 3 3 3 4 4 4 2 2 2 2 2-2-2-2-2-2 0 1 1 1 1 1 3-1-1-1-1<

You can add comments here: --

Would you like to provide any additional information regarding your choice of statements?

Would you like to offer any further comments about statements that you most agreed/disagreed with?

Do you have any further comments or reflections about taking part in this research?

Appendix 12. Socio-Demographic Information SPSS Output – All Factors

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	25	89.3	89.3	89.3
	Male	3	10.7	10.7	100.0
	Total	28	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-25	5	17.9	17.9	17.9
	26-30	5	17.9	17.9	35.7
	31-35	4	14.3	14.3	50.0
	36-40	6	21.4	21.4	71.4
	41-45	1	3.6	3.6	75.0
	46-50	4	14.3	14.3	89.3
	50 +	3	10.7	10.7	100.0
	Total	28	100.0	100.0	

Nationality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	British	15	53.6	53.6	53.6
	American	9	32.1	32.1	85.7
	Canadian	2	7.1	7.1	92.9
	Irish	1	3.6	3.6	96.4
	Other	1	3.6	3.6	100.0

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never Married	19	67.9	67.9	67.9
	Divorced	3	10.7	10.7	78.6
	Separated	1	3.6	3.6	82.1
	Married	5	17.9	17.9	100.0
	Total	28	100.0	100.0	

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	10	35.7	35.7	35.7
	Part time	5	17.9	17.9	53.6
	Not looking for work	13	46.4	46.4	100.0
	Total	28	100.0	100.0	

Highest Education Achievement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secondary school	5	17.9	17.9	17.9
	Apprenticeship or trade cert	9	32.1	32.1	50.0
	Bachelor degree	10	35.7	35.7	85.7
	Postgraduate qualification	4	14.3	14.3	100.0
	Total	28	100.0	100.0	

Study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	3	10.7	10.7	10.7
	Part time	4	14.3	14.3	25.0
	Not studying	21	75.0	75.0	100.0
	Total	28	100.0	100.0	

Diagnosis Length

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 1 year	4	14.3	14.8	14.8
	1-2 years	6	21.4	22.2	37.0
	3-5 years	6	21.4	22.2	59.3
	6-10 years	8	28.6	29.6	88.9
	11-20 years	3	10.7	11.1	100.0
	Total	27	96.4	100.0	
Missing	System	1	3.6		
Total		28	100.0		

Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinically diagnosed with BPD	26	92.9	92.9	92.9
	Idenitfication with BPD diagnosis	2	7.1	7.1	100.0
	Total	28	100.0	100.0	

Appendix 12a. Socio-Demographic Information SPSS Output – Factor A

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	13	92.9	92.9	92.9
	Male	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	26-30	3	21.4	21.4	21.4
	31-35	3	21.4	21.4	42.9
	36-40	3	21.4	21.4	64.3
	41-45	1	7.1	7.1	71.4
	46-50	3	21.4	21.4	92.9
	50 +	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Nationality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	British	8	57.1	57.1	57.1
	American	5	35.7	35.7	92.9
	Canadian	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never Married	9	64.3	64.3	64.3
	Divorced	1	7.1	7.1	71.4
	Separated	1	7.1	7.1	78.6
	Married	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	6	42.9	42.9	42.9
	Part time	3	21.4	21.4	64.3
	Not looking for work	5	35.7	35.7	100.0
	Total	14	100.0	100.0	

Highest Education Achievement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secondary school	1	7.1	7.1	7.1
	Apprenticeship or trade cert	3	21.4	21.4	28.6
	Bachelor degree	6	42.9	42.9	71.4
	Postgraduate qualification	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

Study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	1	7.1	7.1	7.1
	Part time	2	14.3	14.3	21.4
	Not studying	11	78.6	78.6	100.0
	Total	14	100.0	100.0	

Diagnosis Length

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 1 year	3	21.4	23.1	23.1
	1-2 years	2	14.3	15.4	38.5
	3-5 years	2	14.3	15.4	53.8
	6-10 years	4	28.6	30.8	84.6
	11-20 years	2	14.3	15.4	100.0
	Total	13	92.9	100.0	
Missing	System	1	7.1		
Total		14	100.0		

Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinically diagnosed with BPD	12	85.7	85.7	85.7
	Idenitfication with BPD diagnosis	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Appendix 12b. Socio-Demographic Information SPSS Output – Factor B

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	5	100.0	100.0	100.0

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-25	2	40.0	40.0	40.0
	26-30	2	40.0	40.0	80.0
	36-40	1	20.0	20.0	100.0
	Total	5	100.0	100.0	

Nationality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	British	3	60.0	60.0	60.0
	American	2	40.0	40.0	100.0
	Total	5	100.0	100.0	

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never Married	4	80.0	80.0	80.0
	Divorced	1	20.0	20.0	100.0
	Total	5	100.0	100.0	

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	2	40.0	40.0	40.0
	Not looking for work	3	60.0	60.0	100.0
	Total	5	100.0	100.0	

Highest Education Achievement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secondary school	1	20.0	20.0	20.0
	Apprenticeship or trade cert	3	60.0	60.0	80.0
	Bachelor degree	1	20.0	20.0	100.0
	Total	5	100.0	100.0	

Study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Part time	1	20.0	20.0	20.0
	Not studying	4	80.0	80.0	100.0
	Total	5	100.0	100.0	

Diagnosis Length

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-2 years	1	20.0	20.0	20.0
	3-5 years	2	40.0	40.0	60.0
	6-10 years	2	40.0	40.0	100.0
	Total	5	100.0	100.0	

Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinically diagnosed with BPD	5	100.0	100.0	100.0

Appendix 12c. Socio-Demographic Information SPSS Output – Factor C

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	4	100.0	100.0	100.0

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-25	2	50.0	50.0	50.0
	36-40	2	50.0	50.0	100.0
	Total	4	100.0	100.0	

Nationality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	British	2	50.0	50.0	50.0
	American	1	25.0	25.0	75.0
	Canadian	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never Married	3	75.0	75.0	75.0
	Divorced	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Part time	1	25.0	25.0	25.0
	Not looking for work	3	75.0	75.0	100.0
	Total	4	100.0	100.0	

Highest Education Achievement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secondary school	1	25.0	25.0	25.0
	Apprenticeship or trade cert	2	50.0	50.0	75.0
	Bachelor degree	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	1	25.0	25.0	25.0
	Not studying	3	75.0	75.0	100.0
	Total	4	100.0	100.0	

Diagnosis Length

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 1 year	1	25.0	25.0	25.0
	1-2 years	2	50.0	50.0	75.0
	6-10 years	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinically diagnosed with BPD	4	100.0	100.0	100.0

Appendix 12d. Socio-Demographic Information SPSS Output – Factor D

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	2	50.0	50.0	50.0
	Male	2	50.0	50.0	100.0
	Total	4	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-25	1	25.0	25.0	25.0
	46-50	1	25.0	25.0	50.0
	50 +	2	50.0	50.0	100.0
	Total	4	100.0	100.0	

Nationality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	British	2	50.0	50.0	50.0
	American	1	25.0	25.0	75.0
	Irish	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never Married	2	50.0	50.0	50.0
	Married	2	50.0	50.0	100.0
	Total	4	100.0	100.0	

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	1	25.0	25.0	25.0
	Part time	1	25.0	25.0	50.0
	Not looking for work	2	50.0	50.0	100.0
	Total	4	100.0	100.0	

Highest Education Achievement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secondary school	2	50.0	50.0	50.0
	Apprenticeship or trade cert	1	25.0	25.0	75.0
	Bachelor degree	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full time	1	25.0	25.0	25.0
	Part time	1	25.0	25.0	50.0
	Not studying	2	50.0	50.0	100.0
	Total	4	100.0	100.0	

Diagnosis Length

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-2 years	1	25.0	25.0	25.0
	3-5 years	2	50.0	50.0	75.0
	6-10 years	1	25.0	25.0	100.0
	Total	4	100.0	100.0	

Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinically diagnosed with BPD	4	100.0	100.0	100.0

Appendix 13. Screen Shot of the Focus Group Boundaries