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What Remains? An Interpretative Phenomenological Analysis of Therapists' Psychological Boundaries in Crisis Work

Dana Santiago
University of Denver

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Abstract

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Dana Santiago

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Advisor: Pat Garriott, Ph.D.

Author: Dana Santiago
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ABSTRACT

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CHAPTER ONE: INTRODUCTION

Psychotherapists across work settings are at risk for professional burnout. The percentage of mental health professionals endorsing high levels of burnout range from 21% to 67% (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Therapists regularly experience heightened reactions and intense feelings during interpersonal and psychological encounters with their clients as a consequence of psychotherapeutic work. In a recent pilot study, substance abuse counselors reported high levels of depersonalization and detachment from clients or work after interpersonal interactions with their challenging and resistant clients (Baldwin-White, 2016). Arguably, repeated exposure to distressed clients presents a challenge to therapists' psychological well-being. Furthermore, working with clients in a state of crisis may also add to the psychological demands. This study aims to understand how therapists who work in crisis settings establish psychological boundaries to reduce these risks.

Providing direct care to vulnerable and suffering populations often requires therapists to utilize their personal psychological resources including empathy and compassion in their work with clients (Newell, Nelson-Gardell & MacNeil, 2016). Compassion and empathy are tools therapists use to help them understand and respond to clients appropriately (Figley, 2002). According to Rogers (1975) empathy is a necessary condition to promote client healing and described it as:

> The way of being with another person…It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. (p. 3)

In order to enter into a client's subjective world, therapists must use a wide range of cognitive and emotional functions while relating to a client empathetically (Malin & Pos, 2015).

The concept and practice of empathy has become a common factor in psychotherapy and undergirds therapeutic alliances across theoretical orientations. Nevertheless, it would be difficult to imagine the psychotherapeutic relationship without these essentials. The necessity of empathy elicits a broader inquiry regarding the use of one's own psychological resources and its effects on the treating psychotherapist. More specifically, how are therapists working with crisis populations able to separate themselves from their client's complex trauma or suicidality when they are also tasked to empathetically engage with it?

Psychological Cost of Caring

It is widely accepted that people can be traumatized without being directly harmed physically or emotionally (Walker, 2004). Many therapists, for example, are often privy to detailed accounts of their clients' past trauma and recurrent distress. Despite therapists' training and knowledge, they are not immune from their own painful thoughts and emotions as they engage with survivors of trauma (McCann & Pearlman, 1990).

This phenomenon in psychology has not gone unnoticed. In fact, there are several constructs highlighting the effects of psychological interplay with clients including:

countertransference, burnout, secondary traumatic stress, vicarious traumatization and compassion fatigue. Each of these constructs represent a response or outcome to the complexity of engaging with suffering clients.

Therapists' countertransference reactions may be one of the more well-known inner responses to clients' presenting trauma and a central concept within psychodynamic theory and practice. Countertransference is described in the literature as an intrusion of a therapists' unresolved material (Harrison & Westwood, 2009) and is seen as a crucial piece of the therapeutic relationship that may act to deepen the psychotherapeutic work leading to growth and transformation (Walker, 2004).

In contrast to countertransference, scholars created a construct called Vicarious Traumatization (VT) to capture the cumulative effects on the therapist both cognitively and emotionally as a byproduct of empathetic engagement with a client's traumatic material (McCann & Pearlman, 1990). Long-term exposure to working with victims of trauma can lead to changes in therapists' basic schemas about their selves and world, which can impact multiple facets of the therapists' personal and professional life (McCann & Pearlman, 1990). According to one study on VT, participants were asked to identify the most difficult aspects of working with survivors of sexual violence. Researchers found that over 50% of the sample identified maintaining boundaries and setting limits as a difficult task; the second most common reported difficulty was helping their clients process emotions regarding the abuse including fear, anger, denial, pain and shame (Schauben & Frazier, 1995).

Compassion Fatigue (CF) is a unique form of caregiver burnout or "cost of caring" in which therapists experience a decreased capacity to bear the suffering of others

(Figley, 2002). Relatedly, Secondary Traumatic Stress (STS) results from exposure to those suffering through trauma in which professionals may mirror psychological symptoms found in post-traumatic stress disorder (Baird & Kracen, 2006). Researchers investigated STS in a sample of humanitarian aid workers in India (n=76) who worked with individuals exposed to violence, sexual trauma and housing/safety crisis. Though not formally trained as mental health professionals, all participants reported at least one symptom of STS and directly attributed it to working with people exposed to violence (Shah, Garland & Katz, 2007).

Burnout results from occupational strain and is characterized by exhaustion, cynicism and decline in professional efficacy (Maslach, 2017). In an effort to curb burnout, ongoing research has investigated risk and protective factors. A recent meta-analysis investigated the effectiveness of burnout interventions for mental health providers over a span of 3 decades. Researchers concluded that although these interventions were successful at reducing overall burnout, the average effect sizes were small ranging from .13 to .22 (Dreison et al., 2018). Most notably, researchers suggested that person-directed interventions such as teaching providers specific coping skills, relaxation and mindfulness, were beneficial for emotional exhaustion, a symptom commonly found in burnout.

Research has noted specific adverse consequences that may impact the therapist including elevated symptoms of depression, anxiety, suicidality and acute stress (Gilroy, Carrol, & Murra, 2002; Pope & Tabachnick, 1994; Killian, 2008). One survey of 800 psychologists found that 61% reported at least one episode of clinical depression and

29% endorsed suicidal feelings (Pope & Tabachnick, 1994). In sum, there is clearly a cost for caring.

Some studies suggest there is an increased risk for mental health therapists working with specific client populations or clinical work settings. For example, one study found that community mental health outpatient counselors reported significantly more burnout than private practice or inpatient counselors (Lent & Schwartz, 2012). Another study found that sexual violence counselors, who work with higher rates of survivors, endorsed more disruption in their schemas and more symptoms of PTSD as compared to their psychologist counterparts (Schauben & Frazier, 1995). Oberlander (1990) noted that staff members working with clients experiencing severe and persistent mental illness reported lower satisfaction and higher levels of stress than other staff who did not work with this population. Finally, Barnett et al. (2007) noted that responding to crisis might also add to psychologists' risk of distress. Such findings illuminate that contextual factors likely exacerbate the risks to therapists' psychological well-being.

Trends of Severity

Adding to the necessity of understanding therapists' burnout prevention efforts is a shifting clinical landscape that is leaning towards increased severity and crisis. One sign of this trend is seen across college campuses. Specifically, in a national survey amongst college counseling centers, 94% of directors perceived an increase in both the frequency and severity of mental illness among students in recent years (Gallagher, 2014). Across clinical settings, mental health therapists are also being increasingly tasked to engage in crisis interventions working with traumatized and suicidal clients (Brown & Rainer, 2006; McAdams & Keener, 2008; Roberts & Ottens, 2005). The Centers for Disease

Control have identified suicide as the 10th leading cause of death for Americans with trends revealing a 24% increase for age-adjusted suicide from 1999 to 2014 (Centers for Disease Control and Prevention [CDC], 2016).

As the rates of suicide increase, there is a growing demand for practicing therapists to attain more training in crisis intervention (McAdams & Keener, 2008). Unlike more traditional psychotherapy work, crisis therapists work with a specific population of clients during times of heightened emotional states. Telephone crisis workers, for example, regularly work with clients during times of acute distress or imminent suicidal danger (Gould, Kalafat, Munfahk, & Kleinman, 2007). Brown and Rainer (2006) noted that therapists practicing crisis intervention are required to make difficult choices about treatment and outcome in an effort to restore the client's pre-traumatic functioning. Such demanding work in a short-term context is likely to exacerbate the innate risks involved in psychotherapeutic work. To date, however, there remains limited research on the psychological impact of crisis work and even fewer studies addressing coping and self-care strategies for these clinical professionals.

Self-Care

Despite the wealth of research highlighting the harmful effects of psychological encounters in therapy, there are several studies linking various self-care and protective practices to improved psychological health. Research has found several beneficial self-care practices including social support, clinical supervision, physical self-care, spirituality, mindfulness practice, and maintaining emotional boundaries (Harrison & Westwood, 2009; Killian, 2008; Phelps, Lloyd, Creamer & Forbes 2009).

The importance of self-care extends beyond attempts to buffer the damaging effects of psychotherapeutic work. Several researchers and professionals argue that self-care is an ethical imperative because the lack of effective self-care strategies can lead to impairment and decreased professional competence (Barnett et al., 2007). The American Psychological Association's (APA) Ethics Code (2002) outlines that "psychologists should strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work. (p.1062)" Barnett et al. (2007) adds that in addition to this awareness, psychologists should also engage in ongoing self-care practices to reduce the potential impact of this distress and preserve clinical competence and professional functioning. This remains a relevant topic and is highlighted as the APA Advisory Committee on Colleague Assistance (ACCA) compiled resources aimed at providing tools and coping strategies promoting psychologist wellness (Bridgeman, 2009).

Boundaries in Therapy

How are therapists able to work in distressing clinical settings while simultaneously attend to their psychological well-being? Research suggests that maintaining boundaries in therapy is a beneficial self-care practice that protects therapists from increased emotional distress (Harrison & Westwood, 2009; Phelps et al., 2009). In particular, psychological boundaries refer to emotional and intellectual resources that allow therapists to uphold an effective separation between the client's emotional world and their own (Halevi & Idisis, 2018).

Rogers (1975) alluded to the importance of this process in his description of empathy as he noted:

> In some sense it means that you lay aside your self and this can only be done by a person who is secure enough in himself that he knows he will not get lost in what may turn out to be the strange or bizarre world of the other, and can comfortably return to his own world when he wishes (p. 3).

Multiple studies build on this idea and offer recommendations highlighting the importance of emotional boundaries as a protective factor. In one review, researchers argued that emotional boundaries are critical given that empathy for the distressed other can be traumatic for the helping professional (Phelps et al., 2009). Results from a qualitative study suggested that exemplary clinicians were able to differentiate their worldview from that of their traumatized clients and did not confuse their clients' feelings with their own (Harrison & Westwood, 2009). In this study, researchers described a concept of "exquisite empathy" as a protective practice that signified a clinician's ability to maintain clarity of interpersonal boundaries in which their empathetic attunement with their clients is nourishing for the therapeutic alliance without fusing with the client's perspective (Harrison & Westwood, 2009).

Most of the existent literature on boundaries in therapy focuses on ethical and legal guidelines to protect client and therapists from potential harm. There remains little research on psychological boundaries. Despite multiple studies arguing for the importance of emotional boundaries, most offer conceptual and thematic recommendations without clarifying how such practice can be established. For example, one qualitative study investigated how clinical psychologists managed boundaries in therapy. Researchers noted two themes that referenced psychologists' boundaries including: noticing their own personal needs outside of session and attending to their emotional involvement with their clients (Frankel, Holland & Currier, 2011). Another

study investigating protective practices, detailed that therapists utilized visualizations, metaphor, and personal rituals in an effort to maintain boundaries, but failed to offer more specifics on what these practices entailed (Harrison & Westwood, 2009). The focus of this study will build on previous research and add to the literature by exploring what therapists are doing to create psychological boundaries and how this impacts their psychological well-being.

Statement of the Problem

The growing rate of clients presenting in a state of crisis places new demands on the psychological resources of practicing therapists. As the severity of clients' presentations rise, there remains a strong need for a more thorough understanding of how therapists can maintain their psychological well-being in the face of increasing demand and crisis. If compassion and empathy are necessary components of psychotherapeutic work with suffering clients, what can be done to protect and replenish therapists' emotional energy? Exploring how clinicians cope psychologically with the demands of their client's needs may illuminate an important piece of the therapeutic encounter that remains understudied. To date, there is little research addressing the specific psychological well-being of crisis therapists, who often work in highly stressful and demanding settings. This study aims to address this gap in research by exploring multiple dimensions of psychological boundaries in the psychotherapeutic work of crisis therapists.

Purpose of the Study and Research Questions

This research utilized a qualitative methodology to obtain rich contextual descriptions of crisis workers as they experience the suffering of their clients and how

they maintain boundaries in the midst of a psychotherapeutic relationship. A critical area of inquiry is therapists' utilization of protective practices when working with clients in crisis. Thus, the primary purpose of this study is to understand the experience and use of psychological boundaries in crisis work.

The proposed research study answered the primary research question: "What are therapists' experiences of psychological boundaries in crisis work?" Secondarily, the proposed study also aimed to understand how therapists are impacted psychologically, and how they manage their emotional reactions. This research contributed to a better understanding of how mental health therapists experience and create psychological separation when working with clients in crisis. Findings from this study uncovered approaches to increasing therapists' self-care, decrease therapist burnout, reduce compassion fatigue, and increase healthy functioning in the midst of client suffering. Applying these findings to other clinical settings, such as community mental health agencies, may have a more widespread impact on the quality of client care that benefits therapists and clients.

CHAPTER TWO: LITERATURE REVIEW

Establishing psychological boundaries in clinical work is often experienced internally rather than directly studied or observed. To best understand how psychological boundaries arise within psychotherapeutic work, it is essential to review how engaging in a therapeutic relationship with a client poses potential risks to therapists' well-being. Not surprisingly, therapists' use of empathy within the therapeutic relationship has been found to promote positive outcomes for the client (Duan & Hill, 1996; Norcross & Wampold, 2011; Watson, Steckley & McMullen, 2014). The impact of empathetic engagement with clients who are suffering or traumatized holds inherent risks and benefits for the treating therapist. This review provides a background for understanding the role of this study in the context of therapists' psychological well-being and provides an overview of crisis work as a clinical specialty.

Empathy, Compassion and Psychotherapy

> When the other person is hurting, confused, troubled, anxious, alienated, terrified; or when he or she is doubtful of self-worth, uncertain as to identity, then understanding is called for… In such situations deep understanding is, I believe, the most precious gift one can give to another.
>
> – Carl Rogers, 1975

Empathy is recognized as a common factor in therapy across theoretical orientations and remains one of the most essential ingredients in forming a therapeutic

relationship with clients. Carl Rogers (1975) viewed empathy as a necessary condition to promote client healing. Likewise, Figley (2002) suggested that professional helpers are tasked to put personal feelings aside to evaluate their clients objectively while also recognizing that "we cannot avoid our compassion and empathy. They provide the tools required in the art of human service" (p. 1434).

Though no consensual definition exists in the professional literature, some scholars define empathy as "understanding the client's frame of reference and way of experiencing the world" (Bohart, Elliott, Greenberg & Watson, 2002, p. 89). Wampold (2015) expanded on the affective level of empathy by suggesting that it is "a complex process by which an individual can be affected by and share the emotional state of another, assess the reasons for another's state, and identify with the other by adopting his or her perspective" (p. 273). Thus, despite empathy being recognized as a foundational variable in psychotherapy, there remains some ambiguity about how to understand this multidimensional construct (Bohart et al., 2002).

Current trends have focused on clients' perspectives of empathy rather than therapist-rated or observer-rated empathy, as it has been shown to be a better predictor of outcome (Greenberg, Watson, Elliott & Bohart, 2001). A recent study examined how clients' perception of therapists' empathy impacted their attachment styles and treatment of self following 16 weeks of treatment for depression. Researchers found a significant association between therapists' empathy and improvements in clients' secure attachment in their interpersonal relationships and decreased reports of treating themselves negatively (Watson et al., 2014). This strengthens the argument that therapists' use of

empathy promotes positive client outcomes in both interpersonal and intrapersonal domains.

Clients often initiate psychotherapy treatment in an attempt to ease their symptoms or suffering. In addition to therapists responding empathetically while trying to understand a client's private world, it is not unusual for therapists to display compassion towards their clients' suffering. According to Germer and Neff (2013), compassion can be understood as "an intimate awareness of the suffering, by oneself and others, with the wish to alleviate it" (p 856).

In one qualitative study, researchers interviewed therapists who were nominated by their peers as "compassionate" in an attempt to learn more about how to conceptualize compassion in psychotherapy (Vivino, Thompson, Hill & Ladany, 2009). Participants experienced compassion as a felt resonance when they were able to understand and identify with the client's suffering that appeared "broader or deeper than empathy." They also noted that their experience of compassion toward their clients vacillated and they had to actively work at managing their emotions and reactions when they were unable to connect in a compassionate way (Vivino, et al., 2009). The use of therapists' own psychological resources begins to impact them on an emotional level. This highlights that although therapists might experience compassion and empathy in session, such a process of engagement with the client takes work and may require some degree of self-regulation.

Relatedly, therapists are often encouraged to "use the self" as a tool. This suggestion has a multitude of meanings depending upon one's theoretical orientation, type of clinical work and other contextual factors. In psychodynamic treatment, for example, countertransference is seen as a necessary and natural response to

psychotherapeutic engagement with the client. In this sense, therapists are tasked to find the "delicate balance between sensitivity to their clients' needs and awareness of their own boundaries…therapists need to be able to work within an emotionally intimate relationship while not losing sense of self" (Halevi & Idisis, 2018, p.699). Walker (2004) identified that countertransference responses that were recognized and explored by the therapist could lead to a deepened understanding of the client's experience. On the other hand, countertransference with trauma survivors tended to be more complex and harmful if therapists were exposed to their client's secondary trauma too frequently. Walker (2004) adds, "This impacts further on the practitioner who is likely to feel hopeless and useless and is therefore vulnerable to accepting rather than containing negative transferences from the client" (p. 180).

Psychological Effects of Psychotherapeutic Work on Therapists

The psychological aftermath of working with clients in distress is multifaceted and holds inherent risks. The literature provides ample support of therapists endorsing elevated symptoms of depression, anxiety and suicidality as a result of their response to their clinical work (Gilroy, Carrol, & Murra, 2002; Killian, 2008; Pope & Tabachnick, 1994). The evidence is clear and noteworthy as scholars have created a number of psychological constructs to highlight the complexity of this phenomenon including: Vicarious Traumatization, Secondary Traumatic Stress, Burnout, and Compassion Fatigue. Though each construct refers to a response or effect of helping traumatized or suffering clients, each is distinct.

Burnout is one of the more common constructs used describe the psychological strain of working with difficult populations across various disciplines (Maslach, 2003).

For mental health professionals in particular, one recent study found 21- 67% endorsed high levels of burnout (Morse et al., 2012). Though not entirely surprising due to the complex nature of working with clients in distress, the resulting symptoms of emotional exhaustion, depersonalization and reduced personal efficacy has been shown to negatively impact client care (Maslach, 2003; McCarthy & Frieze, 1999).

In response to these alarming statistics, current research on burnout has focused on identifying antecedents and interventions intended to minimize harm for professionals (Dreison et al., 2018). Lee and collogues (2011) conducted a meta-analysis investigating antecedents and consequences of burnout. This study suggested that psychotherapists' over-involvement increased their risk of emotional exhaustion and depersonalization. In other words, therapists who were overly concerned with client care reported more exhaustion and cynicism. These results support the argument for an optimal level of involvement or empathy and underscore the importance of establishing boundaries with clients in a way that sustains rather than depletes the therapist's emotional resources. Ignoring the symptoms of burnout can lead to a host of problems that may impair social and occupational functioning (Phelps et al., 2009).

In contrast to burnout, Vicarious Traumatization (VT) refers to the cumulative emotional and cognitive effects as a natural byproduct of engaging empathetically with a client's trauma (McCann & Pearlman, 1990). Literature suggests that therapists are often secondary victims of their clients' trauma. Specifically, therapists who work primarily with survivors of trauma may experience long-term changes to their cognitive schemas in how they view the world, themselves and others (McCann & Pearlman, 1990). This is

significant because such a change can be harmful to therapists' personal relationships and overall functioning (McCann & Pearlman, 1990; Phelps et al., 2009).

As a way to mitigate these conditions, VT research has focused on identifying both protective and risk factors. Cohen and Collens (2013) conducted a recent meta-synthesis of 20 qualitative studies investigating the impact of trauma work. They concluded that the use of organizational factors that decreased professional isolation such as: supervision, debriefing, peer support and education helped professionals cope with the inherent stress of trauma work. Additionally, routine self-care behaviors improved therapists' ability to manage the impact of trauma work by helping professionals regulate their emotions (Cohen & Collens, 2013). Studies have identified variables that moderate the impact of harmful effects such as therapists' age (Craig & Sprang, 2010) and years of clinical experience (Adams & Riggs, 2008). However, these studies do not identify practices that can be initiated by therapists, which is the focus of this study.

Figley (1995) conceptualized Secondary Traumatic Stress (STS) as natural "behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other: the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). Therapists endorsing STS, later called compassion stress/fatigue, present with similar symptomology as clients with Posttraumatic Stress Disorder (PTSD), the difference is that the therapist's condition is activated from indirect exposure through knowledge of the traumatizing event (Figley, 2002). This process can be observed, for example, in therapists who work with survivors of child abuse who often experience shock and horror in response to hearing clients' accounts of abuse and violence (Walker, 2004). A study of Canadian mental health workers found that over half

of participants reported that hearing their clients' graphic description of their trauma was traumatizing to them and as a result they felt the need to distance themselves from their clients (Buchanan, Anderson, Uhlemann and Horowitz, 2006).

Another problem rests in understanding how therapists providing direct care are affected in their work with future clients, given the potential of harmful consequences. Adams and colleagues (2006) defined Compassion Fatigue (CF) as the reduced capacity for empathy toward clients after repeated exposure to their client's trauma. Figley (2002) presented a multi-factor model of CF to illustrate the process of the costs of empathy and promote a dialogue for limiting compassion-related stress. Researchers recommended several methods to help therapists including speaking openly about struggles with compassion stress, employing stress management and self-soothing techniques in-and-out of session, and engaging in some type of desensitization program (Figley, 2002).

The effects of engaging in psychotherapeutic work is rarely one-sided. Though the adverse impacts of psychotherapeutic work are clear, it is also important to acknowledge that benefits of engaging in psychotherapeutic work have also been found. Scholars and practitioners have studied Post-Traumatic Growth (PTG) and Compassion Satisfaction (CS) as two positive outcomes that can exist for practicing therapists (Tedeschi & Calhoun, 2004; Stamm, 2010).

Killian's (2008) study provided support for three variables: social support, work hours, and internal locus of control at work, as buffers from stress that account for 41% of variance in measures of compassion satisfaction, a term used to describe the gratification of one's role in their helping profession (Figley, 2002). Craig and Sprang (2010) conducted a national study investigating CS, CF, and burnout in a sample of

trauma therapists (n= 532). Researchers found that 46% of clinicians reported high levels of compassion satisfaction. These findings support the argument that the experience of clinicians providing direct care is complex and dimensional.

In addition to reporting satisfaction in helping, researchers have also found positive psychological outcomes when working with trauma survivors. Arnold and researchers (2005) conducted an exploratory study to investigate the in-depth positive experiences of therapists (*n= 21*) working with trauma survivors. Despite all participants reporting negative effects, they also found that participants endorsed positive responses to their trauma work. More specifically, results indicated that 90% of the sample (n= 19) reported that observing and encouraging clients' PTG was a positive experience. Researchers also noted that 86% of the participants (n= 18) attributed their work with trauma survivors as an impetus to trait changes involving increased empathy, insight, tolerance, compassion and sensitivity (Arnold, Calhoun, Tedeschi & Cann, 2005).

Thus far, we have seen how continual exposure to client suffering has manifested into empirical support for several theoretical constructs that impact therapists' psychological well-being in both positive and negative ways. Moving forward, it is essential that these findings translate into practical recommendations that therapists can utilize in an effort to strengthen both their psychological well-being and practice of clinical work.

Therapists' Well-being and Self-Care Practices

> Self-care derives special importance from the fact that the person of the psychologist is, in large part, the tool of our work: The personal is the professional.

–Nancy Elman, 2007

Given the wealth of studies acknowledging the risks of helping suffering clients, it remains important to identify who and what helps the helper. Though there is evidence of protective variables that buffer the negative effects, such as therapist's age and caseload (Craig & Sprang, 2010), this review focused on the protective practices that therapists can actively initiate in their workspace and personal lives. The lack of such a discussion may have consequences ranging from increased absenteeism to ethical violations that may threaten client care (Barnett, Baker, Elman & Schoener, 2007).

Barnett and colleagues (2007) argue that self-care is an ethical imperative for mental health professionals, without which could lead to psychologist impairment and detrimental effects on the field and practice of psychology as a whole. Scholars reference the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct as the basis of their argument for the promotion of self-care (APA ethics code; APA, 2002; Barnett et al., 2007). Specifically, under the principles of Beneficence and Nonmaleficence the code outlines that psychologists must be aware of the possible effects their own physical and mental health may have on the clients they serve (APA ethics code; APA, 2002).

Therapists' well-being is a topic that has been growing in response to empirical findings that psychotherapeutic work can lead to harmful symptoms and conditions that compromise therapists' well-being. For the scope of this study, well-being will refer to psychological well-being as conceptualized by Ryff (1995) rather than subjective well-being which focuses on happiness and quality of life. Ryff (1995) developed a multi-

dimensional model integrating six distinct components of psychological functioning. Ryff details:

> In combination, these dimensions encompass a breadth of wellness that includes positive evaluations of oneself and one's past life (Self-Acceptance), a sense of continued growth and development as a person (Personal Growth), the belief that one's life is purposeful and meaningful (Purpose in Life), the possession of quality relations with others (Positive Relations With Others), the capacity to manage effectively one's life and surrounding world (Environmental Mastery), and a sense of self-determination (Autonomy) (Ryff and Keyes, 1995, p.720).

This description of psychological well-being provides a greater context to the purpose of this study since it is intended to understand how therapists manage boundaries related to their clients' acute distress and crisis.

Therapists' practices of self-care have been shown to improve psychological functioning (Figley, 2002). A review of the literature has identified several practices utilized by therapists to mitigate the aforementioned risks including supervision, organizational support, spiritual practices, emotional boundaries and holistic self-care practices (Cohen & Collens, 2013; Harrison & Westwood, 2009; Illife & Steed, 2000). Despite these numerous recommended practices, there may be a tendency for therapists to avoid personal self-care in favor of focusing on their client's needs (Figley, 2002).

Psychotherapy and the Suicidal Client

No discussion of crisis would be complete without mentioning psychotherapeutic work with suicidal clients. Recent statistics have identified suicide as the 10th leading cause of death in the United States (Centers for Disease Control and Prevention [CDC], 2016). It is important to note that due to the stigma surrounding suicide, this statistic is likely underreported.

As one article describes, “To face death is a terrifying prospect for humanity. The treatment and management of suicidality might be considered the most vexing dilemma a therapist will face in their entire clinical career” (Moore & Donohue, 2016, p. 24). The prevalence of suicide is widespread; one study found that almost 1 in 4 (23.7%) professional counselors have experienced the death of a client by suicide irrespective of their gender, age or years of clinical practice (McAdams & Foster, 2000). Working with a suicidal client has been described as an “occupational hazard” for those working in the mental health field, as most therapists providing direct care will encounter clients who endorse suicidal thoughts at some point in their professional life.

In addition to the likelihood of working with suicidal clients, it is also necessary to understand how working with clients endorsing suicidal thoughts impacts the therapist. Hendin and colleagues (2000) were interested to learn about therapists’ reactions following their client’s suicide, which many described as “the most profoundly disturbing event of their professional careers” (p. 2022). Researchers noted that: grief, shock, anger, self-doubt and fear of blame were the most endorsed emotional reactions to their client’s suicide. Interestingly, researchers had to adjust their study beyond their original intent to accommodate therapists’ request to expand on their emotional experiences and virtually all participants found their participation in the study to be therapeutic. Researchers noted:

> Therapists who participated in this study had a need to explore and resolve long-lasting feelings connected with their patients’ suicides. We suspect that such a desire is widespread among therapists who lose a patient to suicide. Many therapists whose suicide cases did not meet the criteria for inclusion in the study nonetheless wished to share with us the experiences that still troubled them (Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000, p. 2026).

This unexpected finding illustrates the importance of acknowledging the emotional and psychological impact of working with suicidal clients.

Therapists who experienced the death of a client to suicide reported a moderate to moderately high degree of impact this clinical incident posed on their personal and professional lives (McAdams & Foster, 2000). More specifically, therapists reported a loss of self-esteem, intrusive thoughts and intensified dreams while also experiencing feelings of anger and guilt. Professionally, following a client's death by suicide, therapists endorsed an increased likelihood to consult with colleagues and refer at-risk clients for hospitalization, more attentiveness to legal liabilities and a strong increase in their focus on their client's suicidal cues (McAdams & Foster, 2000). These findings were expanded by qualitative studies that explored how the experience of a client's death by suicide impacted therapists. Moore and Donohue (2016) concluded that the trauma of a client suicide altered the therapists' "inner landscape" on three levels: disruptions to the self, other-intimacy and professional identity.

Crisis Work

> "I'm most alive in this work and it's exhausting… I love crisis work and it's really, really scary"
>
> - Anonymous, 2014

In crisis work, therapists must employ a unique set of clinical skills in order to assist their clients in various states of crisis. Silverman (1977) defined crisis as "the interaction of a stress event and a perceived lack of resources either to overcome or to accommodate to it. A stress event is one which produces threat to the physical or psychological integrity of the person" (p. 293). Broadly, this may include clients

experiencing suicidality, trauma, severe mental illness, violent behavior or acute distress (Callahan, 2009; McAdams & Foster, 2000). Similar to the probability of working with clients endorsing suicidality, therapists may also view working with clients in crisis as an occupational hazard that is an intrinsic piece of their professional responsibility (McAdams & Keener, 2008).

Roberts (2005) argues that the landscape of crisis intervention practice was forever changed following the September 11th terrorist attack on the World Trade Center in 2001. This event sparked a greater demand on professionals to engage survivors with a range of needs. In addition to these large-scale life-threatening incidents, scholars also note that crisis can take the form of many other types of trauma-provoking events including violent crimes, traumatic stressors, onset or recurrence of mental illness, natural disasters, accidents and transitional or developmental stressors (Roberts, 2005). In response to the prevalence of traumatic and crisis-inducing events, individuals are seeking support services through 24-hour crisis hotlines, community mental health crisis units and outpatient hospital-based programs (Roberts, 2005).

Cavanagh and Levitov (2002) suggest that crisis resolution takes precedence over all other counseling goals until the crisis situation is resolved. Therapists must reprioritize typical counseling goals by "providing the client with firm direction to end the crisis and with clear instructions on how to appropriately do so" (McAdams & Keener, 2008, p. 392). Similarly, Brown and Rainer (2006) argue that crisis therapists are tasked to make difficult choices about treatment and must replace traditional psychotherapeutic techniques with new paradigms in an attempt to restore clients' functioning within short-term treatment.

Though there is a growing visibility of crisis intervention, the amount of research on the experiences of crisis workers remains limited. As a distinct sect within the mental health field, it remains crucial to understand the intricacies involved in crisis intervention work as the prevalence of trauma and crisis-inducing stressors continue to increase. Drawing from both qualitative and quantitative research studies, it is evident that clinical work with specific populations and settings elicits different subjective experiences from therapists.

There are relatively few studies examining the subjective experience of crisis workers. One such qualitative study conducted by Carrick (2014) explored the experience of person-centered counselors in their work with clients in crisis. Results indicated several findings that highlight the complexity and uniqueness of working with clients in crisis including: 1) all participants reported distinct differences between clients in crisis as compared to non-crisis clients, 2) participants reported that they experienced a heightened quality of presence and deeper connection faster with their crisis clients, 3) participants both reported both more negative and more positive reactions to clients in crisis, 4) participants noted their perception that clients in crisis were more vulnerable and presented with less defenses than their non-crisis counterparts and 5) crisis clients were perceived as more draining and exhausting requiring more self-care for the treating therapist. Carrick (2014) concluded by suggesting crisis can be a unique therapeutic opportunity to engage with more vulnerable clients and suggests that therapists utilize meaning-making to view crisis as an opening rather than a problem to be resolved.

Psychological Boundaries

The existing literature regarding psychological boundaries is scant. Halevi & Idisis (2018)'s described psychological boundaries as emotional and intellectual resources that allow therapists to uphold an effective separation between the client's emotional world and their own. For the purpose of this study, this definition will be used as a guide to conceptualize the topic of study.

In order to gain more clarity on what effective psychological boundaries entail, it is important to identify what unhealthy boundaries look like. During the experience of emotional contagion, for example, the therapist mirrors the affective responses of their client. Coutinho and colleagues (2014) presented evidence from neuroscience on the topic of empathy and argued that, "in order to respond in an empathetic manner to their clients, therapists should be open to 'feel' the emotional experience of their clients at the psychological level, service like a mirror of the clients' distress" (p. 545). Researchers added that after that initial period of emotional sharing, therapists must learn techniques to self-regulate their affective arousal due to the tendency that experiencing another's suffering can activate the therapist's own fear, which inevitably shifts the focus of treatment from the client onto the therapist (Coutinho, Silva & Decety, 2014).

Psychological boundaries also reflect the therapist's ability to emotionally separate from the other. Corcoran (1982) explored emotional separation as the degree to which an individual is able to emotionally differentiate from another during an empathetic interaction. Similarly, Harrison and Westwood's (2009) concept of exquisite empathy is viewed as protective practice against the harmful effects of VT. Researchers initially considered empathetic engagement to be more of a risk factor in developing symptoms of VT. However, their research found:

> When clinicians maintain clarity about interpersonal boundaries, when they are able to get very close without fusing or confusing the client's story, experiences, and perspective with their own, this exquisite kind of empathetic attunement is nourishing for the therapist and client alike, in part because the therapist recognize it is beneficial to the clients (p. 213).

Summary

The lack of available research on psychological boundaries for crisis workers has limited the comprehensive background for this proposed study. However, this gap in research reinforces the importance of approaching this novel topic through an exploratory lens from a constructivist perspective. Integral themes and variables relevant to the proposed study have been presented to illustrate that psychotherapeutic work holds inherent risk for the treating therapist who often employs their own psychological resources including empathy and compassion to relate to the client's suffering. Research has supported that this exchange leads to positive client outcomes (Duan & Hill, 1996; Norcross & Wampold, 2011; Watson et al., 2014). Lesser known, however, is how continued exposure to suffering impacts the therapists' ability to effectively separate themselves from their clients emotionally and psychologically. Mental health professionals who work in crisis settings often work alongside a litany of high-risk clients presenting in a state of acute distress who likely exacerbate the ambiguous task of navigating boundaries. Thus, this research builds on previous studies in an attempt to promote therapists' well-being through uncovering details about the process and practice of managing effective psychological boundaries in crisis work.

CHAPTER THREE: METHOD

A review of the literature surrounding therapists' use of psychological boundaries in psychotherapy yielded very few studies with no studies directly investigating this phenomenon in crisis work. Morrow (2007) suggests that qualitative methods should be used to explore topics with little previous research and for those variables that are not easily identifiable. Researchers have also suggested that using qualitative methods may facilitate a deeper understanding of the interactions, meaning and experiences encountered in psychotherapy (Wang, 2016).

Psychological boundaries are not visible or easily captured by numerical data. Due to the study's primary emphasis on the psychological experiences of therapists working with clients in crisis, qualitative inquiry remains the most effective method to obtain a sense of participants' lived experiences of working with clients. The data for this study is taken directly from participants' narratives allowing for greater complexity and nuanced perspectives.

Interpretative Phenomenological Analysis

A phenomenological approach was selected to capture the essence of therapists' use of psychological boundaries in their clinical work. In a discussion about the phenomenological position, Moustakas (1994) writes, "Essences are brought back into the world and enrich and clarify our knowledge and experience of everyday situations, events and relationships" (p.48). The strength of utilizing a phenomenological approach

for this study rests in its underlying philosophy that the researcher, despite their own experience and knowledge, is able to engage in genuine curiosity and be open to discovering something unexpected about the phenomenon through the participant (Finlay, 2014).

An Interpretative Phenomenological Analysis was selected to because of its process-oriented and epistemological stance that aligns with the intention of this study to explore how participants' make sense of psychological boundaries. Interpretative Phenomenological Analysis (IPA) focuses on exploring how participants make sense of their lived experiences within a specific context. IPA has two major theoretical aims: understanding participants' experiences and interpreting how meanings are constructed by individuals in personal and social worlds. Central to IPA is the process of "double hermeneutic" in which participants try to make sense of their world whilst the researcher is trying to make sense of participants' reflections on their world (Smith & Osborn, 2004). This form of inquiry yields data that help the researcher gain access to participants' point of view or "insider's perspective." Additionally, it allows the researcher to ask critical questions following participants' narratives including: What is the participant trying to achieve? Is there something leaking out of the data that was not intentional? Is something going on here that the participants themselves may be less aware of (Smith & Osborn, 2004)? Asking and answering these questions provides insights that will illuminate the significance of a process and practice of psychological boundaries that would otherwise remain hidden. IPA provides an opportunity to enter into a participant's perceptual world while also inviting the researcher to examine a more

comprehensive and critical standpoint. This twofold approach will provide critical insights that can be used in support of therapists' wellbeing.

Philosophical and Theoretical Assumptions

Creswell (2012) suggests that researchers begin qualitative research by reflecting on what they bring to the inquiry including one's personal history and perspectives. This becomes an essential piece of the qualitative process as the researcher builds on these to identify theories or paradigms that form the framework for the study. Morrow, Castaneda-Sound, and Abrams (2012) define a paradigm as, "An umbrella containing the researcher's view of reality, how knowledge is acquired, the values that guide the research, the methods used to conduct the research, and the language used to communicate the research processes and findings" (p. 95). Following these recommendations, I reviewed the major philosophical assumptions that undergird IPA and present my perspective on how this research paradigm complements my personal philosophy and intention for this study.

Smith, Flowers, and Larkin (2009) argued that IPA was derived from three fundamental philosophies: phenomenology, hermeneutics, and idiography. The phenomenological philosophy both emphasizes the focus on experience and perception while also recognizing that individuals exist in relationships to other people, objects, and culture. IPA is also grounded in the theoretical underpinnings taken from hermeneutics, the theory of interpretation. Hermeneutics is significant, in that, it highlights the relationship in the analytic process between the "part" and the "whole." In other words, to make sense of any given part, one must look at the whole and vice versa. Finally, idiography denotes a concern with the particular. IPA reflects this theoretical stance in its

focus on the depth of the analysis while also trying to make sense of how an experienced phenomenon is understood from specific people in a particular context (Smith et al., 2009).

Researcher's Background

Personally, I have always been drawn towards qualitative research because of my belief in multiple truths. These foundational beliefs are likely shaped by multiple identities that are salient to my understanding of self, culture, and existence. As a multiracial minority female, I identify with self-characteristics that both oppress and liberate me. I believe that humans are complex beings whose intentions and internal experiences cannot always be easily quantified using traditional positivist methods. Though there is a valuable place for positivistic inquiry, I am more interested in understanding an individual's experiences with rich data and vivid descriptions of their personal experiences. I see the value in acquiring in-depth perspectives that may lead to a greater understanding of a difficult and complex phenomenon.

The idea for this study stemmed from my personal experience working as a crisis clinician. Influenced by past trainings in Mindful Self-Compassion, I started to wonder what therapists do to build internal boundaries that allow them to both open themselves to the work and protect themselves in an effort to maintain their sense of self. I heard about co-workers describing their personal practices, routines and strategies that helped them maintain their sense of self in a high turnover field. Thus, my personal interest in understanding these practices coupled with self-compassion trainings shaped the intention of this study.

With my professional experience in the field of crisis work, it was essential to identify my personal perceptions and beliefs about psychological boundaries. Attempts were made to bracket my personal experiences in a way that encourages greater immersion into the participants' worldview. Throughout the research process I journaled as a way to reflect on my emotions, thoughts and experiences. Writing and reflecting helped me to set aside my own personal biases and assumptions to manage my subjectivity. Additionally, personal therapy provided a space to process deeper emotional concerns and manage my distress related to this project. In spite of these attempts, IPA acknowledges that one's personal experiences and perspectives will likely impact aspects of the final analysis.

Participants

Prospective participants were recruited by emailing administrative staff at crisis centers across a large metropolitan city. Emailed flyers and study information were sent to administrative staff and were requested to be distributed to therapists holding in crisis positions. Interested participants were encouraged to reach out via email after looking over eligibility criteria and requirements for participation. Participants were asked to participate in two separate interviews and were compensated with $50 Amazon gift cards for their full participation.

I recruited five participants (n = 5) who were actively employed in a crisis position and working primarily with clients in crisis at the time of interviews. Additional inclusion criteria included: master's degree or higher in social work, clinical, counseling psychology or related field in addition to holding a professional license. Participants were also required to have worked in the crisis field or their current position for longer than

one year. The crisis clinicians represented in this sample provided individual crisis services within a large metropolitan city.

Consistent with IPA, participants for this study were selected purposively from a fairly homogenous sample. Smith et al. (2009) suggests a sample size between three and six participants to be sufficient for developing meaningful and detailed analysis. The rationale for a smaller sample size rests in IPA's focus on quality and depth over breadth in hopes of yielding a detailed account of a complex phenomenon. For this study, I aimed to recruit between 4 to 6 participants. Upon completion of the interviews, I assessed the richness of participants responses as they related to the primary research question and determined that 5 participants (n = 5) was sufficient for the purposes of this study.

Following institutional review board approval, participants were provided information about the study including risks and benefits along with informed consent documents to review in an email. Participants were informed that they were able to withdraw their participation at any point throughout the research for any reason. They were encouraged to ask questions or raise concerns before, during and after each interview. All participants provided verbal consent to participate in this study.

Demographic Survey

Interested participants who identified meeting the minimum requirements for the study completed a verbal demographic survey prior to the first qualitative interview. This survey included closed and open-ended questions related to salient aspects of the participants' identities and information about their clinical work. Participants were asked to self-identify their age, gender identity, racial/ethnicity identity, degrees, social class, current position title, years of clinical work and years in crisis work. The purpose of this

survey was to gather basic identifying information about the participants in the study and ensure that they meet inclusion criteria for the study and provide context related to their narratives. See Table 1 for participant demographics.

Interview Protocol

Phenomenological researchers position themselves to push beyond what is known from experience or established knowledge (Finlay, 2014). Smith et al. (2009) suggest that the aim of the interview is to recall the parts of the experience, explore their connections and discover a "common meaning." The interview should facilitate an interaction with the participant and provide them with opportunities to tell their stories freely and reflectively. With this in mind, I created an initial draft of an interview protocol (see Appendix A). Following recommendations received from my dissertation committee, the interview protocol was split into two separate interviews (see Appendix C and D) and slight variations were made to add clarity and promote reflection.

The semi-structured one-on-one interviews schedule consisted of open-ended questions starting with questions that were more descriptive and allowed the participant to ease into the interview process. Following Smith et al.'s (2009) suggestions, I approached the topic sideways, in which the range and depth of topics covered allowed me to answer the research question through the process of analysis. Follow-up probes were incorporated to help participants elaborate on their responses. The semi-structured format of these interview protocols allowed for flexibility to follow topics that were presented as significant to each participant.

Data Collection

All interviews were conducted between early to mid-December of 2019 via Zoom video conferencing and audio recorded. Participants completed two separate interviews which lasted between 45 minutes to 1 hour each and spaced at least one week apart. These recordings were transcribed using NVivo transcription service which produces an initial draft of the transcript based on audio recordings. I reviewed and edited each transcript while reviewing the audio-recordings to ensure words were captured verbatim. The transcript included notes recording non-verbal interactions, significant pauses and hesitations. Each participant was assigned a pseudonym and all identifying information was replaced or removed during this phase to protect privacy. Finally, completed transcripts were protected by a password to ensure an added level of security.

Data Analysis

Data analysis in IPA is an iterative and inductive process with a primary analytic focus on the participants' attempts to make sense of their experience (Smith et al., 2009). In other words, the underlying assumption in IPA is the analyst's interest in learning about the participant's psychological world, which is operationalized through a sustained engagement with the text and a process of interpretation (Smith & Osborn, 2004). Although there are several strategies to help researchers conduct a quality IPA study, it is recognized that the process of IPA research is not linear and may not follow a prescriptive order (Smith et al., 2009).

As a novice IPA researcher, I used the suggested steps to build a framework of the analytic process while being flexible to the complexity that unfolded. Transcripts were uploaded to NVivo 12 software and used to organize data, write memos and identify themes. Word documents and tables were also used throughout analysis.

During the initial stages of analysis, I immersed myself in the data through a process of reading and re-reading transcripts. I also listened to each audio-recording while simultaneously following the transcript to help visualize the participant, as suggested by Smith et al. (2009) to provide a more complete analysis. During this phase, I noted my initial and prominent observations throughout the transcripts which included questions, thoughts, and ideas. At the end of this process, I created a memo to capture my thoughts and insights after becoming more familiar with the transcripts.

Following this, I engaged in a textual analysis by focusing on the participants' semantic content and language. Though there are no set rules to follow, the goal of this phase is to begin to specifically identify the ways each participant talks about, understands, and thinks about an issue (Smith et al., 2009). One way to operationalize this process is to note three types of comments: descriptive (explicit meanings), linguistic (metaphors), and conceptual (analytical). Using this process produced a detailed set of provisional notes that helped to guide the interpretation process. As the process and transcript became more familiar, I grew a clearer understanding of the intent of textual analysis. Over time, this process developed into a less structured task of commenting on words, phrases, or thoughts that seemed relevant or significant to participants.

Next, I used both transcripts and initial notes to begin developing emerging themes. In this phase, the analyst is tasked with reducing the volume of detail while maintaining the complexity through a process of mapping interrelationships, connections and patterns (Smith et al., 2009). These identified themes were expressed as phrases to capture the psychological essence of the text, which will be reflective of the participant's

original words and thoughts combined with the analyst's interpretation (Smith et al., 2009).

Following the initial interpretation of themes, I searched for connections across themes through by creating a list of themes and proceeded to form clusters of related themes as a way of charting connections (Smith et al., 2009). The analytical process described was repeated for each participant. Prior to each case, I bracketed ideas from previous cases in order to allow for new themes to emerge for each participant (Smith et al., 2009). After all cases were analyzed, the final stage in the analytic process involved looking for patterns across the cases. This was achieved by using large poster boards to visually move clusters of themes, relabeling themes and identifying ways that that participants expressed idiosyncrasy while sharing higher order qualities. These new categories were labeled as super-ordinate themes and are representative of a higher level of analysis. At this stage in the analysis, I reviewed the primary research question and edited out subthemes that did not connect to topic of study.

Rigor

Elliott, Fischer and Rennie (1999) suggest that trustworthiness is the equivalent of validity in a qualitative study, which refers to the use of appropriate, adequate and reliable methods to collect the data. Morrow (2005) reinforced the importance of establishing trustworthiness for specific paradigms and across research paradigms. Since this study was framed utilizing a constructivist lens, steps were taken to strengthen the trustworthiness of the data in accord with this paradigm.

To increase the quality of this research, I adjusted my original plan from conducting one interview into two separate interviews. This allowed me to follow-up

with participants and inquire about their reflections, ask for clarity regarding previous statements and build more rapport. In an effort to triangulate my findings, I asked each participant to voluntarily provide a photo of their workspace or an object of significance that represented some aspect of their identity as a crisis counselor. I also requested that they include a brief description as to why this object held significance to them. This artifact served as another source of data adding to the richness of the participants' narratives. These artifacts were reviewed and integrated into the results. For example, one participant provided a picture of a gift from a colleague that held significance related to social support. I made sure that extracts from this participant captured this dimension as a way of honoring the significance of their artifact.

Finally, I conducted member checks as a way to improve the internal validity of the emerging themes. All participants were emailed a brief synopsis of themes and descriptions and asked to provide feedback about the accuracy of the themes as related to their experiences. Any feedback provided was incorporated into final analysis and documented in the results.

CHAPTER FOUR: RESULTS

The primary aim of this study was to understand therapists' experience of psychological boundaries in crisis work. This chapter will present the findings from the semi-structured interviews. Transcript excerpts will be included to provide examples of thematic content. As readers are a critical component of the hermeneutic dialogue in IPA, close readings of the text along with commentary will allow readers to join the analytic process and come to their own conclusions about the data being presented. Themes will be presented to allow for participant idiosyncrasy and convergence and divergence of emerging themes and concepts. Contextual information will be added for clarity to support interpreted themes.

Participants

Five current crisis workers ($n = 5$) were interviewed for this study. All participants, at the time of the interview, were currently working as a mental health professional with clients in crisis and were licensed as professional counselors. Two of the five participants worked in crisis co-responder roles which meant they provided crisis interventions for mental health related emergencies and worked with an interdisciplinary team. One of the five participants provided both walk-in and mobile crisis services which involved occasional travel to meet clients. The remaining two participants provided walk-in crisis services. Of this sample, four of five participants indicated working on a shift schedule, meaning that they worked outside of traditional working hours. A selection of

participant demographics and pseudonyms are illustrated in a table to provide more context into the findings.

Table 1. Participant Demographics

Participant Name [1]	Age Range	Gender Identity	Ethnic/Racial Identity	Years in Crisis	Total Years in Mental Health
Antonia	Early 30s	F	White	4 ½	6
Beverly	Mid 30s	F	White	3 ½	10
Celia	Mid 30s	F	White/Black	3 ½	9
Dora	Mid 60s	F	White	5	23
Ellis	Mid 50s	M	White	1[2]	23

Antonia identifies as a heterosexual, White female in her early 30s and described a middle-class socio-economic status with no religious preference. She is currently working as a co-responder/clinician for clients in crisis. In her current position she responds to mental health related crisis alongside police officers. She noted responding to a wide range of clinical crisis including situations of domestic violence, suicidal risk, family conflicts, psychosis-related emergencies. Antonia has worked in a crisis role for 4 ½ years and has worked a total of 6 years in mental health field. She received her bachelor's degree in Studio Art and Art History along with a master's degree in Creative Arts Therapy. She currently holds a licensed professional counselor (LPC) license.

[1] Pseudonym used to protect identity and privacy.

[2] Ellis indicated that he has done some crisis-related work in other positions for over 20 years. In this table, 1 year represented his time in a primary crisis role.

Beverly identifies as a heterosexual, White female in her mid-30s and described an upper-middle class socio-economic status. She holds a Bachelor of Science degree in Psychology and a master's degree of Science in Counseling with 10 years of employment within the mental health field. She is currently a crisis counselor for a community mental health center and has been working in the crisis field for 3 ½ years. She currently maintains an LPC license. Beverly noted other important identities as a mother and a Christian.

Celia is in her mid-30s and identifies as a Biracial, Black and White heterosexual female with a middle-class socio-economic status. She has a bachelor's degree in Psychology and a master's degree in clinical mental health counseling. She has worked in the mental health field for 9 years total with 3 ½ of those in a crisis role. Her current position title is a Crisis Intervention co-responder for a community mental health center. In her position she responds to mental health related emergencies with police officers. She maintains an LPC license.

Dora is mid-60s and identifies as a married, White, heterosexual female with a middle-class socio-economic status. Her current position title is a walk-in and mobile crisis clinician for a community mental health center. She has worked in the crisis field for over 5 years and has been working in the mental health field for a total of 23 years. She holds master's degree in Counseling Psychology with an undergraduate degree in Business. She holds an LPC license.

Ellis identifies as a White, heterosexual male in his mid 50s with a middle-class socio-economic status. He attained a bachelor's degree in Christian education and a master's degree in counseling. He is currently employed as a crisis clinician at a

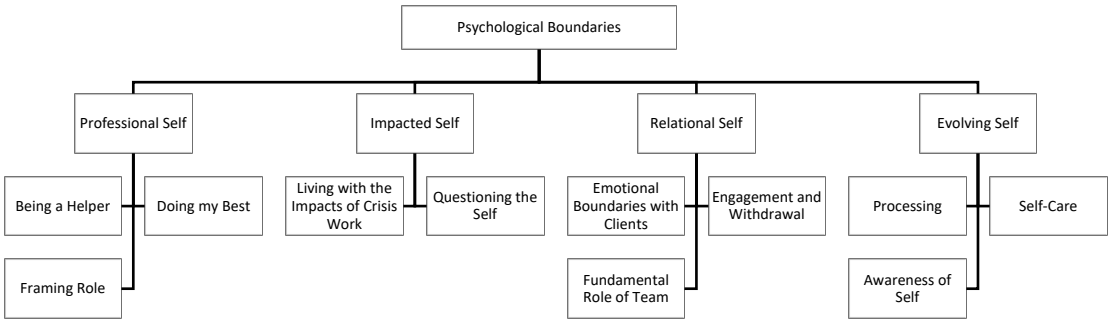
community mental health center and has worked in this position for over a year. Ellis has about 20 years of crisis-related experience in his earlier work as a case manager and intake clinician for a mental health clinic frequently working with clients with severe and persistent mental illness and co-morbid substance issues. In total, he has worked in the mental health field for 23 years and currently maintains an LPC license.

Themes

Qualitative analyses yielded 4 superordinate themes and 11 subthemes which are depicted below in Figure 1. Superordinate themes represented higher order categories that related to the primary research focus: 1) Professional Self 2) Impacted Self, 3) Relational Self and 4) Evolving Self. These superordinate themes capture the broader picture and dimensional nature of psychological boundaries in the context of crisis work. Subthemes will be presented to provide insights into the participants' day-to-day experiences and constructs that emerged as significant.

The following section will present a description of each theme along with transcript excerpts, summaries and analytic commentary that will act to provide a rich understanding of participants' experiences in crisis work and psychological boundaries. In line with Interpretative Phenomenological Analysis, a combination of extracts and analytical comments will be presented to capture a rich understanding of participants' lived experiences while making a case for what it all means. Attempts were made to assure that all participants' voices would be represented. However, there may be times when select participant's dialogue will be highlighted creating a more vivid and dynamic picture of the concepts presented.

Figure 1 Presentation of Themes



Professional Self

Professional Self derived from participants' varied attempts to understand and make sense of their professional identities. Participants experienced their role as a "catch-all" which encompassed the unpredictability of serving a diverse range of clients with a wide scope of needs. Dora, a walk-in crisis clinician, articulated this idea as she talked about what it is like day-to-day to work with clients in crisis:

> It's like a grab bag, just don't know what the next client is gonna be. Well I mean it can be anything from a suicidal 6-year-old to a confused 94-year-old. I mean that's pretty much the span of clients that I've seen in five years. So, when I when we get a call from security that's know we say we have a new walk-in and it could be anywhere in between that…I just feel like I take I have a more active role in crisis work. Because I mean every person you see is a new client. So, you've got to get to know them in a short period of time so that that requires more back and

> forth and then in the process of trying to find solutions or resources or whatever I feel like I'm in a more active role.

Dora described each client as a new client and not knowing what to expect. As a way to respond to this unpredictable and fast-paced work, she takes an active role to adapt to the constraints of her job. Encountering regular uncertainty prompted participants to find ways to encapsulate their work in response to ambiguity of their role.

Antonia, a crisis co-responder, works on an interdisciplinary team responding to mental health related emergency calls. She described intervening in situations "where the police are not really sure" how to help when no crime has been committed. She detailed intervening during suicide attempts, family disturbances, psychosis-related incidents, domestic violence situations and everything in-between. She noted:

> Crisis is whatever the other person thinks. And just getting this so I can understand it for myself too be really helpful. Getting those little statements together makes it easier for me to explain to people what I do so that I can do my job which is really helpful especially in my role. People are not expecting to see a clinician.

Antonia nuanced the inclusive nature of crisis as self-defined. In this passage, she illustrated how others are often unclear about her role and indicates that she, too, has struggled to explain her job. This resonated with Beverly, a walk-in crisis clinician, as she stated, "I think a lot of times when people don't know what to do with a client or how to help a client, they come to us." Thus, it became necessary and meaningful for participants to find ways to simplify and make sense of their obscure crisis role.

Being a Helper

It was clear that participants were drawn to the mental health field by a desire and willingness to help others. In the context of crisis work, identity as a helper was salient for all participants. Dora expressed this sentiment after reflecting on her purpose following a guided meditation while attending a workshop. She said, "when I came out of that my answer was to help people understand life doesn't have to hurt…and I especially feel like the crisis you know lends itself to that." Celia, a crisis co-responder, also expressed her desire to help while empathizing with her clients' pain. She noted, "They don't deserve to feel that bad. So, I need to help them feel better." Being helpful to clients emerged as a way for participants to feel that they were doing their job effectively.

Participants' identity as a helper became so prominent at times that they appeared conflicted if they perceived themselves as unable to help. As Beverly recalls a memorable case, she illustrated her struggle:

> I had to report like I needed to do my job and do that. But at the same time like if I report and they don't necessarily find anything like is that a danger for her? And so I feel like in those kinds of situations like no matter what I do like was I really helpful? And you know so that those ones just kind of stick with you think did I even help? Did I even help. Like I don't know.

Beverly revealed an internal conflict as she wonders if filing a report could endanger her client. Feeling unsure about her ability to help her client left her feeling stuck. She re-emphasizes the importance of this concept later as she noted, " I do still struggle with the ones that don't feel like they have much like wrap up…there's the times that I just don't feel like I offered much that could have been helpful (laughs)." She alludes to a lack of

closure when she perceives herself as unable to offer clients something useful. Her laughter at the end of this statement also appears signal her discomfort.

Feeling unable to help or provide resources could often lead to uncomfortable feelings for participants. Ellis added to this idea when he talked about client presentations that made it difficult to feel effective or helpful:

> There's times when people will have alternative motives or secondary gains in their presentation…We had a guy in last night who was very very challenging and nothing we offered was good. And then myself and another clinician we ended up tag teaming it just because he kept bed hopping… The way in which he was trying to bait us in to phrasing things in a way that were negative about him or I mean I felt taunted at times. So he was he angry and start calling us names and you know Drew[3] was the other person who who worked the case with me and afterwards we talked about it. He's like I felt the same way. And it was just being direct about you know these are things we can offer… And he'd literally would say that's not good enough.

Ellis provides his perspective of feeling antagonized by this client while attempting to offer help which was ultimately rejected by the client. His client's response of "that's not good enough" is reminiscent of Beverly's earlier statement "no matter what I do like was I really helpful?" This suggests that one's identity as a helper could be threatened in times when they perceived themselves as ineffective. Additionally, participants' focus

[3] Pseudonym used to protect identity and privacy.

helping on others could be upended when clients presented in ways that inhibited the helping process.

Doing my Best

Participants repeatedly and explicitly stated a desire to do their best in their professional roles. Ellis, the sole male-identified participant and walk-in crisis clinician, framed this as his "A-game" mentality which represented his striving for perfection. He stated, "The reality is no matter how hard we try to do that I can't do it perfectly." Meanwhile, Dora described her desire to offer her best to her clients when she said, "it takes some courage to walk through the doors of a crisis center people that do that, they deserve the best you can give them." Being able to conceptualize one's best effort seemed to hold a lot of meaning for participants and functioned as aspirational standard and a form of coping.

Beverly shared insight into this concept when she described what it was like to work with clients on a one-time basis: "When I go home like I don't have to think about that or you know worry about it anymore. Like I did the best that I could to help this person and that's all I can really do." In this context, Beverly suggests that doing one's best could function as a way to find closure.

In Celia's work as a crisis co-responder, she encountered multiple dangerous incidents involving gunfire and exposure to deceased people. Celia uses the concept of "doing my best" as a way of soothing herself when she described managing thoughts related to negative client outcomes:

> I guess I manage it trying to reassure myself that I did the most that I could do as a professional. And so just like constantly reminding myself maybe having

> conversations with my friend Lou* he's like a personal friend but she's also on my team when we call each other a lot on calls. So he's someone that I know we'll talk to a lot about that kind of stuff and. Give him that reassurance that there's nothing more that I could have done like professionally. Because like you know you have to have like certain boundaries and you know. With your schedule and your time and all that stuff and so. I can't fix everything. Yeah. You know I can't make everything better. So I think it shows that like silent dialogue in my head. That's. I'm just doing the best and the most that I can for that person at that time. I have to like replay it a lot especially the more difficult ones you know especially when someone ends up incarcerated or deceased. I have to definitely like replay that probably a lot more. But it's helpful because it's I mean it's it's the truth. You know I think that I'm good at what I do. And. You know I just have to like trust my brain.

This internal dialogue reminds her that she is doing her best as a professional, which functions as a way cope with negative outcomes. She is conflicted about feeling good about her work while also recognizing this does not guarantee positive outcomes for clients. Antonia, who also works as a crisis co-responder, echoes this sentiment when she said, "just reminding myself of that I can't fix everything but that I'm doing my best." In this way, participants are grappling with their strong desires to help and acknowledging their limitations and lack of control.

Framing Role

Participants used different devices to limit the scope of their work. This process of framing helped simplify and add structure to one's professional role which often resulted in a stronger sense of competency. Antonia conceptualized crisis work when she said:

> It feels like there's a solution like there's a problem and a solution. Even if the solution is maybe not ideal or some people aren't happy with it it's usually a problem that can be solved whether it's safety or safety planning or linking someone up to ongoing services like that.

Antonia conceptualizes her work as solving a problem and outlines different ways to find a solution. It's also important to note how she builds in a caveat related to non-ideal solutions which allows her to still feel effective despite having less-than-happy clients. Using this metaphor allowed her to frame her work in a way that was congruent with her personality. Antonia described herself as a "solution and problem focused" person which related to how she comprehended her role:

> I guess the first thing for me is it's rewarding. Like I said I am a really solution and problem focused person. It's like within the parameters of say an hour. I have done what I can to help solve the problem… It feels it just (pause) feels positive because nine times out of ten I am able to help. In some capacity so it's satisfying to me. I feel like I'm competent and able to do my job to help people who are very high need in the moment.

Being able to solve a problem within the confines of her role led her to feeling a sense of competency in her work. Likewise, Beverly a self-described "extrovert" maintained the importance of helping clients process their crises out loud in a way that helped her use her strengths to guide her role.

Dora, who has the most experience in her current crisis role, framed her work by highlighting what it was not:

> I think that understanding my job and understanding you know what the, what the end goal is of what this appointment is and what it isn't. And when I'm meeting with clients, I'm usually kind of at the back of my mind going over okay you know what are the options…Because I think because I've done it long enough. I don't get hooked into the well let's do therapy because that's not what a crisis center is for.

Dora's ability to clearly demarcate the bounds of her work have helped her to create a system that keeps her focused. She summarizes this clearly as she reminds a newer co-worker "keep in mind, this is a crisis center not a therapy center so you need to get in assess safety resources and send them on their way." For Dora, her experience helped shape and frame her role which acts to limit her emotional investment in client's crises.

Ellis also found a way to narrow the scope of his work by developing a temporal frame that he used to distinguish his role:

> One of the big differences is that our goal is to get people safe so that tomorrow they can engage in a fuller solution of what's going on. And you know what their therapist or whether it's some kind of unit that they get placed in. So crisis work is about getting things safe now I'm getting you to tomorrow safely.

This temporal frame also displays an element of client empowerment as he acknowledges the client's role in engaging in more comprehensive treatment with other providers. He is not accepting all of the responsibility of his client's crisis, rather he has found a way to

play an important, yet limited role. He expanded on this as he reflects on crisis work during his follow-up interview:

> I mean for me crisis work is putting together the puzzle and then it's figuring out so we know what the puzzle is. How do we fix, how we start getting this fixed realizing that we're not we're focusing on acute issues not chronic issues. Point you in the direction of getting chronic issues fixed and acute issues hopefully not becoming chronic. So it's putting together what the appropriate level of care. What do we do now? How much do I do for you? How much do I say this is your homework? You know there's times where people aren't functioning very well and it's like I've better put I'd better put this intake plan together completely and tell you to show up at this appointment on this day and time. There's other times on where it's therapeutic to have people do that work on their own. You know figuring out level of care on occasion you can't get the level of care you want because bed availability payor-source ability. So it's kind of putting together a puzzle and then you know then fighting on the front lines to get things out of the acute phase as much as possible.

Ellis' use of an organizing metaphor invites us to understand the significance of his thinking process. This is a clear representation of how framing one's work allows for both structure- focusing on the acute versus chronic- and flexibility as he adapts treatment based on individual client needs. Finally, the way he describes "fighting on the front lines" evokes a powerful image of his investment into his identity as a crisis clinician.

Impacted Self

Participants expressed that working with clients in crisis takes a toll. This overarching theme summarizes how participants observed crisis work to impact emotional, psychological and behavioral dimensions of their lives. Despite the benefits of creating a frame to guide their professional work, inevitably, participants absorbed some impact related to working with clients in crisis. Not all cases resulted in perceived impacts to the self. Rather, the culmination of repetitive exposure to clients' crises could lead to unanticipated changes. In essence, participants acknowledged that they could not escape their work unscathed.

Living with the Impacts of Crisis Work

The lingering effects of crisis work and how this manifested in their participants' lives was palpable. Participants expressed their perceptions of how crisis work impacted their personal lives. Celia expressed this concept as she reflected on the ways crisis work has changed her:

> I mean it's just it's really hard and it's really hard because it happens over and over again. So how it impacts me. I would say that I feel the world very differently. I'm probably a little bit more introverted than I used to be. I find myself sometimes wondering like when I meet people or when I'm talking to people when I'm not working. Kind of like wondering what's going on in their lives and you know that kind of stuff and I don't think that I thought about it like that as much prior if that makes any sense.

In this extract, Celia's world view has shifted as a result of recurrent exposure to crisis. She identifies how crisis work has amplified her introversion. She provides further insights into this phenomenon as she stated:

> I prefer to spend more time alone I think than before I mean I've always enjoyed my alone time but now it's like I really enjoy my time. So I'm also I am a little like I don't like to be around a lot of people because you know because we've had some calls where like people have like you know you know barricaded themselves inside of their house like there was one just like two weeks ago he was completely psychotic. He was like shooting outside of his house. So there was like there was tons of people. It was just very chaotic so I try to avoid busier things so like like when trying to think of an example, like festivals or farmer's markets stuff like that that I used to really like going to. I don't go to as much and I if I do I feel very like I'm on alert.

It is clear that she is beginning to associate crowds with the danger that she has encountered while on the job. Celia reveals difficulty disengaging from her propensity to be vigilant. This quality of vigilance and assessing this situation may be beneficial for her role in crisis work but was often difficult to turn-off. Relatedly, Beverly detailed the impact of crisis work:

> It makes certain things not seem like such a big deal. Like so like in you know like world of like my friends or my family when they have something happens that's significant for them. And like I find myself like having to work to be empathetic towards that because some of the things that I see are much more significant and I'm like like why are you complaining about this like really guys like it's like move on.

Beverly describes difficulty accessing her empathy when work ends. The magnitude of crises that she encounters at work result in "empathy-related exhaustion" that inhibit her

from being able to more easily related to her loved ones. Antonia sees her symptoms as a direct result of her exposure to trauma, saying:

> Oh it it can be really hard, I have had nightmares. I have definitely had days where I am fearful so I live in the Anderson[4] area so it's not the safest part of town, definitely not the riskiest part. But in the metro area it's fairly dangerous compared to Bend[5] so it can seem I'm being really hyper vigilant when I have to take my dog out and it's dark. I've definitely felt a lot more hesitant to go on a date because everyone's a perpetrator now. You know or everyone has a lot of baggage now or whatever it is. So, I have definitely had PTSD symptoms of my own. I have to be careful not to detach not to isolate myself and that's been a learning curve especially once I came into this job.

Questioning the Self

Participants often engaged in an internal dialogue with the self as they encountered challenging cases or observed the negative effects of crisis work in their personal lives. The construct of questioning one's self led to exploring personal values and emotions that created conflicts within their work. For Ellis, he pondered about his feelings of embarrassment after responding to a client's anger towards him:

> I mean just second guessing myself. Like maybe I shouldn't be doing this. I mean literally had the conscious thought on multiple occasions what's wrong with me

[4] Changed to protect identity and privacy.

[5] Changed to protect identity and privacy.

> that I did that. I mean that's not that's not true. Not okay with my values. What gave me the impression that I could pull that out in that situation.

Ellis' second-guessing can be seen as a self-evaluation as he considers his actions in a larger context. Reconciling his response allows him to be more conscious of how his personal values fit into his work. As he reflects, identifying the incongruency between his actions and values is a source of tension.

Central to this process of internal questioning is the acknowledgement of the self beyond one's professional identity. Beverly makes it clear that the cumulative effects of her work impacts her role as a mother:

> I probably tend to be less responsive to like more like quote unquote normal problems then probably like my friends or my family would like (laughs) just because it doesn't seem like a huge deal um, there's days when I'm more exhausted than I would like to be. Um, and so I mean I think that has an impact in, you know, like I question whether I should keep doing what I do. Does that affect my family? Does that affect my kids? Like is it affecting how I'm mothering them? Um and so I think those all those questions are always back there and that affects me psychologically.

In questioning herself, Beverly reconciles the impacts of crisis work on other important identities. For both Ellis and Beverly, the tension hit a tipping point as they considered whether or not to continue in their roles.

Expanding this discourse, Celia's shared her insights after learning about a previous client's death:

> You know just kind of just thinking about that over and over and over again…

> I mean I think professionally I felt like you know maybe I didn't do what I was supposed to do or like maybe I didn't ask the right questions or I mean that but it was like my fault because I know that that's not my fault. I know that but I felt guilty. And it was just such a weird thing to see someone like alive and then to hear that they're dead. So that's just a very weird thing.

Celia initially ruminates about this client after learning about her death. She attempts to reconcile her feelings of guilt which takes on an existential quality as she tries to make sense of her client's death. Thus, the practice of questioning the self left participants feeling unsure as they weighed the consequences of their work.

Relational Self

Relational Self emerged as a prominent theme that encompassed how therapists related to others. This relational construct appeared to function on a spectrum from avoidance and withdrawal to active engagement with others. Navigating this relational dimension effectively was perceived as gateway to mitigate the harmful effects of crisis work through connection. As Beverly put it, "from what I've seen with other crisis counselors it's the ones that don't have the right kind of support that aren't, that don't handle it well."

Emotional Boundaries with Clients

Participants expressed their attempts to remain distanced from their clients' crises. Conceptualizing boundaries helped participants build rapport in a way that assisted clients and preserved participants' emotional resources. Antonia described how she related to a client struggling with delusional thoughts through empathy:

> Listening to that other person, expressing my understanding. I feel like I can understand where people are coming from. I would be horrified and totally stressed if I thought my neighbors were in the CIA spying on me. I would be freaking out too and I would be calling the police. So even though that maybe isn't happening I can understand that and letting people know that I'm hearing them and understanding them. I don't have to let them know how I came to understand them, why I might understand. I don't have to give any indication whether or not I've had a similar or dissimilar experience. So I can keep myself really locked tight. I feel like people aren't getting to know me so it's not nearly as emotionally draining for me. I'm able to keep it. Use empathy but maintain a pretty intellectual stance holding stance vs. not real joining and working on a longer term.

Antonia relates by imagining how she might respond if she held those thoughts. Whilst expressing this understanding with clients, she employs an intellectual empathetic stance which allows her to keep herself separate. She sees this as a way to preserve emotional resources. In this way, one can balance connecting with clients to help them through their crises while also limiting contact to preserve the self. Beverly echoed this sentiment while describing how she relates to her clients:

> I think a lot of times maybe you haven't gone through exactly what they're feeling and so you have to connect with something that they're feeling right and try to understand them from some perspective. But clients in crisis. I mean you may not have gone through what they're going through or if you have gone through what they're going through it's probably something really hard like maybe somebody in

> their family just committed like suicide and if you've gone through that like it's hard to connect with that because that's a really hard emotion to connect with and so it's being able to connect and empathize without bringing yourself down significant.

Beverly's description details the fine balance between connection and separation. As a self-described empath, Beverly acknowledges the emotional risks of connecting too much. She suggests if one connects too closely with the client's suffering this could impact emotional wellbeing.

Participants who identified as more analytical appeared to struggle less with navigating this emotional balance. Dora, who describes herself as "less touchy feely," expressed how she detaches from her client's trauma. Dora said:

> For most people's trauma and so forth. I think part of being a counselor you've got to be able to detach from that and be you know be more involved in determining how best to help them and not getting as involved in relating to what they're going through.

Dora's ability to guide her boundaries by focusing on ways to help allows her to minimize this relational conflict. Dora reiterates this later when she says, "by the time I've written my notes my clinical notes I'm usually ready to say next." Beverly supported this argument stating:

> I say like 80 to 90 percent of the time like that's really easy. You know I don't tend to see clients more than once. I'm very good at separating like, you know, I don't love that my clients feel a certain way sometimes or you know I do feel

badly that they're going through certain things but I'm able to like separate you know that's their issue it doesn't have to be my issue.

Beverly articulates how she is generally able to separate from her client's issues with relative ease. Despite this, participants acknowledged times when navigating this balance of connection and separation can be difficult. As Ellis described, "I mean there's a certain amount of turmoil that comes with it."

Specific clients or situations that were found to be more difficult to separate from were categorized as those that hit too-close-to-home. In other words, these situations as they resembled or coincided with personal aspects or experiences of participants' lives. Dora acknowledged, "Personally to be perfectly honest with you the two clients that have been most troublesome for me related to their animals. Because I'm an animal lover." She described a memorable case working with a client who accidentally left her dog in the car. As Dora reflected, "she had more on her plate than any one human being should have. And now she had the fact that she killed her dog. And so that one. Yeah that one's really hard."

Beverly described an occasion of working with a client whose family dynamics mirrored her own as she stated, "and so that one was hard when it hits home like that. Like it's harder to because everything she's saying I'm like Yep. You're having a reaction." In this brief statement we see how Beverly recognizes her own personal reactions that arise while simultaneously helping clients work through their crisis. Ellis revealed what it is like for him to encounter a convergence of personal and client issues:

There's times it's sad on occasion. What they're going through parallels with something I have experience with either you know personal friends, family and

you know it's kind of doing an immediate check-in of making sure my boundaries are what they need to be you know.

Ellis identifies the point at which the separation between personal and client issues becomes blurred. During this moment, he articulates the significance of being mindful about his boundaries.

For some, specific cases stirred up personal reactions in such a way that it guided them to seek their own therapy to manage this imbalance. Antonia relates to this as she shared:

> So, nine times out of ten and this is even in a non-crisis setting. I take home young women who've been sexually assaulted. It's personal to me and so seeing them have that struggle and being able to relate on a personal experience base level. So those ones can be really hard for me…That was part of the reason that I got into therapy again was because I was having a hard time and I was bringing stuff home. And it was a sexual assault case actually that I was like this is horrifying and gut wrenching and I had to talk to someone that wasn't at the scene with me.

In this passage, Antonia articulates a deep empathetic understanding for sexual assault victims that lingers long after her professional role is over. This tension created by relating too closely with her clients encouraged her to process her reactions that made it difficult for her to separate. Beverly addressed this as she described how she regains composure, "I think sometimes when you start like going down that rabbit hole with clients it makes you feel just a little unbalanced and a little like you're not in control. And so I think the processing just helps me get back. To feeling in control." In this way, the

term “rabbit hole” is used to symbolize losing contact with the self which leads to feeling unbalanced. Processing was a way of getting back in balance.

Engagement and Withdrawal

The demands inherent in crisis work impacted participants’ interpersonal relationships in marked ways both inside and outside of the professional sphere. Celia references this relational dynamic as she explained:

> Yeah actually I started seeing a therapist of my own about a year ago because the other part is like you know I don't necessarily want to tell my friends and my family about the horrible things that I've seen because I don't want to like re-traumatize somebody else so I was keeping a lot of stuff to myself and I was not reaching out maybe to my co-workers.

For Celia, recurrent exposure to traumatic cases manifested interpersonally as withdrawal from family, friends and co-workers in an attempt to protect them from being traumatized by her disclosure. These avoidance behaviors were also the impetus to engaging with a therapist suggesting that relational effects of crisis work are both fluid and complex.

Celia observed her co-workers’ make attempts to increase interpersonal connection by facilitating an extended meeting where therapists could support each other through difficult cases. She describes, “at first it was really great but then slowly over time people stopped staying. I stopped staying because I'm like look I need to go to work and do this and like whatever.” When asked what she attributed this to she responded, “avoidance and not wanting to talk about it. That's the story of my life. And you know I'm probably I would imagine it's similar for other people. So it just stopped happening.”

What initially started with the intention to build a forum to engage with peers dissolved as avoidance behaviors took over.

Beverly experienced her own version of relational withdrawal as she shared, “there's times that I am just shut down at night and feel like I'm not super present for my family because I just haven't had the time I need you know process it.” Without sufficient time and space, Beverly observed herself withdrawing through being less present. Antonia noticed an interpersonal shift in her romantic relationships as she described attempts to conceal her work identity while dating:

> Talking about my work I used to talk about my work. And now it's something I kind of avoid unfortunately because then people ask more questions and I'm like I'm not working right now. I can't talk to you about that. Because ninety-nine hours on my job is traumatic. And most of that trauma I can handle and I'm dealing with coping with I kind of want to tell you what I do.

She expressed the dilemma of wanting to connect by sharing her work, but also recognized how others’ curiosity could put her in too much contact with the trauma she wants to escape.

In contrast, crisis work also created conditions that encouraged participants to engage and receive support from others. As mentioned previously, some participants initiated therapy as a method of re-engagement to combat their tendencies to isolate. Ellis references this concept as he discussed his attempt to orient a new intern:

> You know we've got someone who just started two weeks ago with us and she was an intern and now she's come on part time you know and just you know how do we know what's going on with you. How do we support you? This is

somebody who was one of the best interns I've ever worked with you know and so yeah overtly you know so have you been taking care yourself.

This passage illustrates the team's collective goals of encouraging transparency and willingness to provide support. Ellis seems to invite this intern to share more about themselves as a way to facilitate connection. Similarly, Dora perceived her team as supportive and accessible as she describes:

> Well one of the one of the reasons I one of the reasons for my longevity is our team is a true team very supportive. I've got a manager and a second level manager that I can walk into their office at any time and as long as they're not in that meeting or phone conversation something their door's always open.

She attributes her longevity in the crisis field to being able to engage with her team. In a sense, the open door she described symbolizes a supportive environment where she is encouraged to connect which proved significant in crisis work.

Fundamental Role of Team

All participants expressed the importance of having a support system and explicitly emphasized the fundamental role of their peers and supervisory relationships. Sharing a common identity and relating to the unique demands and experiences of crisis work cultivated particularly meaningful relationships. Despite the variation among participants' relationships with their peers and supervisors, teams served multiple functions that were important for participants' psychological well-being. As Ellis stated, "It's a matter of not trying to do everything on your own…use your peers heavily. You know when you're stumped when you're frustrated when you know when it's like I feel lost or you know any kind of difficulty use the people around you."

Antonia expressed the importance of feeling connected to a community within the field and provided insight into her experience at a trauma training:

> Having met those people that you can not only talk to but relate to because it's such a unique thing. You know whether it's your own counselor that can help you kind of relate and normalize what you're experiencing, or you make a connection with your peers. I definitely wouldn't call any of my colleagues my best friend but definitely colleagues that I feel close to and that I talk to them about work-related things because I know that they understand and I know that they'll have a better sense of my experience vs. other people from other people, other therapists. Making sure that you have some sort of community around you even if just one or two people that you feel like you can go to.

Managing the secondary effects of working with clients in crisis can be an isolating experience. Antonia suggests that building community and camaraderie with others in the field can provide invaluable support and validation.

Beverly's narrative indicated that she has close relationships within her team. She routinely discusses utilizing her team for support:

> I think we're all pretty good at realizing like when our co-workers maybe need to set boundaries. I think we all will push for people to set boundaries if we think it's important at that time. I think we all realize that we're therapists and we want to help and so sometimes we suck at setting boundaries for ourselves but we all know that it's important. And so I think that's another place that my team really comes in and as helpful as we help each other set boundaries when maybe we're not as good at it ourselves. But we all you know I mean and we discuss like it's

> important too. I mean clients even when they're in crisis have to do the work. Like we can't do it for them. So. Just being able to remind each other in and know. Where some of our more strict boundaries are and we let each other know where some of our more strict boundaries are and we're able to support each other in that.

In this excerpt, Beverly presents a picture that appears more collective than individual. The team serves an accountability function reminding each other to set boundaries. Similarly, Dora reflects on the deep connection she shares within her team:

> It's as much a friendships situation as it is just a professional relationship. And I think we all have an understanding of how hard it can be to work with clients sometimes and there just seems to always be an openness to be able to talk to talk to people and sometimes people even come up and say you know what can I do to help. And so, it's just feels like a real supportive environment. And several these people I've worked with for four and five years so I know how to read them to where you know I know how I know the look on Lana's[6] face when she just you know and I'll just go over it and say hug you need hug and she'll to say yes and it's like you know so that I think the familiarity and the understanding that we all have these.

Dora's friendships within her team suggest a sense of trust amongst her peers that create a safe environment for sharing and receiving support. In this way, the team's attunement

[6] Pseudonym used to protect identity and privacy.

to one another facilitates a mutual process of caring which benefits the psychological wellbeing of the whole team.

Supervisors also played a crucial role in creating a culture of support within teams by leading through example. Unlike peer-related support, supervisors were more apt to respond to participants' concerns as they had the systemic power to enforce change. Dora illustrated this as she described a conflict with a medical professional who disagreed with her clinical recommendations. She decided to consult with her manager about her concerns and detailed his response:

> I looked over, he was standing over my cubicle and said do not ever question your skills. He said you are a skilled clinician. Do not let anyone ever make you question your skills. So that was a really emotional….I could have smoldered over that awhile but I was glad I finally went to talk with him, his door is always open and he's so supportive and those are the things that make it OK to be you know to be where we are and know that we have that support.

Dora explained how her manager consulted with other administrators to address this issue on a systemic level. This type of support was emotional for Dora, who was reminded of her competency and validated through the words and actions of her supervisor. Similarly, Antonia described her manager's response after a particularly traumatic case where she witnessed someone being shot and killed. She described, "my manager came and picks me up from the crime scene took me back to the office to get my car and then followed up with me the next morning to say hey are you good? Do you want to go back to work today? Do you want some more time off?" She described this as "rock-star supportive" and noted how his response signified that her wellness and wellbeing were important.

Evolving Self

Evolving Self represents a central concept of participants learning about themselves through their experiences in crisis work. In a sense, this concept reflects aspects of the aforementioned themes while acknowledging participants' growth and the developmental shift within the self that occurred as a result of engaging in crisis work. Participants encountered discomforts, recognized their limits, navigated relational space, reconciled positive and negative emotions through their work which ultimately led to a greater appreciation, awareness, and acceptance of self. Ellis articulated in his reflection, "I'm a firm believer that we all do what we do for a reason and we don't necessarily understand what those reasons are especially early in our career. And those of us who choose this career tend to have issues that this career helps with."

Processing

All participants engaged in some form of processing with peers, supervisors, therapists or within themselves. The act of processing represented a way for participants to make sense of their personal reactions as related to their professional work. It encouraged participants to reflect, question, assess, and acknowledge themselves in a way that led to greater awareness of the self. Celia noted that processing in her personal therapy helps to "feel freer, I feel like my time is my own." In a sense, processing functions as a way to discern what parts of the crisis experience the keep, let go of or work-through which allows participants to come to the forefront and be active agents in their journey.

In the following statement, Celia details the conditions that prompted her to explore her experience of death with her therapist:

> Some of this stuff that happens that I have a hard time letting go of when I see a lot of like you know like horrible horrible stuff. You know I've only seen like two dead people prior to this job. I was like when I was a child like my grandpa died I went to his funeral. So you know not really having experience of death. So that's still kind of a weird thing for me. So she has been really great because I'm able to like kind of like talk to her about the things that I see. And process that a little bit out loud and a little bit more of a free space than I can with even my co-workers.

Celia's description illustrated an intersection of professional and personal history. She expressed having difficulty disengaging from these "horrible" images. Processing these in therapy gave her the space and safety needed to explore her reactions to encountering death. Antonia echoed this sentiment as she described talking through work-related issues in her therapy sessions:

> Honestly not very often do I bring work stuff in to my session but he helps me unpack anything else in my life so that I can be more present at work and not feel drained out by everything else my life and I have to be present and on and ready to go. But I mean I have honestly I think my last session I spent most of it talking about cases like how hard they were for me and kind of my reaction to them. I always know there's gonna be an opportunity if I need to deal with works off outside of work to talk to him then it also helps me be present at work. So I can get everything done and just leave it there.

Antonia relates processing as an unpacking suggesting that her personal life and crisis work can feel burdensome. She is able to release some of this burden as she acknowledges her personal reactions which helps her separate from her work. She notes

the added benefit of processing as it also improves her ability to be more present in her work. Dora also endorsed the use of processing as closure as she said, “I think because I have worked in a supportive environment I know that I've got people I can if I'm confused or angry or sad or I've got people that I can process that with and let go of it.” In this way, participants recognize that they don’t have to go through this alone, others are available for support.

Similarly, participants implied that processing could be viewed as a safeguard to manage personal reactions as needed. Beverly acknowledged that she is not always able to identify cases that can be activating. She said, “sometimes you don't know that it's going to be a triggering client until you're halfway through. You know so I'm an hour in with this client and I'm like oh this wasn't good for me. But I think it's just about being aware of that and then processing it afterwards.” Being caught off-guard by her emotional reactions feels more manageable knowing she has access to supports. When asked how she experiences processing as helpful, Beverly said:

> You know I just. It makes you feel a little less insane after you've seen certain clients right like am I losing it to like what is happening right now. But also you know it just gives you kind of that break you need to regather yourself and know that it's not just you that experiences that…That's what makes me an extrovert like I don't like to be alone. I like to be with others. And you have to process. And so that's I think for me where it really comes back to my team because they're the ones that I'm allowed to. Process stuff with like I can't come home and talk about my clients with my family.

Beverly explains the significance of processing as tied to her identity as an extrovert. By talking though her personal reactions with her team she regains her sense of self and feels validated. Ellis also felt validated after processing his reactions with a co-worker following an encounter with a challenging client. Ellis stated, "so he was angry and started calling us names and you know Len[7] was the other person who worked the case with me and afterwards we talked about it. He's like I felt the same way."

Prior to engaging in her own therapy, Celia described her experience without processing her emotional reactions related to her clinical work. She talked about her internal state after learning about a client's suicide weeks after providing follow-up support following an earlier suicide attempt. She stated:

> I would just think about her a lot, you know. I just have no idea what it's like right because I've never had depression, I've never been so depressed where I've thought about taking my own life and it's hard to imagine. It's hard to imagine that so you know I guess I was always I was thinking a lot about her and I was thinking about like how much pain she must have been in because you know to already try and do it once and you were saved and offered all the support. And it still wasn't enough. You know just kind of just thinking about that over and over and over again.

Celia describes ruminating about this case as she attempts to understand the depth of her client's pain and make sense of her client's decision. In this way, we can see the how the lack of processing one's emotions can lead to work infiltrating life outside of the

[7] Pseudonym used to protect identity and privacy.

professional sphere. Celia noted that being able to process the traumatic aspects of her work helped her to spend "less time thinking about what happened at work versus like my own personal life." Thus, processing proved to be an essential feature in creating psychological boundaries.

Self-Care

Participants considered self-care practices as what they do for themselves and also emphasized how these practices influenced their ability to do their jobs. Ellis put it simply, "for me at least I think this is fairly universal self-care is key. I need to keep me running well." Participants discussed how crisis work required them to be calm, alert, focused, and present. Celia noted, "I think it's so important to like take care of myself because I have to be in that position. I have to be alert. I have to be but I think most importantly I have to be present on some level I have to connect. To help them have better than what they're having." Engaging in self-care allowed participants to intentionally detach from the demands of their roles which, in turn, helped them feel better more whole. In this way, participants experienced self-care as a mutually beneficial process that improved the quality of their work and life.

Participants described self-care practices that ranged from mindfulness-type activities, crafting, spending time with loved ones, to taking time-off to detach from work. For Dora, a self-described animal lover, she described the solace of being able to connect with her animals:

> You can be having the worst day of your life when you go down and spend a half hour with an Alpaca and it's like life is good they're just such gentle beings that I love being around…They've got a real soft little hum their way of communicating

> and there's wonderful to touch because they're so soft. It's just it's hard to be It's hard to be upset when you're around alpacas.

The shift that occurs when she engages with her Alpacas illustrates how she is able to escape from the emotional residue of work. Disconnecting from work also resonated in Celia's practice of self-care as she discussed utilizing visualization:

> If I'm feeling like off-balanced, my therapist is big on like visualizing things. So when like letting things go so like putting something in a box and you know putting it that way. Like I did what I did. That instance is over. Put it in the box and put it away. So those kind of those kind of things are have been helpful and kind of trying to keep some distance from all of the I guess the trauma that I'm exposed to.

This practice facilitated a separation from trauma which helped Celia feel more balanced. Ellis described using humor and fun to disconnect from the seriousness and fast pace of crisis work. He noted, "it's having fun at work when we can. I mean the nature of crisis work there's some nights, last night we saw one client in eight hours it was right at the beginning of the shift so last night part of the goofing around making things light and humorous." Essentially, participant self-care activities varied but the underlying element centered on the need to be away. As Beverly puts it, "I just make sure that I get plenty of time away from it."

Antonia detailed learning about the concept of delight which was transformational for her self-care practice. She said, "you've never heard of this before is delight in doing things just for fun with no secondary purpose…And so doing those things that are just nice for me." Allowing herself to do things just for her was "groundbreaking." Other

participants also referenced the irony of therapists' struggle to engage in self-care. When asked about self-care, Celia noted "so we're actually pretty bad about it which I find ironic." Beverly also alluded to this when talking about setting boundaries "because even though we're all therapists, you know, we all kind of suck at doing it for ourselves sometimes." Thus, shifting from other-focused crisis work to taking care of the self required some degree of intentionality as participants could easily forget to attend to their needs.

Self-care practices were cultivated through encouragement from peers and supervisors, learned through personal therapy and trainings, and developed through an increased awareness of the impact of crisis work on the self. Participants demonstrated that self-awareness informed their self-care practices. In other words, participants were more likely engage in specific practices that matched what they needed if they were able to identify their in-the-moment needs. For example, Ellis described staying up late to watch television as way of not having to think after work. After reflecting on this during the interview, he acknowledged that getting more sleep would be more advantageous. Intentional self-care helped clients feel rejuvenated in their work and more whole as a person.

Awareness of Self

Participants consistently described a process of learning about themselves in the process of crisis work. Navigating relationships, challenging clinical encounters, personal reactions and other constraints and demands of the job cultivated a deeper self-awareness. This could be used to access strengths and resources while also allowing participants to identify their limitations. Antonia illustrates this concept as she said, "I have to

acknowledge that I won't always be able to handle this job. Because there's no such thing as being totally competent in managing and handling yourself when you're in such a high trauma job." Awareness and acceptance of personal limitations served participants as they communicated their needs with their respective teams and supervisors. In the following statement, Celia uses her self-awareness to advocate for her needs:

> I've had to be very proactive about being vocal to my supervisor like you know I might take some time off because I'm exhausted you know. And so because of the way that our team is set up like that is really forced me to. Speak up like. I can't work this I can't do all of this. I can't be responsible for all of this…I'm just like completely saturated. So we met last week and I told him I said you know things are just really not good. So I've just had to be very vocal about that which is weird because it's like it's not something like I'm not somebody who asks for like help a lot.

Celia's awareness of feeling exhausted and saturated led her to be more communicative about needing time away. She recognized reaching her threshold and decided to be proactive. This stands in contrast to her earlier experiences in crisis work as she noted "keeping a lot of stuff to myself and I was not reaching out maybe to my co-workers." This shift highlights Celia's growth and acceptance of her personal needs. Over time, participants' awareness of their emotions, needs and limitations became more clear.

Self-awareness was not restricted to reflections after-the-fact. Instead, it could appear before, during, and after the clinical encounter. For Antonia, her awareness peaked while in-between clients which encouraged her to set boundaries:

> Sometimes I know when I have to be done with work for the day. Sometimes there is a call and I'm like unfortunately I cannot continue with my day. Whether it means I'm going back to the office to just kind of do paperwork and trainings or if I need to put in some PTO for the rest of my day. I have to really be OK with that boundary. So if it's not good. I deteriorate.

Recognizing one's threshold allowed participants to set strong boundaries. Similarly, being cognizant of how one's personal life could interfere with clinical work proved to be advantageous. As Ellis stated:

> I had something going on my personal life. The first part of this week and on Tuesday there was a client that what she was coming in for had a significant parallel to what I was going through and I asked someone else to see the client like this you know this case is a little close to home. Any chance you can see them for me. I'll take I'll take the next one.

Ellis illustrates the utility of self-awareness and how it can be used to meet his needs. It can be assumed that he developed this self-awareness over time as this passage relates to an earlier statement when he asked a newer intern "How do we know what's going on with you? How do we support you?" Participants became more skilled at using self-awareness to access the support they needed.

Beverly echoes the gravity of self-awareness as an integral piece of managing demanding work:

> I guess it's hard to describe but it I mean it's exhausting work. You have to make sure you take really good care of yourself. Anytime interns come in you know you tell me you like I can't automatically tell that you're not having a good day

like you have to tell me and I will make sure that you get what you need even that if that's you know going home early. But you have to be very aware of how you're feeling and how things are going for you that day and nobody else can do that for you. And so it's just it's just it's really important to have a really good self-awareness.

Like Ellis, Beverly shared her insights to interns regarding the importance of self-awareness in this field. She also infers that self-awareness acts as a form of self-care.

Antonia's "on the street" exposure to clients in crisis caused her to experience PTSD symptoms. For Antonia, being aware of one's thoughts and responses to traumatic experiences in the context of vicarious trauma was very personal to her:

> I think in order for there to be more crisis clinicians and workers clinicians who are competent and doing well for themselves. We need to talk about vicarious trauma and how it's OK that we have our own struggles which sounds really silly. But just acknowledging that in a crisis setting specifically you have bad thoughts you have weird thoughts you have different stressors you know something might freak you out more than it would freak other people out. We may have a numbed response when other people like you should be reacting more to a dead person or whatever it is so I think that that's big. That's something that's really big for me and I try and talk to colleagues and peers about a lot.

In this statement, she advocates for increased dialogue about vicarious trauma after attending a meaningful training for trauma professionals. This training was significant for her as her "weird" thoughts were normalized and validated. Increased awareness and

acknowledgment of one's reactions, feelings and struggles generally led participants to a greater feeling of connection and community.

CHAPTER FIVE: DISCUSSION

The present study sought to explore the psychological boundaries of crisis therapists, which has been given little to no attention in the literature. Using an Interpretative Phenomenological Analysis provided insight into participants' perspectives and understanding of this concept. The primary research question anchoring this study was: What are therapists' experiences of psychological boundaries in crisis work? The crisis therapists who participated in this study described their experiences in four interpreted themes: *Professional Self, Impacted Self, Relational Self* and *Evolving Self.* Several components of psychological boundaries are important to highlight.

Crisis work was described as a "catch-all" service that was unpredictable, fast-paced and time-limited. In addition to this, participants described serving a wide demographic of clients with safety concerns, co-occurring disorders, trauma history, and other complicating environmental factors. The dichotomy participants experienced between the positive feelings of helping are contrasted with the psychological strain of caring for clients "in their worst moments." Much like the paradigm of growth through adversity referenced by Joseph and Linley (2005) in trauma work, the findings suggested that navigating this dissonance prompted participants to engage in a process of exploration that opened up the potential of positive growth. Thus, the conditions and constraints produced both exhausting and rewarding work.

Participants displayed a range of withdrawal and avoidance behaviors such as keeping to one's self, use of distractions, disconnecting from work and self-isolating which were interpreted as a form of self-preservation. Without sufficient time, space or access to resources, participants used these behaviors in the interim as a form of coping to distance themselves from their emotional and psychological discomforts experienced as: confusion, anger, sadness, and helplessness. Cohen and Collen's (2013) findings from a meta-synthesis of qualitative studies in trauma closely aligned with the emotional impact experienced by participants. Emotions often lingered and led some participants to think about clients and cases long after the clinical encounter. For some, it reached a point where they contemplated whether or not to continue in their crisis roles. Connecting this with Joseph and Linley's (2005) theory of growth through adversity, these behaviors can be seen as reflective of cognitive-emotional processing after trauma. Relatedly, participants also indicated expressions of personal growth as a result of their work with clients in crisis. In line with literature on Posttraumatic Growth, participants expressed positive consequences including increased clarity and heightened awareness of their values, and improved relationships with supervisors and peers as they opened up more their needs and struggles (Arnold et al., 2005).

Participants managed their emotional reactions in a number of ways including intentional self-care and other prosocial behaviors that allowed them to regulate their emotions. The current study supports Bellamy et al.'s (2019) findings suggesting that stronger emphasis on self-care and stress management reduced levels of stress for crisis counselors who provided disaster recovery outreach. Researchers in this study also reported that crisis counselors perceived low levels of stress (Bellamy et al., 2019).

Despite not asking about stress directly, it was clear that participants in the present study often experienced crisis work as exhausting, hard, and stressful. One way of understanding this difference could be related to the different range of services provided by crisis counselors. In Bellamy's study (2019) crisis counselors provided community-wide outreach services which are more visible and could be perceived as having a larger impact on the community as compared to individual crisis services. Several participants in this current study discussed that their work could be "thankless" and acknowledged that the lack of known client outcomes related to their work, at times, left them wondering if their interventions were impactful.

Participants resolved their internal discomforts through engagement with others. McCann and Pearlman (1990) recognized the importance of having contact with other professionals in the field to reduce professional isolation. Participant's prosocial behaviors such as being transparent with colleagues about boundaries, engaging in personal therapy, processing cases with peers and supervisors, and practicing intentional self-care were restorative. In doing so, their natural responses to challenging or distressing cases were validated internally and externally allowing the emotional residue to dissipate.

Consistent with previous work (Linley & Joseph, 2007), personal therapy and formal supervision were found to be beneficial as a means to process personal reactions to clinical incidents which participants experienced as freeing and validating. In contrast, the present study identified peer supervision and consultation as another avenue to facilitate personal growth. Benson and Magraith (2005) argued that peer support groups that encourage processing and normalizing emotional reactions can reduce stress and help

practitioners maintain appropriate boundaries. All participants expressed wanting to connect and create more opportunities for transparency and dialogue within their organizations and beyond. Participants indicated that crisis work remains a vague and largely obscure profession to many and opportunities to feel connected and validated were perceived as beneficial.

Based on participants' interviews and analytical interpretations of the data, it was evident that managing psychological boundaries in crisis work contributes greatly to therapists' psychological wellbeing. Consistent with Ryff's (1995) conceptual model, participants reported similar themes of self-acceptance, personal growth, clarity of purpose and positive relationships that were identified as important features of psychological functioning. Participants' use of processing cultivated a greater self-awareness that acted to enrich psychological boundaries. This finding is consistent with Satkunanayagam and researchers (2010) study which discussed the significance of reflective practice as a self-monitoring strategy.

Another important finding relates to the different types of crisis roles reported in the study. Two participants indicated that their roles as crisis co-responders put them in more direct contact with clients, as their clinical interventions were provided at the scene of the incident. For these co-responders, Figley's etiological model of compassion stress and fatigue (2002) suggested that direct exposure to suffering client comes at a great cost and is a contributing factor to compassion fatigue. In line with previous research, these participants reported more symptoms of hypervigilance, avoidance, and nightmares (McCann and Pearlman, 1990) as compared to participants in the sample who provided support services at a crisis center.

Halevi and Idisis (2018) suggested that psychological boundaries are emotional and intellectual resources that allow therapists to uphold an effective separation between the client's emotional world and their own. The findings from this study support this conceptualization and take it a step further to include the relational and interpersonal resources that helped participants discern their personal responses related to their clients' crises. This relational feature was not identified in Figley's (2002) etiological model of compassions stress. Participants considered their relational supports as integral to their longevity in the field as it appeared to regulate stress, reduce isolation and increase feelings of validation. Thus, it is possible that these relational supports could also reduce compassion fatigue.

In essence, participants initially discussed boundaries as a way to keep their personal selves "locked up tight" or "checked at the door." What emerged over the course of analysis presented a different picture that involved therapists opening up to their natural reactions to distressing events. Taken as a whole, psychological boundaries are not fixed attitudes or practices that ensure work stays at work. Instead, they are fluid and respond in cadence with one's awareness of self, which functions to both preserve and develop the self. Greater self-awareness prompted participants to identify options and resources that supported their psychological wellbeing. Giving more space to their personal responses helped them to connect with themselves and others. As participants navigated healthy and unhealthy boundaries, they learned how to negotiate closeness and separateness in a more fluid and responsive way that takes into account the self as the helper. In this way, intentional self-care activities led to an intersectionality of personal and professional work which felt more rewarding and sustainable for participants.

Limitations and Future Research

Findings from the present study are limited by the research design, methodology and participant demographics. For IPA studies, homogeneity of the sample helps the researcher to learn about nuanced experiences that might otherwise be missed using other methods. The sample of participants reflected some degree of variation in years of experience, types of crisis work, age, gender and ethnic/racial identity. For the purposes of this study, these variations were conceptualized as beneficial as differences allowed for more divergence leading to a richer contextual understanding of psychological boundaries. However, the selection of a more homogenous sample limits the larger representation of a therapists who reflect differences in social class, age, gender identity, sexual orientation, racial and ethnic backgrounds and other salient identities that likely impact their experiences navigating psychological boundaries. Additionally, the focus of the interviews centered on work with clients and did not explore or largely capture the intersectionality of participants' identities as it related to finding ways to separate from work.

As with other qualitative research, the results from this study are not generalizable. While the current study contributes to understanding psychological boundaries in crisis work, further study is needed to expand this discourse. Quantitative studies can build from this research to explore relationships between the themes found. Future research could illuminate this further by examining demographics, personality variables and interpersonal characteristics as they relate to psychological boundaries. Additionally, it may also be interesting to explore factors attributed to longevity in the field. This could be operationalized in a mixed-methods research by identifying

characteristics of those who have persisted in the field in comparison with those who leave. Psychological boundaries could be one aspect explored in the qualitative inquiry to add context to quantitative findings. As trauma research seems to have a more substantial presence in the literature, studies in the trauma field could be replicated for a population of crisis counselors. For example, it could be interesting to explore Joseph and Linley's (2005) organismic valuing theory of growth through adversity in a population of crisis counselors.

Another limitation was the small number of participants. For the purposes of this study, IPA suggests a smaller sample leads to a richer nuanced understanding of a specific phenomenon. Beyond the scope of this project, it would be beneficial to explore more therapists' experiences of psychological boundaries. Future studies could employ a method involving a team of researchers that would allow for more perspectives and interpretations of larger sets of data.

Finally, another limitation was the location of this study in a metropolitan city where access to resources for both therapists and clients is likely to be greater. The experience of psychological boundaries may be very different for therapists working in more remote areas with less robust resources. It would be interesting to explore these differences in setting by teasing out whether greater access to resources moderates therapists' wellbeing.

Expanding research on psychological boundaries through alternate qualitative, quantitative, and mixed-method inquiry can be used to refine and add nuance to the concept of boundaries in therapy. The term "boundaries" in the literature is associated with ethical conceptualizations without acknowledgement of the emotional,

psychological and social domains. To date, only a handful of articles discussed psychological or emotional boundaries. Based on the findings of this study, I propose the term psychosocial boundaries as a possible term that captures the psychological and relational features described in this study. Without an identifiable construct that is recognized across disciplines it becomes difficult to promote wider research.

Implications for Practice

Support for therapists' wellbeing remains as important as ever. The widespread impact of COVID-19 along with the increased visibility of racial trauma have emphasized the importance of crisis services and trauma-informed care. Despite all the constraints and unique demands of crisis work, participants indicated several resources and practices that helped them to mitigate the challenges they endured. Thus, the implications noted in this section will be geared towards operationalizing the findings to create a supportive structure and will discuss coping mechanisms that have been shown to support therapists' wellbeing and personal growth.

To support the crisis workers within the field, organizations should identify ways to promote camaraderie amongst the team. Using evidenced-based techniques from group counseling, organizations and administrators can develop formal and informal ways to facilitate connections amongst staff. This could be operationalized through quarterly retreats, trainings and peer consultation groups. As findings from this study show, participants expressed the need to process their personal reactions to their clinical encounters. Participants who experienced layered support and camaraderie from their peers, supervisors, managers and organizations perceived less damaging long-term effects. Another recommendation is the utilization of a mentorship model connecting

more experienced crisis clinicians with newer hires to build safety and rapport especially in the early stages. The guidance of supervisors was also viewed as an important resource to manage psychological boundaries. Thus, I suggest increasing access to supervisors as needed in addition to regularly scheduled formal supervision to process the emotional residue from clinical encounters. Sufficient time off, regular discussions about self-care and rewarding balance can create a climate and culture conducive to promoting wellbeing.

Working outside of traditional business hours is a common experience for therapists providing crisis services. Findings from this study made clear that this limited opportunities to connect professionally. For example, if a monthly meeting was scheduled in the morning, participants who worked evening or overnight shifts would have to make sacrifices to attend during their time-off or would decide not to attend. One recommendation is to build in time for meetings and group events for all shifts instead of meetings occurring outside of the therapist's working hours which would allow greater access of resources.

On a larger scale, establishing a crisis counselor association is crucial in creating a collective identity that would enhance the visibility of crisis workers and lead to a greater sense of enfranchisement within the mental health field. This association can act as a forum for ideas, research, resources, and support that are directly related to crisis work. Annual conferences can provide a larger community of support while providing relevant trainings and practices that build competency within the field. Trainings on vicarious trauma, burnout, and secondary traumatic stress can be used to validate therapists'

experiences and bridge the dialogue using evidenced-based literature to promote wellbeing.

For organizations that require therapists to fulfill weekly or occasional crisis coverage, it is important to note the differences between the work. More specifically, the needs of therapists in crisis roles may look different from traditional psychotherapy roles. For example, when operating in a crisis role, therapists are focused on assessing the most urgent concern and providing support and resources to help stabilize the client in the moment. Organizations and supervisors should adjust for this while maintaining transparency about resources offered to support this new demand including access to supervision as needed, increased consultation, and specialized training.

Finally, I suggest regular training aimed at helping therapists in crisis work understand and establish boundaries. In addition to training on ethical boundaries, discussion about psychological boundaries and reflections on how individuals can practice intentional self-care to engage in their work and relationships in a meaningful way is paramount. Intermittent activities that promote self-reflection and evolving sense of self can help strengthen these practices.

Researcher Reflections

The intention for this study developed from my personal experience working with clients in crisis. The range of emotions I experienced while doing this work remains one of the most terrifying and satisfying that I have ever encountered in my clinical experiences to date. With that said, my investment in this research project was personally meaningful and driven by a hope to understand more about the experience. I found

myself to be very curious and open to learning more about participants' experiences and was energized by their honesty and willingness to reflect.

Due to my personal experience as a crisis clinician, my knowledge and clinical base were sufficient to comment and code the data. IPA emphasizes the importance of the interplay between analyst and participant which impacts the findings. Despite this, I attempted to bracket my ideas in various ways including journaling personal reflections, engaging in my own personal therapy to process my emotional responses, meditation and other self-care exercises to increase my awareness of self and manage distress related to this study.

One of the unexpected findings in this process was the relational dynamic that emerged as significant in the management of psychological boundaries. I expected to learn about how therapists independently navigated boundary issues as they would be the only ones privy to their internal experiences of such work. However, results appeared to suggest that managing one's reactions apart from others was experienced could be isolating. Engaging with others and sharing collective experiences revealed the importance of connection. It is evident that this adversarial work stretches one's professional identity beyond the context of work. As we've seen from the results, every therapists' journey is different and allowing space for the self to have needs, reactions and personalized support elicits a greater awareness of self that mutually benefits the work and the self.

My role as a researcher is interwoven throughout this study. The process of selecting participants' excerpts, categorizing large portions of data and highlighting nuanced expressions is a reflection of how I have engaged in the dialogue with

participants. What emerged beyond the findings was a great appreciation for crisis workers and the work they do for the community. In a sense, this research was intended to spotlight these professionals who endure and give so much despite their work often going unnoticed. When people are coming to crisis professionals in disarray or in the worst moments of their lives, despite all attempts to be a "professional" one's humanity often leaks out. It's in the quiet moments before, during and after the clinical encounter that hold a great deal of meaning. In making sense of client's crisis, we also encounter our own feelings, beliefs, fears and limitations. I hoped that being curious about therapists' experiences, exhibiting compassion and encouraging self-exploration would lead to revelations that would be beneficial for the crisis field. I experienced my participants as eager to share their experiences and perspectives when given the space. I strongly believe that crisis workers are some of the most impressive in our field as they work with so many constraints in a very high-risk situations that they have to adapt to in-the-moment. I hope that this research begins to highlight their important work and brings attention to their efforts.

Conclusion

This is the first study to focus on the experience of psychological boundaries in crisis work. Despite its limitations, this study provides an insightful and conceptual view of how therapists navigated closeness and separation from their work with clients in crisis. A key contribution of this study is the identification of the relational features that supported participant's use of psychological boundaries. Participants learned how to create healthy psychological boundaries as they processed their personal reactions to clinical cases with supervisors, peers and therapists. Cultivating greater self-awareness

allowed them to have more access to their natural reactions, identify their limitations, engage in intentional self-care practices and advocate for their needs. These practices helped participants to effectively separate from their work and recognize interactions and emotions that could blur these boundaries. The possibilities for expanding on this work remain an important field of inquiry that can yield benefits for crisis work and beyond. It is my hope that this study inspires further interest and encourages the wellbeing of all helpers whose work reduces the suffering of others.

REFERENCES

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76*, 103–108. doi:10.1037/0002-9432.76.1.103

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education In Professional Psychology*, *2*(1), 26-34. doi:10.1037/1931-3918.2.1.26

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060–1073.

Arnold, D., Calhoun, L.G., Tedeschi, R.G. & Cann, A. (2005). Vicarious post-traumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*(2), 239–263.

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, *19*(2), 181-188. doi:10.1080/09515070600811899

Baldwin-White, A. (2016). Psychological distress and substance abuse counselors: An exploratory pilot study of multiple dimensions of burnout. *Journal Of Substance Use*, *21*(1), 29-34. doi:10.3109/14659891.2014.949316

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research And Practice*, *38*(6), 603-612. doi:10.1037/0735-7028.38.6.603

Bellamy, N. D., Wang, M. Q., McGee, L. A., Liu, J. S., & Robinson, M. E. (2019).

Crisis-counselor perceptions of job training, stress, and satisfaction during disaster recovery. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(1), 19–27. https://doi-org.du.idm.oclc.org/10.1037/tra0000338

Benson, J., & Magraith, K. (2005). Compassion fatigue and burnout: the role of Balint groups. *Australian family physician*, *34*(6), 497.

Bohart, A. C., Elliott, R., Greenberg, L., & Watson, J. (2002). Empathy. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp.89–108). New York, NY: Oxford University Press.

Bridgeman, D. (2009). APA's Advisory Committee on Colleague Assistance (ACCA). https://www.apa.org/practice/resources/assistance/acca-toolkit.pdf

Brown, F. F., & Rainer, J. P. (2006). Too Much to Bear: An Introduction to Crisis Intervention and Therapy. *Journal of Clinical Psychology*, *62*(8), 953-957. doi:10.1002/jclp.20281

Buchanan, M., Anderson, J.O., Uhlemann, M.R., & Horwitz, E. (2006). Secondary traumatic stress: An investigation of Canadian mental health workers. *Traumatology, 12*, 1-10. https://doi-org.du.idm.oclc.org/10.1177/1534765606297817

Callahan, J. (2009). Emergency intervention and crisis intervention. In P. M. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization* (pp. 13–32). Washington, DC: American Psychological Association. doi:10.1037/11865-001178

Carrick, L. (2014). Person-centered counsellors' experiences of working with clients

in crisis: A qualitative interview study. *Counselling & Psychotherapy Research*, *14*(4), 272-280. doi:10.1080/14733145.2013.819931

Cavanagh, M. E., & Levitov, J. (2002). The counseling experience: A theoretical and practical approach. Prospect Heights, IL: Waveland Press.

Centers for Disease Control and Prevention (2015). National Vital Statistics System, National Center for Health Statistics. Retrieved from: https://www.cdc.gov/injury/images/lccharts/leading_causes_of_death_age_group_2014_1050w760h.gif

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, And Policy*, *5*(6), 570-580. doi:10.1037/a0030388

Corcoran, K.J. (1982). An exploratory investigation into self—other differentiation: Empirical evidence for a monistic perspective on empathy. *Psychotherapy: Theory, Research and Practice, 19*, 63-68.

Coutinho, J. F., Silva, P. O., & Decety, J. (2014). Neurosciences, empathy, and healthy interpersonal relationships: Recent findings and implications for counseling psychology. *Journal of Counseling Psychology*, *61*(4), 541-548. doi:10.1037/cou0000021

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping: An International Journal*, *23*(3), 319-339. doi:10.1080/1061580 0903085818

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five*

Approaches (3rd ed.). Sage Publications.

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology*, *23*(1), 18-30. doi:10.1037/ocp0000047

Duan, C., & Hill, C. E. (1996). The current state of empathy research. *Journal of Counseling Psychology, 43*(3), 261-274. doi:10.1037/0022-0167.43.3.261

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

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York: Brunner/Mazel.

Figley, C. R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. *Journal of Clinical Psychology*, *58*(11), 1433-1441. doi:10.1002/jclp.10090

Finlay, L. (2014). Engaging phenomenological analysis. *Qualitative Research In Psychology*, *11*(2), 121-141. doi:10.1080/14780887.2013.807899

Frankel, Z., Holland, J. M., & Currier, J. M. (2012). Encounters with boundary challenges: A preliminary model of experienced psychotherapists' working strategies. *Journal of Contemporary Psychotherapy*, *42*(2), 101-112. doi:10.1007/s10879-011-9189-x

Gallagher, R.P. (2014). National Survey of College Counseling Directors 2014. University of Pittsburg, PA: International Association of Counseling Services, Inc. Retrieved from http://scholarship.pitt.edu/28178/1/survey_2014.pdf

Germer, C. K., & Neff, K. D. (2013). Self‐compassion in clinical practice. *Journal Of Clinical Psychology*, *69*(8), 856-867. doi:10.1002/jclp.22021

Gilroy, P.J., Carroll, L.,& Murra, J.(2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology Research and Practice, 33,* 402–407.doi:10.1037/0735-7028.33.4.402

Gould, M. S., Kalafat, J., Munfahk, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 2: Suicidal callers. *Suicide and Life-Threatening Behaviour*, 37, 338–352. doi:10.1521/suli.2007.37.3.338

Greenberg, L. S., Watson, J. C., Elliot, R., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 380–384.

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(6), 698–705. https://doi-org.du.idm.oclc.org/10.1037/tra0000318

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 203-219. doi:10.1037/a0016081

Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wynecoop, S. (2000). Therapists' reactions to patients' suicides. *The American Journal Of Psychiatry*,

157(12), 2022-2027. doi:10.1176/appi.ajp.157.12.2022

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence*, *15*(4), 393-412. doi:10.1177/088626000015004004

Joseph, S., & Linley, P. A. (2005). Positive Adjustment to Threatening Events: An Organismic Valuing Theory of Growth Through Adversity. *Review of General Psychology*, *9*(3), 262–280. https://doi-org.du.idm.oclc.org/10.1037/1089-2680.9.3.262

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 32-44. doi:10.1177/153476560831908

Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice*, *42*(3), 252–258. https://doi-org.du.idm.oclc.org/10.1037/a0023319

Lent, J., & Schwartz, R. C. (2012). The impact of work setting, demographic characteristics, and personality factors related to burnout among professional counselors. *Journal of Mental Health Counseling*, *34*(4), 355-372. doi:10.17744/mehc.34.4.e3k8u2k552515166

Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, *26*(3), 385–403. https://doi-org.du.idm.oclc.org/10.1521/jscp.2007.26.3.385

Malin, A. J., & Pos, A. E. (2015). The impact of early empathy on alliance building,

emotional processing, and outcome during experiential treatment of depression. *Psychotherapy Research*, *25*(4), 445-459. doi:10.1080/10503307.2014.901572

Maslach, C. (2003). Job burnout: New directions in research and intervention. *Current Directions in Psychological Science*, *12*, 189–192. https://doi-org.du.idm.oclc.org/10.1111/1467-8721.01258

Maslach, C. (2017). Finding solutions to the problem of burnout. *Consulting Psychology Journal: Practice and Research*, *69*(2), 143-152. doi:10.1037/cpb0000090

McAdams, C. R., III, & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, *22*(2), 107–121. https://search-ebscohost.com.du.idm.oclc.org/login.aspx?direct=true&db=aph&AN=3312967&site=ehost-live&scope=site.

McAdams, C. R., & Keener, H. J. (2008). Preparation, action, recovery: A conceptual framework for counselor preparation and response in client crises. *Journal of Counseling & Development*, *86*, 388–398. https://doi-org.du.idm.oclc.org/10.1002/j.1556-6678.2008.tb00526.x

McCann, J.L., & Pearlman, L.A. (1990). Vicarious traumatization: A contextual model for understanding the effects of trauma on helpers. *Journal of Traumatic Stress*, *3*, 131–149.

McCarthy, W. C., & Frieze, I. H. (1999). Negative aspects of therapy: Client perceptions of therapists' social influence, burnout, and quality of care. *Journal of Social Issues*, *55*, 33–50. https://doi-org.du.idm.oclc.org/10.1111/0022-4537.00103

Moore, H., & Donohue, G. (2016). The impact of suicide prevention on experienced

Irish clinicians. *Counselling & Psychotherapy Research*, *16*(1), 24-34. doi:10.1002/capr.12060

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250-260. doi:10.1037/0022-0167.52.2.250

Morrow, S. L. (2007). Qualitative Research in Counseling Psychology: Conceptual Foundations. *The Counseling Psychologist*, *35*(2), 209-235. doi:10.1177/0011000006286990

Morrow, S. L., Castañeda-Sound, C. L., & Abrams, E. M. (2012). Counseling psychology research methods: Qualitative approaches. *Handbook of counseling psychology*, *1*, 93-117. doi:10.1037/13754-004

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*, 341–352. http://dx.doi.org/10.1007/s10488-011-0352-1

Moustakas, C. (1994). *Phenomenological Research Methods*. London, UK: Sage.

Newell, J. M., Nelson-Gardell, D., & MacNeil, G. (2016). Clinician responses to client traumas: A chronological review of constructs and terminology. *Trauma, Violence, & Abuse*, *17*(3), 306-313. doi:10.1177/1524838015584365

Norcross , J. C., & Wampold, B. E. (2011) . Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, *48*(1), 98-102. doi:10.1037/a0022161

Oberlander, L. B. (1990). Work satisfaction among community-based mental health

service providers: The association between work environment and work satisfaction. *Community Mental Health Journal*, *26*(6), 517-532. doi:10.1007/BF00752456

Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. *Journal of Aggression, Maltreatment & Trauma*, *18*(3), 313-330. doi:10.1080/10926770902835899

Pope, K.S., & Tabachnick, B.G.(1994).Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology Research and Practice, 25,* 247–258.doi:10.1037/0735-7028.25.3.247

Roberts, A. (2005). *Crisis intervention handbook assessment, treatment, and research* (3rd ed.). New York; Oxford: Oxford University Press.

Roberts, A. R., & Ottens, A. J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment And Crisis Intervention*, *5*(4), 329-339. doi:10.1093/brief-treatment/mhi030

Rogers, C. (1975). Empathic: An unappreciated way of being. *The Counseling Psychologist, 5*(2), 2-10. https://doi-org.du.idm.oclc.org/10.1177/00110000 7500500202

Ryff, C. D., & Keyes, C. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*(4), 719-727. doi:10.1037/0022-3514.69.4.719

Ryff, C. D. (1995). Psychological well-being in adult life. *Current Directions In Psychological Science*, *4*(4), 99-104. doi:10.1111/1467-8721.ep10772395

Satkunanayagam, K., Tunariu, A., & Tribe, R. (2010). A qualitative exploration of

mental health professionals' experience of working with survivors of trauma in Sri Lanka. *International Journal of Culture and Mental Health*, *3*(1), 43–51. https://doi-org.du.idm.oclc.org/10.1080/17542861003593336

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*(1), 49-64. doi:10.1111/j.1471-6402.1995.tb00278.x

Shah, S.A., Garland, E., & Katz, C. (2007). Secondary traumatic stress: Prevalence in humanitarian aid workers in India. *Traumatology*, *13*, 59-70. https://doi-org.du.idm.oclc.org/10.1177/1534765607299910

Silverman, W. H. (1977). Planning for crisis intervention with community mental health concepts. *Psychotherapy: Theory, Research & Practice*, *14*(3), 293-297. doi:10.1037/h0086540

Smith, J.A, Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* London, UK: Sage.

Smith, J. A., & Osborn, M., (2004). Interpretative phenomenological analysis. In G. M. Breakwell (Ed.), *Doing social psychology research* (pp. 229–254). Oxford: Blackwell.

Stamm, B.H. (2010). The Concise Proqol Manual. Pocatello, ID: Proqol. Org. https://proqol.org/uploads/ProQOLManual.pdf

Tedeschi, R. G., & Calhoun, L. G. (2004). Target Article: Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*, *15*(1), 1–18. https://doi-org.du.idm.oclc.org/10.1207/s15327965pli1501_01

Vivino, B. L., Thompson, B. J., Hill, C. E., & Ladany, N. (2009). Compassion in

psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research*, *19*(2), 157-171. doi:10.1080/10503300802430681

Walker, M. (2004). Supervising practitioners working with survivors of childhood abuse: Counter transference; secondary traumatization and terror. *Psychodynamic Practice, 10,* 173–193. https://doi-org.du.idm.oclc.org/10.1080/1475363041000 1686753

Wang, Y. (2016). Qualitative Research: Complexities and Richness from Digging Deeper. In Heppner, Research Designs in Counseling (pp. 357-406). Boston, MA: Cengage Learning.

Watson, J. C., Steckley, P. L., & McMullen, E. J. (2014). The role of empathy in promoting change. *Psychotherapy Research*, *24*(3), 286-298. doi:10.1080/10503307.2013.802823

APPENDIX A: INITIAL DRAFT OF INTERVIEW PROTOCOL

I am going to ask you some questions regarding your experience working with clients in crisis. Please feel free to include in your responses any information that you think will help me better understand this experience.

1. Can you tell me about your introduction to crisis work and what you do in your current job? *Possible prompts: What made you choose a crisis position within the clinical field? What are the main duties in your clinical position?*

2. Can you describe a recent time when you encountered a memorable client in crisis? *Possible prompts: What made this client memorable? What do you recall about your role in managing this crisis?*

3. Can you describe a recent or memorable case in which you had difficulty separating yourself from your client and/or their crisis? *Possible prompts: How did this impact your day/week? In what ways were you impacted by your clients' crisis?*

4. How, if at all, has working with clients in crisis changed the way you think or feel about yourself?

5. How would you describe how crisis work has affected you personally and professionally?

6. How might you describe crisis work to others clinicians who are less familiar with working with this population? *Possible prompts: What do you think would be helpful for them to know?*

7. Can you describe what you do or have done for self-care while working in the crisis field? *Possible prompt: How have these practices affected your well-being?*

8. What, if anything, have you discussed or learned about boundaries in your work? *Possible prompt: How do you leave work at work? Are there any boundary issues that are common in your daily work? How are they typically handled in your organization?*

9. In what ways do you think this work has impacted how you relate to your clients?

10. Is there anything that I missed that you believe is important to tell me about how crisis work has impacted you- psychologically, emotionally, behaviorally?

APPENDIX B: DEMOGRAPHIC SURVEY

Before we get started, I'd like to confirm that you have reviewed the informed consent document and agree to participate in this interview which is being audio-recorded. If you consent, please say yes. Thanks!

I will begin by asking you some demographic and work-related information.

- What is your current position title? Are you primarily working with clients in crisis?
- How long have you worked in the crisis field?
- What degrees do you hold?
- What is your clinical license?
- How long have you worked as a mental health professional?

Feel free to answer the following questions based on your level of comfort:

- How old are you?
- What is your gender/gender identity?
- How do you identify your race and/or ethnicity?
- What is your socioeconomic status?
- What is your sexual orientation?
- Are there other identities that are significant to you that you would like to share?

APPENDIX C: INTERVIEW PROTOCOL #1

1. Tell me about your introduction to crisis work. *Possible prompts: What attracted you to a crisis position?*

2. What are the main duties in your clinical position?

3. Describe what it is like to work with clients in crisis.

4. How is crisis work similar or different from other clinical work? *Possible prompts: What is unique about crisis work? How might you describe crisis work to other clinicians who are less familiar with working with this population? What do you think would be helpful for them to know?*

5. Describe a recent time when you encountered a memorable client in crisis that you felt really connected to. *Possible prompts: What made this client or interaction memorable? What do you recall about your role in managing this crisis? How did you feel after your interaction with this client, what did you do after this clinical encounter?*

6. Describe an example of a time when you set boundaries well.

7. Describe a recent or memorable case in which you experience some difficulty separating yourself from your client and/or their crisis? *Possible prompts: How did this impact your day/week? How did this interaction with your clients' crisis impact your thoughts, feelings or behaviors?*

8. How does hearing stories about your clients' crisis, trauma and/or suicidality impact you?

APPENDIX D: INTERVIEW PROTOCOL #2

1. After our first interview is there anything that you wanted to share or clarify that might tell me more about how you manage the challenges of crisis work? *Possible probe: How do your personal identities affect how you approach your work?*

2. In your current position what have you discussed or learned about regarding boundaries? *Possible prompt: How do you leave work at work? Are there any boundary issues that are common in your daily work? How are they typically handled in your organization?*

3. Can you tell me about practices, rituals, values or beliefs/spirituality that help you get through difficult or challenging cases? *Possible prompt: What keeps you in the crisis field?*

4. In what ways do you attend to your psychological well-being? What have you done for self-care while working in the crisis field? *Possible follow-up prompt: Are there any norms in your organization with regards to self-care? In your opinion, how have these practices affected your well-being, stress-levels, etc.?*

5. Is there anything that I missed that you believe is important to tell me about your experience in crisis work and/or how this has impacted you- psychologically, emotionally, behaviorally?

APPENDIX E: RECRUITMENT FLYER

The University of Denver's Department of Counseling Psychology is conducting a research study on: The Experience of Boundaries in Crisis Work

If you are a licensed mental health practitioner currently working primarily with clients in crisis, you may qualify for a research study examining how mental health crisis workers manage stressors and boundaries. Eligible participants will be asked to complete 2 interviews online via Zoom video conferencing (estimated 45 minutes to 1 hour per interview). Every participant will receive a $50 gift card to Amazon for completing the study.

For more information, please email Dana Santiago at
dana.santiago@du.edu
Principal Investigator: Dana Santiago, MA
Faculty Sponsor: Pat Garriott, PhD, Pat.Garriott@du.edu

APPENDIX F: TABLE OF PARTICIPANT DEMOGRAPHICS

Participant Name *	**Age Range**	**Gender Identity**	**Ethnic/Racial Identity**	**Sexual Orientation**	**Socio Economic Status**	**Years in Crisis**	**Total Years in Mental Health**
Antonia	Early 30s	F	White	Heterosexual	Middle	4 ½	6
Beverly	Mid 30s	F	White	Heterosexual	Upper middle	3 ½	10
Celia	Mid 30s	F	White/Black	Heterosexual	Middle	3 ½	9
Dora	Mid 60s	F	White	Heterosexual	Middle	5	23
Ellis	Mid 50s	M	White	Heterosexual	Middle	1[8]	23

* Pseudonyms are used to protect client identity and privacy

[8] Ellis indicated that he has done some crisis-related work in other positions for over 20 years. In this table, 1 year represented his time in a primary crisis role

APPENDIX G: EMAIL TEMPLATE TO INTERESTED PARTICIPANTS

Dear potential research participant,

My name is Dana Santiago and I am a doctoral student from the Counseling Psychology Department at the University of Denver. You are receiving this letter because you have expressed interest in participating in a study about the experience of crisis counselors. This study is supervised by Pat Garriott, PhD (Pat.Garriott@du.edu).

I am excited about your interest in participating in this research and consider it a privilege to hear your stories and insights. The purpose of this letter is to give you information about this study and to provide you with an informed consent form for your review.

I am conducting a qualitative study to understand and provide descriptive detail about the experience of mental health crisis counselors working with high-risk populations. My primary focus of this study is on therapists' experiences establishing boundaries and managing stressors in their work with clients in crisis. The intention of this research is to understand the essence of how working with clients in crisis affects you as a person and professional. I am particularly interested exploring how therapists separate themselves from their clinical crisis work.

I will be requesting that you complete two video interviews (Zoom) with me, lasting between 45 minutes to one hour per interview. These interviews will be audio-recorded. I will ask you to share about your experiences working with crisis clients including how this impacts you psychologically, emotionally and professionally. I am seeking vivid, accurate, and comprehensive portrayals of what these experiences were like for you. This may include your thoughts, feelings, and behaviors, as well as situations, events, places, and people connected with your experience.

You will be receiving a phone call in the next few days to ensure that you are eligible for the study and to schedule interviews.

I appreciate the time and energy that you will give to be a part of this study. Remember, this is completely voluntary. You may choose to participate or not without consequence. Please review the attached informed consent documents. If you have any questions, please feel free to reach out to me via e-mail (dana.santiago@du.edu).

Best,
Dana Santiago, M.A.

APPENDIX H: EXEMPT RESEARCH INFORMATION SHEET

Title of Research Study: An Exploration of Therapists' Boundaries in Crisis Work
Academic Title: What Remains? An Interpretative Phenomenological Analysis of Therapists' Psychological Boundaries in Crisis Work

Principal Investigator: Dana Santiago, M.A., University of Denver

Faculty Sponsor: Pat Garriott, PhD., University of Denver

IRBNet Protocol #: 1409656

Voluntary Participation: Your participation in this research study is voluntary and you do not have to participate. You may choose to not answer questions and/or discontinue with the interview for any reason. This document contains important information about this study and what to expect if you decide to participate. Please review the information carefully and feel free to ask questions before making your decision whether or not to participate.

Description: You are invited to participate in a research study. The purpose of this study is to understand how therapists experience and use boundaries in their clinical crisis work. Secondarily, the study will aim to understand how therapists are impacted psychologically and the ways they manage their emotional reactions to their clients in crisis.

Eligibility: Participants must meet the following criteria: Currently working with clients in crisis, hold a license (LPC, LCSW, etc.), have a master's degree or higher in Counseling or related field (i.e. Social Work, Clinical Psychology, etc.) and at least 1 year providing direct service to clients in crisis.

Risk and Benefits: Potential risks and/or discomforts of participation may include feeling some distress upon sharing your stories, experience, and feelings related to crisis work. Additionally, some participants may feel concerned about their confidentiality and privacy when sharing personal information and perspectives.

Some of the benefits of your participation in this study include being able to tell your stories and share your perspectives which may feel validating or empowering for some participants. Additionally, you may have positive feelings knowing that your participation may be used to help other clinicians.

Compensation: You will receive a $50 Amazon gift card for your full participation in this research project. Compensation will be sent electronically to your email within 14 days following the completion of second interview.

Procedures: If you agree to be a part of the research study, you will be asked to provide your email address and phone number to complete a brief call to ensure your eligibility and schedule your interviews. You will be asked to complete 2 interviews via Zoom video conferencing that will take approximately 2 hours of your time (45 minutes- 1 hour per interview).

Confidentiality: You will be audio recorded for the duration of the interviews. If you do not want to be audio recorded, please inform the researcher so that we may end your participation in this study.

Please note that the data you provide may be collected and used by Zoom as per its privacy agreement. This research is only for U.S. residents over the age of 18. Please be mindful to respond

in a private setting and through a secured Internet connection for your privacy. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Questions: Please take all the time you need to read through this document and decide whether you would like to participate in this research study. If you have any questions about this project or your participation, please feel free to contact Dana Santiago at dana.santiago@du.edu or Pat Garriott at Pat.Garriott@du.edu at any time.

If you have any questions or concerns about your research participation or rights as a participant, you may contact the University of Denver's Human Research Protections Program (HRPP) by emailing IRBAdmin@du.edu or calling (303) 871-2121 to speak to someone other than the researchers.

The University of Denver Institutional Review Board has determined that this study is minimal risk and is exempt from full IRB oversight.

APPENDIX I: CLUSTERED THEMES

Superordinate Theme 1: Professional Self

- Being a Helper
  - Desire to help
  - Willingness to help
  - Strong work identity
- Doing my Best
  - Perfection
  - Desire to offer my best
  - Striving to do better
  - Acknowledging perfection is not possible
- Framing Role
  - Understanding role
  - Identifying scope of work
  - Identifying end goal
  - Refocusing on how to help
  - Use of metaphor

Superordinate Theme 2: Impacted Self

- Living with the Impacts of Crisis Work
  - Empathetic exhaustion
  - Difficulty relating to family/friends
  - Perspective shifts
- Questioning Self
  - Ruminating
  - Existential questioning

Superordinate Theme 3: Relational Self

- Emotional Boundaries with Clients
  - Difficulty separating
  - Boundaries in practice
  - Detaching from client's trauma
  - Setting boundaries
- Engagement and Withdrawal
  - Avoidance behaviors
  - Disconnecting from work
  - Relational avoidance
  - Willingness to support team
  - Environment supportive of boundaries
- Fundamental Role of Team
  - Supportive work environment
  - Using team to help with challenging case
  - Building camaraderie
  - Trusting support of peers and supervisors

- Communicating needs with team

Superordinate Theme 4: Evolving Self

- Processing
  - Opportunities to connect
  - Needing to process
  - Externalizing feelings
  - Processing with team
  - Validation from team
- Self-Care
  - Prioritizing self
  - Attending to personal needs
  - Reminding self to engage in self-care
  - Using self-care to soothe and distract
  - Practices that promote wellbeing
- Awareness of Self
  - Awareness of personal struggle
  - Maintaining awareness of self
  - Acknowledging and accepting personal limits