# Case illustration: 'Star' - Relational ethics around Containing and Boundarying

Star, 39 years old, was referred to an inner-city Women's Counselling Service via the police as part of their 'Support for Victims of Crime' programme. She had been mugged and sexually assaulted. She was deemed 'vulnerable' as she has a history of suicide attempts (overdoses) or self-harm (cutting herself) and her psychiatric records indicate both in-patient and out-patient treatment for 'dual diagnosis' (including substance abuse, depression and borderline personality disorder).

When she arrived at the Centre to be **assessed** by her counsellor, Star was well made-up, fashionably dressed, attractive and articulate. In a shaky and tearful manner, she told of how the recent attack had triggered flashbacks of childhood trauma, leaving her feeling fearful and overwhelmed. Noting her long sleeves despite the warm weather, the counsellor assumed she was hiding scars.

Star spoke of growing up with two alcoholic parents, routinely witnessing violent arguments and being physically beaten herself. She had run away from home aged 15 and had had no contact with her family since. She'd had a few encounters with community mental health services and occasionally ended up living on the streets. However, by drawing on various support services she'd eventually managed to establish herself in the community. Significantly, she decided to re-invent herself by changing her name and moving to another city. Despite her somewhat volatile work history, at the age of 28 she found her feet in a high street fashion shop where she was eventually promoted to floor manager. Being successful in her job was important to her, enabling her to build a more stable sense of self-worth. The same could not be said about her private life, where several 'serious' relationships had ended badly, leaving a trail of emotional wreckage.

Filled with compassion, the therapist expressed how impressed she was by Star's story of survival, resilience and courage. She commended Star for having done so well, despite her traumatic early experiences. She then offered Star twenty sessions of weekly supportive (humanistically-orientated) counselling to help her through this current crisis – the maximum allowed by that particular service. In addition, she suggested that Star might benefit from the aromatherapy relaxation group offered at the Women's Centre. This Star gratefully accepted.

They began therapy by exploring how Star might **manage her distressing flashbacks** focusing on stabilising techniques. She seemed to find relief from talking about her early trauma and having it witnessed by this empathetic, listening therapist. Her initial shakiness receded, and their alliance grew along with Star's sense of 'survivor pride'. The therapist, for her part, enjoyed Star's vibrant presence and insightful expression of emotion. In addition to their weekly meeting, Star turned to her therapist at points through the week via texting. When faced with stress, she would reach out and was soothed and re-grounded by their text exchanges. Star admitted that without this she would have used her self-cutting for emotional release and to get self-soothing.

After three months, the therapist took two weeks' holiday while Star planned her 40$^{th}$ birthday night out, clubbing with friends. The evening proved disastrous and ended with Star in Accident & Emergency after drunkenly cutting her wrists. One of her cuts proved so deep it severed a tendon, flagging up her attempt as a serious risk. The duty psychiatrist referred her for formal assessment by the local community mental health team, which then fast-tracked her for dialectical behaviour therapy (DBT) with its own specialist Personality Disorder Service.

The counsellor only learned of these events after Star missed their next appointment nearly a month after their previous contact. She phoned Star to find out what had happened. Star was apologetic but her excuses didn't ring true. Star missed a further session before returning with a still bandaged arm and a fuller story. The therapist was openly shocked and distressed for Star but contained the uneasiness building in her that their work together had been less successful than she'd previously thought. She also felt bad that she had gone on holiday without thinking through self-care plans with Star. With some relief, she welcomed the idea of DBT as another resource for Star.

A week later, Star returned to her counselling in tears. She told her therapist that she had been assessed by the DBT team and offered six months of out-patients treatment -- but was required to stop their counselling sessions. "I don't want to lose you!" she cried plaintively. "Can't we just carry on? If it's got to be them or you, I think you can help me much more. I want us to carry on anyway but I'll tell them I'm not seeing you no more."

The therapist felt pulled towards the idea of continuing with Star. But was she perhaps being 'played'? Uncertain of the way forward, she resolved to take her dilemma to **supervision** and suggested to Star that they think about it over the coming week.

Her supervisor's immediate response was to issue a challenge. Suggesting that she was too confluent and enmeshed, and in danger of 'rescuing', he posed the key question: "What's in Star's best interest?" They considered the benefits of an intensive specialist DBT intervention, along with the potential drawbacks of continuing counselling alongside this. One danger was that Star might 'split' her therapy by playing off her counsellor against her DBT therapist. They also explored why the counsellor might have become pulled in, even perhaps 'enabling' Star's continuing self-destructive behaviour. Recognising the influence of her own history of caring for an alcoholic parent, the counsellor ruefully admitted that "rescuing is part of my process". The supervisor encouraged the counsellor not to hold on to Star "out of ego" and rescuing for her own self-esteem.

The counsellor understood what she must do. The following week, she gently, though reluctantly, told Star they had to **end**. She recommended DBT as 'best practice' for Star at the moment while owning that she did not have sufficient expertise. Perhaps they could plan one more session to try and find a more positive ending and Star could consider returning to therapy with her in the future? Star was having none of it. She stormed out, shouting "I thought you were on my side! But you're just like all the others."

The next evening the therapist received a text from Star saying she was back in A&E. She signed off her text with "I hope you're happy!"

The therapist replied the next day, and (after consulting with her supervisor) simply offered the date/time for a final appointment. Then, when Star didn't show up, she sent a 'discharge letter' saying that she respected Star's decision to not attend and hoped she would make the most of the DBT opportunity. She signed off with "Warmest best wishes", and never heard from Star again.

The therapist felt burned and shamed that she had become so enmeshed with Star and guilty that perhaps she had "let Star down". Perhaps in parallel process with Star, she owned a sense of confusion, helpless loss, failure, abandonment and rejection.

## Concluding reflections

Has anything like this happened to you? What do you think counsellor did right? In her situation what would you have done?

As therapists, all of us face times when we misjudge situations or therapy ends badly or we get caught up in wider messiness to do with organisational/institutional politics. The relational ethical question concerns how well and appropriately we manage these situations. Can we contain and tolerate our emotions and use our supports? Can we learn from our mistakes and try to protect future clients from them? Can we contribute to ensuring that the wider services on offer are appropriately 'joined up'?

This case study raises many contentious issues, among them the significance of keeping the bigger picture in mind; the importance of holding boundaries; the issue of mutual trust; the need to pursue the client's best interests; and the need to resist the urge to 'rescue'.

1) **Keeping the bigger picture in mind** – It is a relational ethical imperative to consider the client in their wider life context – *past-present-future*. In this story, Star came into counselling with a traumatic and complicated past along with a lengthy history of previous diagnoses and treatments. While being treated she also engaged other psychological services. All this needed to be factored in, particularly as the therapist became aware of Star's adeptness at drawing in multiple support services.

   In part it's about keeping the person's history in mind towards seeing their current needs more accurately. In Star's case, her history of repeated relational themes and trauma needs serious attention. But there is a tricky balance to be struck here. While I would be reluctant to resort to labels such as 'borderline personality disorder' (or even 'complex post-traumatic stress disorder'), in cases such as Star's I might keep such *diagnoses* loosely in mind as a precautionary footnote. Linehan (1993) described individuals who meet the BPD criteria as emotional 'burn victims' in the way they experience the slightest touch as intensely painful. Applied to therapy, the slightest miscommunication or empathic 'error' can have problematic consequences. The therapist in this story might have been forewarned by a better understanding of the patterns manifested by individuals with this tendency: unstable relationships; intense, changeable moods; negative self-image, and impulsive behavioural/emotional dysregulation. This would have made her alert to the repetition of problematic dynamics; and perhaps taking this all to supervision earlier may have helped.

2) **Holding boundaries** –Building on Masterson's work with personality adaptations, the gestaltist Yontef (1988) argues that therapists need to be consistently and energetically present when working with individuals with *borderline* disorders. In particular, they need to maintain strong boundaries (containing and limiting), in a non-judgmental rather than authoritarian way, to encourage individuals to take self-responsibility. It could be argued that the therapist in this story tacitly encouraged Star to be dependent on her by offering soothing texts rather than nurturing Star's coping skills. That the A&E crisis occurred while the therapist was on holiday may well be relevant. It is for matter of debate whether the therapist being away at that time was a trigger or not. Could she have done anything to prevent the incident?

   Therapists are likely to differ over whether texting between sessions should be viewed as useful or damaging. Some would say the therapist should have considered a 'no texting'

boundary between sessions to ensure both parties were properly present and held in the appropriate sessional frame. Others might go along with the texting intervention while arguing that the therapist should have gradually reduced her availability.

Beyond questions about texting, there is an issue about how well the therapist held the boundaries of the therapeutic frame in terms of preparing her clients for her absence. Some therapists would organise some 'emergency contact' cover or at least discuss the use of self-care and support systems. While we are not told how well the therapist prepared Star for her period of absence, we can assume the therapist would have held a no-communication boundary over the holiday period. That would be appropriate, not least as good modelling for the therapist to have time off (self-care boundary).

3) **Mutual trust** – The idea that clients must trust therapists within the therapeutic alliance is well accepted. What is less often recognised is that this trust needs to be *mutual*. If the alliance is going to be effective, therapists need to believe (at least mostly) in what clients say and have some trust in their integrity and sense of responsibility: that they will turn up and follow through contractual obligations. Clients, too, need to be able to place a strong degree of trust in us. For example, they might ask themselves: "can I trust this therapist to respect and not belittle me?" (Recognising the role played by negative transference, therapists tend to be more sanguine about being shamed.)

   That said, all therapists can expect to be deceived at points. It would be naïve on our part to assume that clients always tell the truth. Mostly we can expect clients to be honest in the sense that they tell us the truth as they currently understand it. However, clients might also be guilty of trying to manipulate the system and engage in deceptions about suicide risk, or other defensive, diminishing deflections around admitting to problematic behaviours. Less often clients may engage in sustained pathological lying. Our role is usually to wait to build the trust, subtly asking questions that may challenge any confused/conflicting accounts.

   In this story, it's possible that Star had massaged the truth for her own instrumental purposes. Over time, this eroded the therapist's trust, both in Star and in herself. Had the therapist picked up on Star's process here and explicitly worked with it, the relational ethical approach would be to examine any deceptions for what they might indicate about Star's history, her past and/or current stresses, and her transferential relationship with her therapist.

4) **Pursuing the client's 'best interests' –** Judging what is in the best interests of the client is never easy though this should be the question on the tongue of every relational ethical therapist. In Star's case, this question was raised regarding texting: would it be therapeutic, or would it result in dangerously loose boundaries? These are the kinds of question which tax us frequently in practice. When should we intervene? When should we step back?

   Thinking about treatment, which is in the client's best interests? The current therapy or DBT? And how should therapy be terminated? I would be concerned about the consequences of ending with a client who was not ready for it, or actively against it, since they might justifiably experience this as 'being abandoned'. On the other hand, continuing therapy may not be the most effective route and questions need to be asked about what the client is doing by 'pulling' in competing services.

Sadly, the very services set up for clients can sometimes let them down. This is particularly the case when different statutory and voluntary agencies and those in private practice do not communicate effectively or coordinate their treatments. Sometimes this can be due to arrogant assumptions that one's own service is better; at other times, problems surface at an organisational level, resulting in professional boundary confusions and breaches of confidentiality. Much depends on the specific cultural context.

In this case, some therapists would question the process by which Star received a psychiatric referral to community mental health, which (after assessing her) then fast-tracked her for DBT. Arguably, the health professionals involved should have known that Star was already working with a therapist. After offering crisis intervention, they could usefully have referred Star back to the therapist, perhaps with a recommendation for DBT with the specialist unit as a possible route forward later.

Given what happened, maybe the therapist could have liaised with the community or DBT teams to affect a more considered therapeutic route rather than just withdrawing. Here, we might even question the supervisor's insistence on the therapist's withdrawal. Might it have been possible for Star to continue working with both therapists on condition there was a 'release of information' to ensure a joined-up approach? The supervisor assessed the 'problem' as being to do with the therapist's enmeshment whereas maybe it was more about institutionalised practices. That said, the supervisor did well to highlight the value of the specialist DBT service and the risks of 'splitting' services. And, certainly, it would have been ethically wrong, and probably damaging, for the therapist to have colluded with Star's request to continue therapy 'secretly'.

That the proposed DBT would have been part of the NHS free service might need to be factored in had Star been going to counselling privately. It's questionable how ethical some therapists are being if they offer expensive private care when good quality care is available free of charge.

5) **Avoiding being a 'rescuer'** – The parallels between Star's story and elements of the counsellor's own background help explain why the counsellor found herself getting pulled in to 'rescue' and why she found it challenging to hold containing boundaries. While we might criticise this counsellor for not consulting her supervisor earlier, the fact that she did so at that crucial end stage is important. We don't hear what support the counsellor received for her crisis of confidence; perhaps her supervisor reassured her that she wasn't 'responsible' for Star's bad choices. We can only hope that she received the 'holding' she needed as she confronted her tendency to rescue.