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Research Paper

Boundary Constructions in Psychotherapeutic Relationships

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ABSTRACT

Boundaries define the nature of psychotherapeutic relationships. How these boundaries are defined and subsequently perceived by the client is key. The way the client construes the boundaries in such a relationship is instrumental in therapy efficacy as shown in the literature. A lack of clarity around boundaries confounds the client and threatens safety and heightens vulnerability in the therapeutic relationship. If boundaries can be viewed through legal, ethical and socioemotional lenses. Hence, the way boundaries are presented are very important. If presented without rationale or the intent of caregiving they can come across as intimidating to limits. 11 participants from various parts of India have been recruited for the study. They were interviewed about their negative experiences in therapy, special emphasis was given to the client therapist relationship. An interpretive phenomenological method revealed that unclear boundaries make the client feel ignored, manipulated and invalidated. They also create power imbalances which make it difficult for the client to communicate therapeutic distress. This paper also views the clients personal boundaries as a pertinent relational issue. When assessments are imposed without giving choice or rationale to the client. Clients report feeling disrespected and stifled in the therapeutic process.

Keywords: *Boundaries, Therapeutic Relationships, Psychotherapy, Relational factors*

Boundary issues come up in therapy very often. These issues can undermine the trust and a sense of safety that is created in the therapeutic space. This can be detrimental to the efficacy and longevity of therapy. Boundaries present themselves at the intersections of ethical, legal and interpersonal spaces. Hence, navigating them becomes important in terms of communicating the intent of caregiving that is essential to psychotherapy in India. The treatment of boundaries in the field of psychotherapy has come to differentiate psychotherapy from other kinds of social facilitation (Supriel, 1983). Boundaries have been conceptualised as a frame and it has come to define the ground rules of psychotherapy which are impermeable. Boundaries include structural elements like money, time and space as well as content in terms of what transpired in the session. Simons (1992) defined principles of neutrality and abstinence from the therapist. Although different therapy orientations have different boundary prescriptions, clients need to feel heard, seen, respected and cared for. In India clients have an increased need to feel cared for. Hence, this creates a chasm between the therapist and the client. The communication of caregiving is

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lost if the chasm is not navigated well. There have been many studies on boundary violations in the context of sexual misconduct and multiple relationhsips with clients,but none on how boundaries are perceived by the client and how they interact with the nature of client therapist relationships. Boundaries need to be studied from a relational perspective. This study aims to do that. Relational aspects of boundaries include empathy, positive regard and consistency in portraying them and hence warrants boundary crossing (Hermansson, 1997). The current study was undertaken to understand the course and development of therapeutic ruptures in psychotherapeutic relationships. Very few studies have explored the way boundaries are construed and how they affect the process of therapy. Studies in the field of nursing have explored boundary management between the nurse and the patient but such studies have not been done in psychotherapy. Many studies on boundary management have been done in the context of ethics such as studies by MacNeil et al., (2021). Martin et al., (2010) studied sexual attraction and how boundaries were managed in them. The study concluded variability of agreement when it came to flirtation and fantasy but there was consensus on the transgression of boundaries at extremes of sexual engagement in the therapeutic relationship. Studies on dual relationships in rural areas have also been studied in the context of ethics by (Endacott et al., 2006). The most recent studies are about boundary management in the context of online psychotherapy. One such study by Simpson et al., (2020) concluded that video therapy allows clients to express and connect more deeply and that such opportunities must be explored. Hardly any studies that study how clients experience boundaries were found during review. Hence, the rationale of the study is to enhance understanding about how clients make sense of boundaries set by psychotherapists and their impact on the therapeutic relationship.

METHODOLOGY

Sample

11 young adults aged between 18-30 years who have attended a minimum of 4 psychotherapy sessions were asked to appear for semi structured interviews. The interviewees were screened by using a survey form with inbuilt inclusion and exclusion criteria. Participants who have terminated psychotherapy or have had negative experiences of therapy were selected for the study. Those in the age range of 18-30 years and who had taken at least 3 sessions with a therapist in India were selected. The participant has taken psychotherapy sessions in India only. All those Participants with neurological and psychotic disorders or with a history of in-patient admissions and those inconsistent with psychotherapy were excluded.

Procedure

Participants were approached via email. A screening for all potential participants was carried out via a survey form. The inclusion and exclusion criteria were embedded in the survey form**.** Informed consent was sought from the potential participants. Those who consented to participating in the study were interviewed using a semi structured interview both online via zoom meets due to pandemic restrictions. The interviews were recorded, transcribed and stored with the consent of the participant. On an average each interview lasted 45 mins. The longest one took up 1 hour 15 mins. The sequence of questions and the flow of the interview was kept free. The following domains were looked into while drafting an interview schedule: trustworthiness, respect, usefulness of therapy, warmth, empathy, genuineness and positive regard. These domains were examined in the context of different psychotherapy events through the course of therapy. IRB approval was sought and granted to the researcher by Christ University. The researcher then circulated a G-form containing demographic questions and informed consent with an inbuilt exclusion and inclusion criteria. A total of 27

responses were recorded. Out of 27 responses, only 19 were selected for the interviews as the rest did not meet the inclusion criteria. Out of 19 interviews three of the participants did not want their interview used for the purposes of the research due to the sensitivity of their narrative that was in the interview. A few other interviews were not analysed as they pertained to the death of the therapist, a case of misdiagnosis by multiple practitioners and in-patient accounts as such accounts might distort the homogeneity of the sample.

A qualitative approach to inquiry embedded in an interpretivist phenomenological paradigm has been used for this study. Phenomenological approaches can explain in depth the meaning making process of client experiences. They aim to understand how the clients perceive the therapeutic relationship and how they construct or make meaning out of therapeutic events, techniques and gestures. It is a descriptive analysis of the experience.

The researcher chose to position herself in the study as an interpretivist. The researcher realizes that reality cannot be captured objectively but only its representations can be sought scientifically. The interpretive paradigm aims to recognize and narrate the meaning of human experiences and actions (Fossey et al., 2002).

The ideas of confirmability, trustworthiness have been kept in mind in the process of data collection and analysis. Precautions to make the data credible and transferable. This is ensured by check out questions at the end of the interviews. The researcher summarized what was understood and confirmed such a summary from the participant. Three experts were consulted for expert validation. A sample expert, methodological expert and field expert. The researcher-maintained field notes and audio recordings of interviews. The field notes chronicle the decisions taken in the course of the research and general impressions.

Interpretive phenomenological analysis takes into consideration textural and quality related aspects of a clients' experience. The interviews were open ended and non-directive, semi structured,.. Giorgi's phenomenology aims to find commonalities and differences between cases and describes it. The determination of the essential structure of the psychological experience is the ultimate aim. Giorgi's idea of scientific reduction retains Husserl's epoche, scientific reduction is used to describe phenomenon as it is experienced by the experiencer (Giorgi et al., 2017).

A detailed consent form containing information about the research, risks/benefits and rights to the participants was provided. Further clarifications were also provided.

Consent for audio recordings, transcription and presentation was obtained from the participants. Participants are informed that their confidentiality and anonymity will be maintained throughout the period of the study and after the presentation of findings. Data is encrypted and stored. Participants reserved the right to withdraw from the study at any time without any repercussions. The participants were told that there is no monetary compensation for participating in the study.

The researcher has avoided quasi therapeutic relationships. In such a situation the participants were debriefed and the study will be discontinued. The researcher did not engage in diagnosis or correcting diagnosis of a participant or in criticizing another mental health worker. No names or identifiers of any mental health professional was asked. The interview is securely encrypted on zoom meetings.

RESULTS

Boundary presentation

Table 1 Rupture from incorrect boundary presentation

Themes	Sub-themes
Boundary explanation	Pointed objectivity Monetizing approach Unclear boundary explanation On dot therapy No communication Privatising time space

On the dot therapy, pointed objectivity, a constant mention of money, and a lack of consistency in conversations outside of psychotherapy sessions are perceived by clients as therapists' fakeness. The intent of caregiving is lost. The presentation of the boundary with the intention and expression of caregiving is needed by clients.

On the dot therapy

This sub theme describes instances where clients feel that their sessions are quick, precise and end abruptly according to time restrictions. SS says "Time was a factor. I was not given the space to articulate myself well. I did not have the time to think, breathe, contemplate for a second and then speak about things. I felt that I was always on the clock."

AMR says "*And sometimes we as human beings can be flexible with the time I asked therapists, probably the therapist could be flexible for, say, 5-10 minutes, but it was on the dot, it's like you have five minutes left, you have four minutes left, you know, it was not a verbal thing*." The therapist's body language and on dot psychotherapy with no rationale made the client feel like the therapist does not care about the client but cares about money.

Monetizing approach

Clients perceive an eagerness for money as a lack of presence in the relationship. "seemed more of a monetizing approach, rather than being there for the fly" "But you could see in her body language kept clocking the minutes that we had, and the kind of environment that she would probably create, right," says AMR

Indian clients want to feel genuinely cared for when they talk about the personal layers of their life. If the boundary around time and money is set without an explanation then the intent of caregiving gets lost in translation.

No communication

"They left me on seen on WhatsApp. She did not reply for a week. My trust started breaking down. I texted her that if you do not want to continue with me or you are busy just let me know. Her response was when did I say I did not want to continue my mother is sick. Another 2 weeks passed without any communication...I felt ignored. I felt I was taken lightly. It made me feel undervalued as a client. That's the beginning of it." says RS

Pointed objectivity

NP a client was late to pay the fees by the day. The therapist wrote to the client asking if they would like to continue therapy. "So you are just showing that me continuing or not

continuing is not going to bother you. All you want to know is if you should be free for that hour…..I would rather like it if she asked if I was okay. Like, start there… You can't be all kind and empathetic in the session and then be like I am fine if you don't come. You do not have to create the whole two faces." Client RS was facing communication issues and was feeling lost in therapy. Hence, she wanted more clarity from the therapist. The client was denied increased access to the client without a rationale. "I wanted more sessions to deal with the lack of clarity. She said once a week is fine. I felt like she dismissed it. After this I did not feel like telling her about my issues".

A lack of clear boundary explanation

The client was told that her therapist will always be available for her but she was not told she can't text outside of the clinic initially. The client reports that the phrase I will be there for you haunts her. The phrase was used by the therapist on multiple occasions and the psychotherapy sessions were always very unemotional and detached. The client felt like the phrase was used only to bring her to the session to pay money without giving her enough space or time to speak. "She kept telling me she will always she there for me no matter what even outside the clinic. But even when I kept texting her. She would tell me why did you not tell me all this in the clinic." MM

Communication barriers

This superordinate theme includes the difficulties faced by clients in conveying therapeutic distress. Across cases, it is observed that the therapist is perceived as the more knowledgeable, one whose expertise must not be questioned. Across cases, clients shy away from expressing their needs upon being dismissed once or after an initial rupture.

Expertise

When asked if TM communicated her dissatisfaction she said, "I did not. Again, I did not. This whole thing I completely thought she must know what she is doing. I accepted anything she told me back then". This barrier in communication and the underlying power dynamic made the client feel she was wrong about her experience of distress. She experienced bouts of self-doubt around therapy. This was seen in many other cases.

Coming across as needy

Clients experience a loss of power or voice when a rupture takes place and they do not want to communicate their distress around it to a person they perceive as more powerful and uncaring. This can be seen in the case of NP "I don't know I was too uncomfortable. This person was acting so distant so I did not want to sound all, oo, I need you to not be distant. I need you to be there for me." This was the reason given by the client on why they did not want to communicate distress experienced in the session.

As a whole, Indian clients felt that therapists were being very suggestive and paternal which was not expected from therapy. . I am not asking for suggestions I just want to be heard. I know it is the work of therapists but it felt like they were just waiting for me to complete to say the same thing they always say" says SS. Ruptures without resolution led to a perception of psychotherapy being unsafe. Further attempts to take psychotherapy were impeded by fears around psychotherapy being similar to the previous rupture experience. "What if the new person turns up or turns out to be just a mere shadow of the old one? Or exactly like the old one." Trying psychotherapy again was also perceived as too much work as it came without a guarantee for a good experience.

Privatizing time space

Clients wanted to privatize time in the therapeutic setting. Here time is seen as space in the client therapist relationship. They wanted to personalize such a space and feel safe in it by guiltlessly venting their frustrations and talking about their desires. "*Someone you can confide in without feeling guilty because they don't have any stakes in you".* They wanted to be heard and felt understood. "*Time was passing by and she was there for me. The fact that they were taking time out and listening to me was nice."* says SS. It is this desire that is contained within choice of boundary with the therapist.

DISCUSSION

The rationale for the study was to highlight how boundaries affect the potency of the client therapist relationship which is at the heart of therapy efficacy. The current study has looked at the idea of boundaries from a relational perspective in the Indian context. Boundary violations have been dichotomised into sexual vs non sexual boundary violations. Another area that has been studied is therapist self-disclosure. However subtler forms of boundary establishment and its impact on the therapeutic relationship is not studied in the last 20 years. In Indian culture the psychotherapist is given a lot of power and authority. They are considered to be knowledgeable experts or gods as seen in the current study (De Souza, 2016). Clients in India expect more proximity and sensitivity simply due to the nature of emotional problems being discussed. In the current study, it has been observed that clients especially who come with emotional issues test empathy by the amount of space the therapist makes for the client. This is measured by time spent with the therapist in the ambit of the relationship.

At the outset the researcher explored how the successful establishment of a safe therapeutic relationship happens. It has been found that clients negotiate safety in therapeutic relationships when they feel subjectively understood and given space. The phenomenological nearness of the therapist to client distress helps build trust. Kind eyes, empathic listening and touch have been key in establishing trust. In the Indian context the non-verbal communication of caregiving intent is seen as crucial in establishing a therapeutic relationship. Prosodic continuity predicted empathic communication (Peräkylä, 2014). The Indian context of Mamta or motherly love is an expectation that clients hold implicitly from the therapist.

If boundaries are too rigid it becomes therapeutically ineffective in communicating this sense of nearness. It can obstruct clinical artistry if chosen over humane interventions (Lazarus, 1994). However, there are no current studies in this area. Boundaries are trapped in the ethico legal paradigm. There is a need to look at boundaries from an interpersonal paradigm.

This is a primary expectation from the therapist as it establishes warmth and emotional safety in the relationship. Therapist expertise and skills taught to the client help the client feel in a productively safe relationship. Privatising space in this context happens by privatising time and it is a precursor to feeling, prioritised, respected and heard. Clients who present emotionally want to feel seen in an empathetic light and it involves being accommodated when need arises having very impermeable boundaries creates a perception of not feeling cared for. A constant insistence on money can create a feeling of being served and not heard.

Therapists' expertise and their ability to empower the client with technique or skill further builds trust in the relationship. Wampold (2017) contextual model posits that an environment of healing, relationship, explanation of client distress and procedure to deal with such distress is essential to psychotherapy. In a recent study professional competence was shown to facilitate psychotherapy relationships. Good intentions with expert position is essential (Wilmots et al., 2020).

Empathy is an important ingredient of client therapist relationship. However, the current study shows how the perception of empathy changes in the client's subjective experience of therapy. According to the current study perception of empathy requires consistency through the course of therapy. This helps the client understand and put faith in the therapist figure. Research by Elliott et al., (2011) showed that perception of therapists' empathy is an important predictor of outcomes. Consistency is important for the perception of empathy in translation. A study by Wilmots et al., (2020) shows that clients appreciated feeling accepted and understood by warm non-judgmental therapists. Feeling listened to translates phenomenologically to the client as a feeling of caring. The current study goes a step further to delineate what constitutes feeling accepted and seen by highlighting the role of consistency.

A lack of communication in the relationship can lead to a misunderstanding between having a boundary and being prioritized. Clients emotional urgency if ignored can loosen the bond of trust as a client therapist relationship also is based on attachment. Maintaining a secure attachment is at the core of a healthy and safe therapeutic relationship. A secure attachment leads to better working alliances without risking transference (Parish & Eagle, 2003).

Unclear communication such as using idioms and unclear language can lead to an overestimation of the relationship and a loss of objectivity from the client's end. Drawing an unclear boundary leads to inconsistency in the expression of therapist empathy which can be detrimental to the relationship. There are no current studies on the impact of unclear boundaries and its impact on therapy efficacy. Such boundaries provide an inconsistent environment for the client. Effective boundaries are semi permeable and allow for expression and containment of affective experiences (Bridges, 1999).

Therapist objectivity is a good marker of a therapist however, pointed objectivity that undermines the nature of the therapeutic relationship can be detrimental to the therapeutic effect. Hence, the communication of such objectivity is key. It has been found that inquiring about the clients' current needs while addressing the conversation on boundaries is essential. Dismissing the need for clarity in boundary questioning moments has proved to be counterproductive as seen in this study. Hence, addressing the need and explaining the boundary could be a plausible suggestion. Communication must carry the core essence of the caregiving intent. Patients are harmed by too rigid boundaries that are too distant from the relational context (Bridges, 1999).

A meta analysis by (Pinto et al., 2012) found that patient centered interaction style showed a positive correlation with therapeutic alliance. These included showing sensitivity to clients emotional concerns. However, more qualitative studies are required in this area in the context of boundaries. Boundaries are negotiated in each interaction with the client and hence is a core dynamic construct in therapy. Studies in medicine focus on improving the quality of care by focusing on communication. However, this is not seen from the perspective of navigating boundaries (Popa-Velea & Purcărea, 2014).

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Conflict of Interest

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