

# Setting Goals in Psychotherapy: A Phenomenological Study of Conflicts in the Position of the Therapist

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The present study is concerned with the ethical dilemmas of setting goals in therapy. The main questions that it aims to answer are: who is to set the goals for therapy and who is to decide when they have been reached? The study is based on four semi-structured, phenomenological interviews with psychologists, which were analyzed using the framework of the Interpretative Phenomenological Analysis (IPA), with minor changes to the procedure of categorization. Using Harré's (2002, 2012) Positioning Theory, it is shown that determining goals and deciding if they have been reached are processes that are based on asymmetric collaboration between the therapist and the client. Determining goals and deciding when they are reached are not "sterile" procedures, as both the client and the therapist might have different agendas when working therapeutically. The psychologists that participated in this study are seemingly not fully aware of the power that is inherent in their positions as therapists.

*Keywords:* Goals in therapy, Values, Positioning Theory, Interpretive Phenomenological Analysis

## INTRODUCTION

In some therapeutic traditions (e.g., the psychodynamic tradition<sup>1</sup>) neutrality of the therapist is central to doing good therapy. Moreover, the same traditions often cite the client as the expert in their own lives and the therapist merely as a catalyst or mediator of the therapeutic process. But how can a therapist remain neutral? How can he/she consider the client "the expert" when the therapist is the one with a university degree in psychology? And how can he/she get around the fact that the client seeks help with a problem, and therefore he/she seeks an expert? Can the therapist really go beyond the fact that he/she is positioned as an expert by others, including the client? The present paper uses Positioning Theory to explore some of the strategies used by therapists to construct their position vis-à-vis their clients and as such their responsibility to them.

Through the lens of Positioning Theory, this paper explores the strategies by which therapists construct a position for themselves in relation to the ethical dilemmas of setting goals in therapy, especially how they navigate the tension between neutrality to the client and having expert knowledge. Neutrality is not that the therapist does not hold ethical views or never displays them. Rather the therapist should try to minimize his/her influence on clients and "...provide a nonjudgmental environment, be flexible and open-minded, [and] tolerate ambiguity..." (Tjeltveit, 1999, p. 180), in accordance

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<sup>1</sup> We take our point of argument in relation to the psychodynamic approach, as it is the view held by most of the participants in this study.

with the guidelines in the psychodynamic approaches to therapy. The problem is that the therapist can be influenced not only by his own theoretical stance, but also by societal and discursive norms. Therefore remaining neutral becomes a hard-fought battle between identifying one's own stance and the societal norms and values that influence it. Therapy is necessarily value-laden because its goals are formulated in a certain society and at a certain time.

Harré (2012, p. 8) defines a position as, "a cluster of beliefs with respect to the rights and duties of the members of a group of people in certain ways". The concept is meant to replace the more static concept of role by pointing to how positioning is always a dynamic process negotiated in practice. Positioning Theory explores how rights and duties are ascribed, refused and resisted by people in everyday social action. This process entails higher-order acts of positioning, where rights and duties are distributed between people in social situations. Thus, people are said to live their lives and act within normative frames, that is, spaces of oughtness in terms of their rights and duties (Harré, Moghaddam, Cairnie, Rothbart & Sabat, 2009). Harré (2012) states that there is asymmetry in human relations, because of the available social actions that can be chosen, and the concrete circumstances each individual is embedded in. This means that positions determine what cultural resources people have access to.

As we speak, we create and exchange bits of discourse. For example, therapists draw on discourses of theories and professional ethical guidelines. As we construct a position for ourselves through these resources, we also implicitly offer a certain position to our addressees (Winslade, 2005). Harré (2012) adds that the position a person occupies is determined in part by the *story line* realized in the unfolding episode. Story lines are a common basis for those taking part in an interaction (Davies & Harré, 1990). Story lines are the common framework people in interaction share, which in turn influences the way they see a certain situation. In taking part in a story line, people are expected to act in accordance with their beliefs about their positions in it. Moreover, if one position changes, all positions change in relation to it.

The tension between an assertion of knowing better (or 'paternalism') and maintaining client autonomy through 'neutrality' is the heart of the therapist's position. The present paper seeks to explore this tension in relation to the process of setting goals in therapy. Goals are formulated on different levels of abstraction (e.g., 'to make the unconscious conscious' versus 'not to yell at my husband') and have been defined in a number of different ways. For our purposes, goals are the ends which therapy wishes to attain. This definition entails that goals are not necessarily attainable and that they may be attached to a specific kind of therapy or may be specific to a particular client. To point out the tension between autonomy and paternalism has previously been made. This study, however, aims to cast new light upon how this tension is embodied in the concrete therapists' experience.

### **Setting Goals as a Value-Laden Process**

There have been many different classifications of goals in therapy – some focusing on the outcomes, some on curative effect of therapy, and so on. Much of the literature on goals is descriptive in nature (Blass, 2003). Even less literature focuses on hidden values and assumptions that influence the process of identifying goals (Keenan, 2010). In the following we look at the influence that the therapist exerts and the autonomy of the

client in relation to setting goals, highlighting the different discourses therapists have at their disposal to manage this tension.

Tjeltveit (1999) says that the implicit understanding in most societies is that therapy is value-free. Therefore, the implicit understanding between the client and the psychodynamic therapist is that therapy will be value-free, even though it is demonstratively not the case. Hence, in this discourse the position of the therapist is defined as something neutral and value-free.

Tjeltveit (1999) and Keenan (2010) point out that psychotherapy is definitely value-laden. Tjeltveit (1999, p. 4) says: "A central reason for the inevitability of therapy's value-ladenness is that all therapy involves value-laden goals". If Tjeltveit is right, then according to Positioning Theory, the only position that is available for the therapist is that she/he inevitably imposes values on the client. Further, the only position that is offered for the client, is one in which they are inevitably influenced by therapy-values.

In spite of the differences in values, if the client and therapist can agree upon goals, it can help to define a successful outcome of therapy. However, the client's and therapist's internal resistance and unconscious agendas might hinder or sabotage this process. In these cases, a successful therapy would occur when the client becomes willing to allow the process to take its time. This, however, is again a position that is defined, not explicitly, but implicitly by the storyline of therapy (Murdin, 2001; Keenan, 2010; Wollburg & Brakhaus, 2010). Murdin (2001) also states that all clients have a value system but that it can be distorted for different reasons, which means that clients are not necessarily in a state that allows them to set realistic goals. Clients are often only focused on pain versus happiness and only have a criterion of success based on this focus (Murdin, 2001). However, clients are still active agents in the discourse of therapy. This means, as also stated in Positioning Theory, that they can influence the process of therapy as much as the therapist, but only in and from the position that is available to them in the discourse. This means that even if therapy is value-laden because of the psychodynamic therapists' point of view, the client still has some agency to exert in the discourse.

In sum, psychodynamic therapy is likely not a value-free process, but it is hinted that it is viewed as such by society. These values, however, are not necessarily the only factors that influence therapy, as the client still has agency to act within the discourse.

### **The Clash of Value Systems**

Difficulties occur when the two value-systems of the client and the therapist meet, and the concrete goals have to be established. Positioning Theory would have it that the two value systems offer certain positions for both therapist and client, and that these are not always compatible. In this interaction, paternalism often occurs because of the overarching discourse wherein the client and the therapist are embedded – the overarching discourse that positions the therapist as an expert. Paternalism is problematic when the professional's idea about what is good for a client trumps the client's ideas. Even if the therapist does not want to impose goals on the client, he/she might have an extensive set of general goals for the clients tied to his/her theoretical orientation and hence to his position dictated by the storyline of being a therapist. Even letting the client choose his own goals rests on a specific ethical framework – liberal

individualism (Tjeltveit, 2006). This principle might be accepted by the therapist (perhaps even uncritically), but not necessarily by the client. Thus, one of the basic problems in setting goals is the differing ethical foundation of the client and the therapist.

To overcome these differences, Tjeltveit (1999) and Wolman (2002) argue that the client should choose goals and that the therapist is obligated to respect his or her choice, which is then to define the position of the therapist not as neutral, but as an accepting and purposely non-interrupting entity in the storyline of therapy. Hawley and Weisz (2003) assert that "...from a consumer perspective, it could be argued that therapists have an obligation to treat the problems for which clients are seeking help and, where therapy participants have differing views, to work with them to reach consensus before beginning treatment..." (Hawley & Weisz, 2003, p. 68). However, the problems and goals identified by the clients are not always the most important focus for therapy – this statement is of course only valid if one accepts that the therapist has an expert position. What the clients deserve is the clinician's best judgment about the key issues in therapy. This means that the therapist might risk imposing his views on the client (Hawley & Weisz).

### **The Imposing Therapist**

Tjeltveit (1999) states that it is false to think that the therapist either imposes his views on the client, or provides objective value-free therapy. The problem is clearly described by Keenan (2010, p. 237):

*"When people have strong views about a belief, these views may be expressed (many times nonverbally)... with great certainty and, at times, judgment, devaluation, disdain, or contempt. When the client's strong view differs from the therapist, the therapist can easily be triggered into a posture of reactivity, which is generally along the spectrum of defensive or protective anger."*

The problem is that the therapist should still work on preserving and enhancing client autonomy in line with the psychodynamic tradition, even if she/he is unknowingly influencing the client. "The ethical ideas embedded in cultures, communities, and professions shape therapy in so many ways – ways often invisible to its participants – that therapists and clients often discuss ethical issues without being aware they are doing so" (Tjeltveit, 1999, p. 171). But the discussion is never equal; the therapist has the leverage and the responsibility to be aware of what values he conveys, as this is the position that is offered to him.

Øvreeide (2002) specifies the problem as an inherent inequality in therapy – (i.e. an inherent inequality in the available positions in the therapy storyline). The psychodynamic tradition assumes that the therapist has superior knowledge to the client (Spinelli, 1994). Moreover, if the therapist has an (almost) unquestioning belief in his or her chosen approach (Tjeltveit, 1999), it could potentially lead to paternalism.

Paternalism becomes evident when observations and conclusions, based on a certain theoretical standpoint, become truths or dogma – i.e. when certain positions are validated on the basis of certain theoretical standpoints. Spinelli (1994) argues that there is no evidence to support the effectiveness of any one form of therapy. Hence,

therapists should be careful to rely too heavily on one theory alone as a sufficient rationale for their interpretations and interventions. Unfortunately, therapists have had a tendency to adapt the “stories” of their clients unquestioningly to the theory that they ascribe to, even if there is little evidence to prefer one theoretical explanation to others. This dynamic can, at times, lead to a client’s resistance to being classified or, in Maslow’s (1962) terms, ‘rubricized’. Therapists should be open to alternative explanations before they convince themselves, or the client, about any particular interpretation (Spinelli, 1994). This is asking the therapist to go beyond the position that is offered to him.

### **Primary Goals and Ideals of Therapy**

The psychodynamic tradition affirms autonomy as the primary goal therapists seek for their clients (Tjeltveit, 1999). Different ethical theories and philosophical assumptions produce diverse ideals for therapy. Obtaining a concise understanding of the ethical character of therapy’s goals involves clarifying and justifying the ethical theory to which therapy ideals are tied (Tjeltveit, 1999). Hence, the executive goals of therapy are founded in a certain storyline. One challenge is that the philosophical or theoretical convictions of the therapist might not be compatible with those of the client, even if there have been a mutual discussion between the client and therapist as to which approach should be taken in the therapy.

Even if autonomy is the primary goal of therapy, according to Rudnick (2002), therapy ideals can be chosen and evaluated on three levels: (1) Ideals for humankind in general; (2) Ideals for therapy in particular (3) Ideals for a given client at a particular point in time. There is a need to strike a balance between the concern for the individual and the concern for the larger group (Tjeltveit, 1999; Rudnick, 2002). Normally, the prime candidate to set goals is still the client, as long as the goals do not involve serious danger (e.g., an eating disorder) and are arrived at competently (Rudnick, 2002).

There is good reason for therapists (and others alike) to be reluctant to identify ethical dimensions of goals and outcomes for a larger group of individuals. The best life for a particular person may well be different from the best life for another (Tjeltveit, 2006). Clients and therapists advocate certain goals, because they think that they are in some way good (Tjeltveit, 2000). Given these complexities, the present study asks: who should set the goals for therapy and who should decide when they have been reached?

### **METHOD**

The present investigation utilized a phenomenological methodology as we wished to attain information on the therapist’s concrete experience of, as well as ideas about, setting goals in therapy. The researchers conducted four semi-structured interviews with a convenience sample of four psychologists.

The preliminary interview guide was created, using earlier knowledge of the field as resource, and tested. This interview guide was then revised. The revision concerned the question order, asking general and open questions. Further, it focused on making the setting casual, so as to help the participants feel at ease. Another main concern was the participants feeling that they were being judged which could be particularly problematic because of the ethical nature of the topic at hand.

The interview guide was divided into five subthemes, all concerning a specific part of the research topic. The subthemes were (1) experience with goals in therapy; (2) establishing goals – wishes and the attainable; (3) evaluation of the therapeutic goals; (4) goals, time and ending therapy; and (5) the ethical ending of therapy. Each theme was to be covered in the interview; and three to five questions were created for each theme to help the interviewer cover every aspect (see Appendix 1 for interview guide).

## Participants

The study consisted of interviews with four psychologists: Jette, Kirsten, Laurids and Tyra (these are all pseudonyms). An overview of the participants' demographic details is presented in Table 1. The participants were somewhat known by the researchers beforehand. Kvale (1997) points out, from the standpoint of phenomenology, that participation in the field that is studied is an advantage because the researcher have gained insight in the local language, daily routines and power structures beforehand. This gives the researcher an idea of what the participants are likely to talk about. The small sample size is due to the fact that generalization is not the purpose of this study; rather the purpose is to develop a theory in relation to the research questions.

Table 1

*Demographic details of the participants in this study.*

Name	Age	Experience	Workplace	Theoretical orientation
Jette	25	2 months	University Clinic	Eclectic - mainly psychodynamic
Kirsten	26	2 months	University Clinic	Eclectic - mainly psychodynamic
Tyra	34	5.5 years	Psychiatric Ward	Eclectic
Laurids	53	26 years	Psychiatric Ward	Eclectic

## Interviews

The interviews lasted between 45 and 60 minutes. They were recorded on a digital dictaphone. Tyra and Laurids were interviewed at their workplace in their offices, which are designed for individual therapy, and therefore well suited to interviews of this sort. Kirsten and Jette were interviewed in an interview room at Aalborg University that was also well suited for the purpose. The interviews were conducted during a four-week period, which left time for transcription between each of the interviews

## Method of Data Analysis

Interpretative phenomenological analysis (IPA), was used because it is often used to explore topics within health, clinical and social psychology, where there is a need to find out how people perceive and understand objects and events (Smith & Eatoun, 2007; Storey 2007; Smith & Osborn, 2008). Multiple writers have established that there are four basic steps to the IPA (e.g. Becker, 2002; Giorgi 1997; Giorgi & Giorgi, 2008; Kvale, 1997; Phillips-Pula, Strunk & Pickler, 2011; Smith & Eatoun, 2007; Smith & Osborn, 2008 and Storey, 2007). The first step is to read the transcripts thoroughly to gain a holistic perspective of the data. This is done to ensure that future interpretations are founded within the participant's original account. Then, themes are refined and organized into clusters that are checked against the data. Afterwards the themes are

refined further, condensed, and examined for connections between them. Lastly, a narrative account is produced based on the interplay between the interpretation of the researcher and the participants' accounts of their experiences. These four steps were used in the analysis of the present study; however, the condensation of categories differed.

As was evident in the theoretical presentation in this article, the available literature discusses goals in the context of three concepts – neutrality, autonomy and paternalism. This formed this study to some degree. However, it seems to be clear that the participants would have discussed the overall theme of setting goals in these terms; hence these concepts are both a product of the researcher's previous thinking and the participant's statements. Thus, these three concepts were arrived at inductively, and are used here as framework for analysis.

## **ANALYSIS**

After the researchers read through the transcripts of the four interviews, they consensually refined themes and then clustered and collapsed the themes into meaningful categories based on the holistic reading of the transcripts. This made it apparent that the participants' accounts clustered around 19 themes. Four of these themes were of primary importance to the research question asked here and were of a more general kind. As such, we used them to create super-ordinate categories, which could encompass the other 15 themes within them (see Figure 1). In what follows, we use the four super-ordinate categories to organize participants' accounts.

### **Client Autonomy**

In discussing goals with the participants, it quickly became apparent that the client has a major role in deciding how goals should be defined. Goals should, according to the participants, be based on a negotiation between the client and the therapist. When asked about goals, Tyra explains:

*T: Well, I listen a lot to uhm, what people think is difficult, painful, and try to start there. And [...] then I always ensure that this is put together with some of the things I hear [...] so that it is based in what they [the clients] bring, but still I, as the professional, give my assessment. [...] I always try to make it coherent, so that it will make sense to people, because if I did not do this, I don't think [...] people would feel understood if I just soldiered onwards [...] with my ideas of things (App. 9, l. 61-68)*

Tyra points out the importance of meeting the clients' needs and listening to what they have to say. If the therapist forces his/her goals on the client, the danger is that the client might feel misunderstood.

All participants agree that no matter what, the client always has the last word about how the therapy should progress. Everything else takes a backseat to what the client wants and what the client needs, which is apparent in the following statement:

*L: Yes, then I would say that that is usually the decision of the patient, I'd say that. Because, if uhm, you try to pull goals over the head of the patient that the patient does not agree with, I don't think it is very conducive for therapy [...] (App. 8, l. 147-149).*

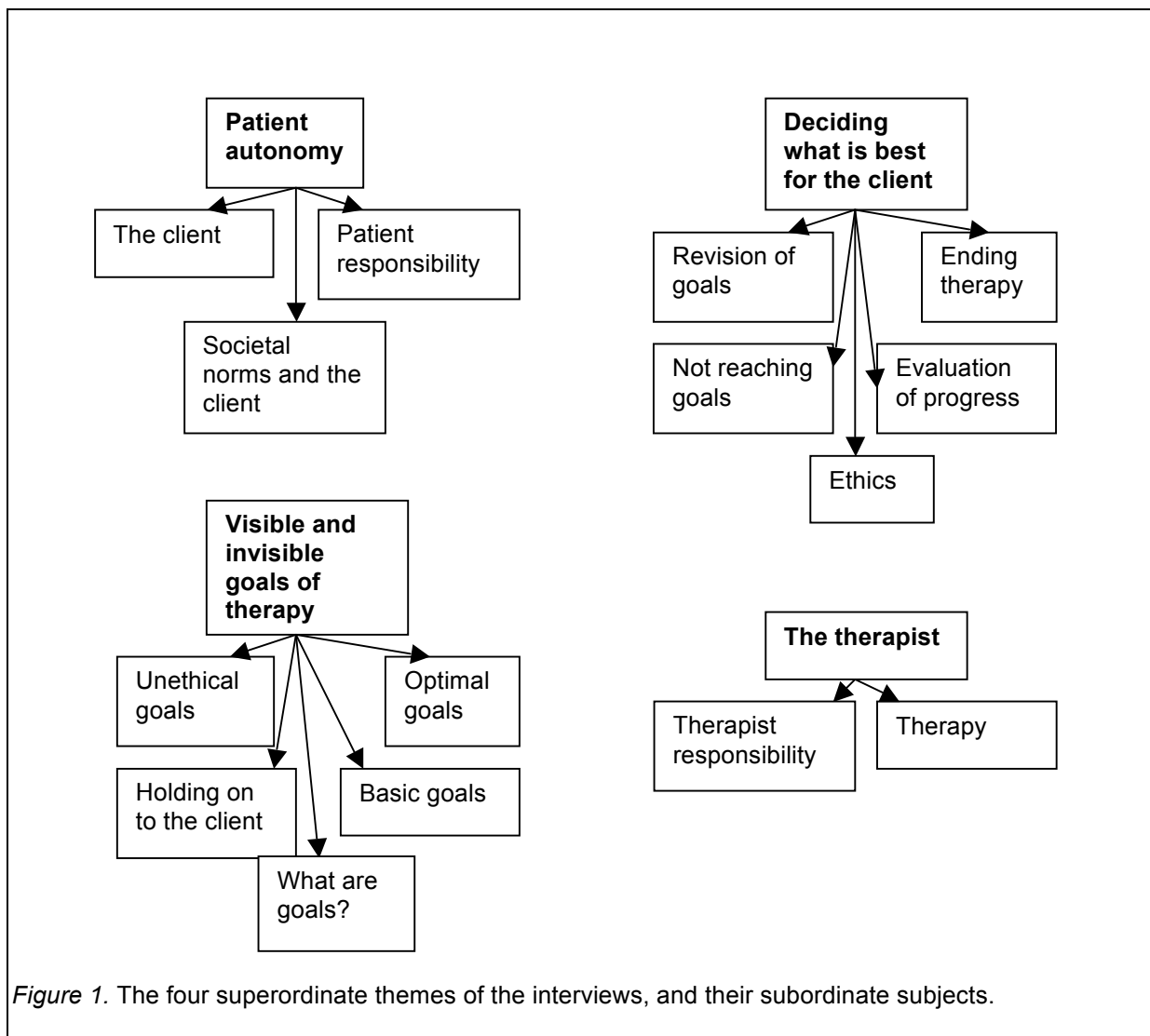


Figure 1. The four superordinate themes of the interviews, and their subordinate subjects.

Letting the client have the last word might be a way to secure the client's independence from the therapist, but could also be a way to ensure that the client's wishes are respected. Respecting the wishes of the client is also a major concern for the participants. What was very prevalent among the four interviews was that the clients and therapists do not always share the same goal.

*J: [...] I think that the client often comes with an idea about what is wrong or what should be solved, and this is not always something that you as, uhm, a therapist agrees with. [...] So, if you can meet in some way or another, I think that is the best (App. 10, l. 26-29)*

It is evident from the statements above, that it is a concern of the therapists that there is a different focus between themselves and the clients. What is important here is that the therapists are aware that they should try to meet the client and his/her wishes, no matter if they think the client is right or wrong about the problems they have.

In the interviews it emerged that what the therapist should do, is to try and give the client the information he/she needs to make an informed choice about his/her problematic situation. Jette explains:



*J: So, if I sensed in December that [...] he needed some extra time, so I would suggest that [...] and I would tell him why I thought like that. Uhm, but I would leave the decision [...] up to the client. Uhm, but I am a strong proponent of [...] informing the client really thoroughly about what it is [...] you [as a therapist] think [...]. The hidden agenda [I think] is [...] a necessary evil. Uhm. Well, it is useful but [...] I wish that you could be entirely open and say everything, uhm. So [I've] begun to, like, explain thoroughly that I believe that you [the client] might need some more time, what do you say about that, and like, and then it would be the answer of the client that decides it (App 10, l. 374-382).*

According to Jette even if the therapist estimates that more therapy is needed, it is still up to the client to decide if he/she wants to continue. To give the client a chance to decide, Jette is a proponent of giving the client all the available information about his/her current situation. This, in order to give the client the best possible scaffolding to make a decision that will benefit him or her the most. This seems to be in accordance with the guidelines prescribed by Hare-Mustin et al. (1995), Wolman (1982) and Tjeltveit (1999). However, there is an inherent problem of communication not being neutral. To present the client with “all the facts” is problematic, and the client might think of “facts” as “recommendations” or “advice”, rather than neutral information about the current situation (Williams, Alderson & Farsides, 2002 and Bernhardt, 1997). This will be extended upon in the discussion.

What seems most important to the participants is ensuring that the client maintains his/her free will, and that they do everything they can to make sure that the client has the best foundation to make his or her decision. This is in full accordance with the psychodynamic tradition and recommendations of Tjeltveit (1999) and Wolman (2002), who state that the maximization of free choice should endure even if the wishes of the client at first seem inadvisable. The problem is that the clients might not perceive the information that the psychologist provides as neutral. The question is if the will of the client (the client's free choice) should supersede the therapist's estimations? And if it is possible for the therapist to convey neutral information? If the therapist estimates that a goal is inadvisable, should he/she redirect the client in some way or just accept the choice of the client? The Ethical Principles for Nordic Psychologists (EPNP) prescribes that the therapist should refuse to take part in any actions that might do harm – even if the positive consequences outweigh the negative. However, forcing the client to do anything that he/she does not want to do is not an option. Both the participants and the EPNP pointed this out.

### **Deciding What is Best for the Client**

The issue of setting goals might not be as problematic if it was only dependent on the wishes of the client. The therapist has to consider what is best for the client. The problem for both therapist and client is to discern when the therapist's ideas/goals are more beneficial to the client than what the client can come up with. The therapist might employ different therapeutic “tactics” to make the client see things the “right” way. In the following, Laurids states that he hopes that the client will see things “the right way” eventually. That the therapist assumes that there is a “right way” shows that he also has an idea of what this “right way” is. Alternatively, the therapist could work from the assumption that “the right way” is held by neither the therapist nor the client, but rather is negotiated between them.

Tyra most explicitly expresses the idea that there are ways to make the client see things in a certain light. Tyra explains:

*T: I try to, uh, ask a lot of open questions, when they come and tell me what happens. And I try to make it their project to find out if, if they want it to remain like this. I'm always very ready to say that, it is not me who should choose if you should be there or not (App. 9, l. 470-474).*

Tyra exemplifies her open questions:

*T: And what is it that you want then? Should it continue to be like this? Well, always the open questions, right (App. 9, l. 524).*

The first of her questions is clearly open. It leaves room for the client to expand in whatever direction that he/she likes. The second question is, however, not an open question. The question "Should it continue to be like this?" can only be answered with a "yes" or a "no". The question is also loaded: answering "yes" entails that you intend to leave everything like it already is. Here we see "tactical" tools at work, which is evidenced by Tyra leading the client down the road he/she has already stated, using classic psychodynamic tools of therapy.

Kirsten explains more precisely what it is that the therapist might try to hide from the client and why:

*K: [...] I always have a knowledge that they are not inaugurated in. So, in that way you cannot really [...] do a lot about it. Then you would have to inaugurate them in everything. But you cannot. That would not be beneficial to inaugurate them in all the hypotheses and goals I think could be [relevant]. Uhm, so I think it, it could do more harm than good, actually. So, that is why you would keep it to yourself.*

Kirsten essentially states that the therapist cannot explain everything that goes on in therapy to the client, which is consistent with the psychodynamic approach she uses. Some of the therapist's hypotheses might even be incomprehensible for the client. Therefore, the therapeutic effect of telling the client everything might even be negative. It thus appears that Kirsten believes that "secret goals" or "hypotheses" are all right, so long as it is therapeutically sound to have them. This is, again, in full accordance with the psychodynamic perspective Kirsten holds. Additionally, Widiger and Rorer (1984) say that revealing all therapeutic details would be counterproductive in therapy.

The point in playing the "tactical game" of psychodynamic therapy is apparently to try to help the client see things for themselves, in the best possible way. What might seem to be dishonest and furtive is really the therapist's attempt to help the client see things the way they should be seen as stated by his/her theoretical perspective. This necessitates that the psychodynamic therapist is aware of the consequences and impact of his/her statements.

Jette states the following:

*J: And I, myself, think that it is a little unethical [...] that I have a perception that, this is the way that things are, and then I just supposed to make him see this, uhm, because, it is not sure that things are like this, it is just my perception. So, uhmm, it is, yes, I definitely think*

*that there is a lot of power in the role we get, uhm, that can cause problems in the room (App. 10, l. 400-404).*

Jette states that just because she sees things one way, she is not certain that this is the right way. Jette underlines that there is a possibility that the clients' ideas might be "just as right" or even more so, than what Jette thinks. Tyra agrees with Jette on this and says the following:

*T: Well, I am not the one who should decide what comes from the insight, but most people, if they start to think, in relation to the boyfriend hitting them because of the food being five minutes too late, could as you know very well begin to think "Okay, this is not entirely reasonable". And, and then I always try to compare it to, a lot of them have experience from their lives [...] where they have been, uhm, well, were there limits have been exceeded [...] and then I try to compare it to that (App. 9, l. 488-494)*

Clearly, there is an understanding that the therapist should not decide what the client gets out of therapy; however there is also an understanding that the therapist does know better because of his/her position as a psychologist. The truth of this presumption is that the therapist possesses a certain kind of privileged knowledge about therapy (see Øvreeide, 2002). This means that the therapeutic situation is inherently unbalanced. However, the therapist's knowledge is qualified by education, experience, and research. The psychologist should be qualified to know things about the client, which the client is not aware of. Taking a phenomenological approach to this issue, one might say that the therapist can never fully know what is best for the client, simply because he/she is not the client. Then the issue becomes whether it is moral to hide anything from the client. If the client is the one who really knows what is best, then he/she should be given every bit of information to make the best decision, which could be done using open questioning that Tyra illustrates, that would help the client and aid the mutual negotiation of goals for the therapy. Further, loaded questions are a valid exploratory or insight-giving device according to the psychodynamic approach (Hill, 2009). However, using loaded questions to change the opinion of the client is not all right when you consider the Ethical Principles for Nordic Psychologists (EPNP) guidelines on respect and competence.

### **The Visible and Invisible Goals of Therapy**

In psychodynamic therapy, there seem to be goals that are immediately visible for both the client and the therapist, mainly because they are usually goals that they have agreed upon, and are working towards. However, there seems to be a class/level/abstraction of goals that is not presented immediately for the client. When asked if all goals in therapy can be revealed to the client, Jette answered the following:

*J: No, I believe that there in a lot of, maybe in all therapy sessions, is a hidden agenda that the therapist [...] gradually tries to reveal to the client and test if the client are into it, uhm, and [...] maybe there are some things that can be rebutted and then slides away, you can hope [...] there are some things that are difficult to formulate and that, are too, too frightening for the client or too overwhelming or [...] they might not [...] be entirely keen on seeing [the things] [...] that the therapist can see. And those goals are latent in the process, and might only surface at an advanced stage (App. 10, l. 77-84).*

The main reason not to reveal the goal seems to be the therapeutic concern about not giving the client too much to think about. Here we see paternalism at work. Even if the therapist does not want to impose his/her goals and understandings on the client, he/she still has them and might be affected by them in his/her approach to the client and therapy. Moreover, the moral foundation for the therapist's goals might be different from the moral ideas of the client. This means that, not only could the therapist be treating the client in accordance with some personal ideas of what should be accomplished in therapy; he or she might also be in conflict with the basic opinion of the client. Therapy does not only move the client towards freedom of symptoms, but also develops in a certain valued direction (Tjeltveit, 2006). However, this does not seem to be the immediate concern for the participants in this study.

Tjeltveit (1999) states that therapists should not adopt the views of the client unquestioningly. Often, the client's view is not the most important focus of psychodynamic therapy. What the client deserves is the therapist's best judgment about a certain situation. In the current study, it seems like the psychodynamic "therapeutic hypothesis" is the standard, instead of a more existential approach of an open mind and an acceptance (Spinelli, 1994) of the simple fact that sometimes the client is right. This is, according to Keenan (2010), a common reaction. Another concern is the contra-therapeutic effect of the revelation of the psychodynamic therapists' therapeutic hypothesis. Kirsten explains:

*K: [...] I believe that there are some things that you cannot reveal to them because it is a therapeutic goal. That might in fact inhibit therapy a bit if you suggested it as a goal. [...] You also need to establish an alliance with the client. So, if you proposed this as therapeutic goals in the beginning, you might risk that they actually dismissed the therapy. But if you held it as [...] a therapeutic focus, by working towards it and then picking it up at a time when they were ready for it, and then you could discuss it as a further goal, where I think you should revise your focus continuously [...] (App. 7, l. 52-55).*

As pointed out in this statement, complete dismissal of therapy is often a concern for the therapist. Hare-Mustin et al. (1995) adds that a premature discussion of goals in therapy might lead to the client discontinuing therapy. Therefore, keeping therapeutic hypotheses that might seem immense and threatening for the client a secret is a way to ensure that the client stays in therapy. Keeping the hypotheses secret then, is a way to make therapy flow, rather than trying to keep secrets from the client.

In the following, Tyra explains how and why the therapist should be careful not to impose certain projects on the client.

*T: [...] one should be careful that one doesn't impose ones own projects on the client. Uhm, it is always a balancing act. And I might have [...] the idea that a [...] suicidal patient [...] should stay [...] alive – yeah? [...] and that could be my goal in itself, which I could be open and honest about. But [...] if can't manage to make it their goal, [...] then it all slides a bit – yeah? Well, and I can sometimes have some intentions [...] with some subjects I address [...] where it is my project (laughs) in some way or another, because [...] it is also a part of my assignment to keep them alive, but, but where I can't always, well, initiate them into everything [...] I've got going on. Also to maintain, that it should be an exploratory process for them, then I can't serve them everything on a platter, as it would become only an intellectual experience, but also that you get [...] an experiencing going – yeah? [...] I think*

*that there are some things where [...] you definitely don't tell how theoretically founded what you are doing is (App. 9, l. 73-90).*

Tyra states that it is all right to have goals for the client – also the ones they do not know about, but there should never be a project that the therapist imposes on the client. And, these goals should never supersede what the client wants. Moreover, revealing all goals and insights to the client might disrupt their exploratory process, which is central to the psychodynamic approach. Tyra states that revealing everything could make the experience more intellectual than exploratory, which is not the goal of psychodynamic therapy.

## **The Therapist**

Surprisingly, all the participants reported that they did not adhere to one specific theoretical stance. Most of the participants said that they were mainly inspired by psychodynamic and cognitive theories, but their approaches were also quite eclectic. For example, Laurids discussed his diverse approach to therapy:

*L: Yes, then I'd say that, that it is eclectic or integrative but uhm, I'm very inspired by, amongst others, cognitive therapy – yeah, but, also get my inspiration in the psychodynamic way of thinking, and existential thinking and, I [...] have confidence in [...] some [...] psychotropics, so I also believe in a more biological model, so, so it's like, you could call it eclectic/integrative, that's probably my standpoint. (App. 8, l. 15-19).*

This falls under the guidelines on responsibility in the EPNP. The psychologist is responsible for choosing scientifically-sound methods. This eclectic view<sup>2</sup> in and of itself might not be proven scientifically, but the different theories that are melded together might be. As such, the psychologist is acting in a theoretically sound way. However, having an eclectic view makes it hard for the client (and perhaps the therapist) to find out what the therapist is really doing. As Murdin (2001) states, this is a problem because the client is effectively not choosing his own treatment. However, as stated in the EPNP it is the responsibility of the psychologist to choose the most suitable theory/approach for the given situation. Once again, the imperative is that the therapist knows better than the client (even in the ethical principles that are meant to guide the therapist). However, the eclectic view could ensure that the psychologist does not get dogmatic about one theory or method, which is important (Spinelli, 1994; Øvreide, 2002; EPNP 2006-2008). Being eclectic could be viewed as a way to ensure neutrality in choice of method and theory, but is problematic because of poor transparency.

Going beyond eclecticism, Jette and Laurids both point out that the goals of therapy are often judged on the basis of some personal moral code:

*J: [...] I think the personal [code red.] is the most prevalent when it comes to [...] the day to day therapy of reality. Uhm, I think that you, as a psychologist, have a [...] a feeling of when you, when you surpass limits that you should not surpass, uhm, but, I also think that it has*

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<sup>2</sup> The eclectic view that is commented on here is a mix of different theories and approaches, which is individual for the specific therapist. Hence, eclecticism does not hint at the fact that the therapist can use different approaches in succession. Rather, it points to the fact that a therapist might use cognitive, behavioural, psychodynamic etc. tools within the same session (indeed within the same spoken sentence) while not stating which is which as he/she might just be doing so because of a pragmatic imperative about what works.

*something to do with me, I'm trained, or am being trained, in these relational [thoughts] uhm, soo [...] you can't set any goal that is technically unethical, uhm, but you can make an interplay that is unethical (App. 10, l. 411-417)*

In the above statement Jette explains that it is a personal moral code that helps the therapist decide on whether or not a goal is unethical. However, she also states that goals in and of themselves cannot be unethical as such. The interplay between the therapist and the client could potentially be unethical. Both the ethical dimensions of the goal and the interplay between the therapist and the client are judged on a personal level by the therapist in the day-to-day therapy. If this day-to-day therapy is in turn directed by some ulterior moral code, it is not readily apparent from the interviews. However, it is expected that the therapists follow the EPNP as best they can.

## **GENERAL DISCUSSION**

In sum, it seems that conducting therapy, setting therapeutic goals, and reaching goals, all include input from both therapist and client. However, it also seems that there is a question of neutrality that should be posed. It seems that no matter what the psychodynamic therapist is doing, he/she is never neutral. This conclusion falls in line with the argument about "privileged knowledge" that was posed in the articles by Øvreide (2002), Tjeltveit (1999), and Brinkmann (2008).

The cases mentioned in this study have their own discourses, positions, rights and duties, which are relevant to look into. The discourses that have been debated continuously throughout this study are among others paternalism and neutrality in the psychodynamic therapeutic setting. The study found that this discourse lends different positions to the participants. First, there is the position of the therapist that knows better. This position is created partly on the basis of the therapists' educational and experiential background and partly by the other position in this discourse –the clients' position. This position gives the client the duty to trust the better judgment of the therapist; however, it also gives the therapist the right to be the one that knows better. Hence, there is a dynamic relation between the client and the therapist in this respect.

The main limitations of the present study are the small sample size and the one-sided view on psychodynamic therapy. Being able to generalize any of the present results would be greatly advantageous to the conclusions, and going beyond psychodynamic therapy. Herein lies possibilities for further research. Expanding the sample size, and even quantifying the format of research, could be very interesting directions to take. Moreover, future research can consider going beyond IPA, and investigating the subject further with discourse analysis or attempting to go beyond the conscious views of the psychodynamic therapist.

The conclusions in this study need quantitative verification to be more directly implicated in practice. However, this study is meant to cast a first glance at the tension between paternalism and autonomy as experienced by the concrete therapist. As such it is heightens the awareness about the issue, and can be used as a point of departure for further research.

As Hare-Mustin et al. (1995) mention, the (APA) ethical principles for psychologists point out that there is a reciprocal relationship between the therapist and the client. The

client is expected to make rational decisions based upon the statements and guidelines that are posited by the therapist – that is, the client has the duty to make rational decisions. When looking at the analysis in the present study, it is clear that statements are never truly neutral. This said, how is the client meant to do anything autonomously? As mentioned earlier, the psychodynamic approach states that autonomy is one of the main goals of therapy. Hence, the therapist is obliged by his/her theoretical background (it is his/her duty) to foster autonomous clients.

Neutrality and autonomy were sought by letting the client have the last word in all matters. However, as the analysis has shown, there are still some remnants of paternalism. The participants do not seem to be fully aware of the indirect ways they might be affecting the clients – even though at least one voiced this concern. Positioning Theory states that in participating in any given episode the individual is expected to act in accordance with their beliefs as to their position (Harré, 2012). Hence, the therapist might just interpret the situation in accordance with the discursively available storyline. This means that the psychodynamic therapist might not be aware of his or her paternalistic ways because he is embedded in an episode where the paternalistic position is the only possibility.

A question could be posed here: Can the information that is provided by a psychodynamic therapist (or any therapist in general) ever be truly neutral? During the interviews, it became apparent that the participants had different agendas, and attempted to influence the clients in a certain direction, in accordance with the psychodynamic approach. This is of the rights of the therapists' position. However, as studies of client-doctor communication (e.g., Williams et al., 2002; Bernhardt, 1997) show, information given by an authority figure is never neutral, or at least not perceived as such by the client. If the psychologist is positioned as an authoritative figure, the client might only be able to take the position of the client who obeys the therapist. Therefore, the weight of the therapist's word is not only in the intrinsic value of the words, but also laden by the position it comes from – the authority. This means that "letting the client have the last say" is not really an action that preserves autonomy. Rather it expresses the pseudo-duty of the client to take responsibility for his or her own actions. Meanwhile the therapist is infusing his or her own ideas by making "neutral suggestions" that the client has the duty to follow.

The notion of paternalism (Tjeltveit, 2006) to come into play again. As stated earlier, some psychological theories presuppose that the therapist simply knows better and has better judgment (Spinelli, 1994). The therapist could be adhering to one of those theories, and is therefore not violating any ethical principles as his position is founded in scientifically backed theories. This does not absolve the therapist from the problem of influencing the client to choose certain kinds of positions. The value-laden way in which the participants conduct therapy is likely an expression of the rights of his or her position. Further, Tjeltveit (1999) states that people are often not aware that they are under influence from societal, cultural or discursive powers. This means that even if the therapist aims for neutrality, it might not be possible simply because he or she is assigned a certain position by the discursive practice of his or her organization (Harré, 2012). As further confirmation of this, Brinkman (2008) states that human functioning cannot be seen as value-free because it always operates within a normative framework. Hence, any activity is always based on some form of duty or right, which in turn means that a value-neutral action might not always be possible.

It could be argued that the psychodynamic therapist is the one who is most qualified to judge the appropriateness of a goal in psychotherapy. However, there is a risk of losing the interest of the client and the client's autonomy if the therapist sets the goals on his/her own. Therefore, the therapist must consider both the ethical guidelines about respect and patient autonomy when making a decision on which goals to pursue. The ethical guidelines are then another part of the discourse that defines the rights and duties of the position of the therapist.

Wolman (1982) suggests that if the client defines a goal, the therapist should always respect this. The therapist should be the agent of the client, not societal norms. The participants in the present study are almost certainly agents of their own theoretical view. This means that their respect for their clients' ideas might not be influenced by societal discourse, but is at least influenced by theoretical discourses. This is not a problem as long as the therapist is aware how and why he/she chooses different actions. However, as was evident from the interviews, each participant in this study utilized relatively eclectic theoretical foundations for their therapy. Hence, the transparency of the theoretical approach of the therapist is somewhat blurred.

In sum, a major issue in this study is the neutrality of the psychodynamic therapist. Whether or not the therapist is neutral has far reaching implications for both the client and practitioner. As has been shown, the ideas and hypotheses of the therapist might influence the process of setting and reaching goals in multiple ways.

## CONCLUSION

This study has explored the autonomy of the client in relation to the paternalistic position of the psychodynamic therapist. It appears that paternalism is more or less unavoidable because of the discursively constructed positions of both the client and the therapist. Even if the therapist seeks neutrality, it is questionable if the client can achieve real autonomy. However, there is a dynamic relationship between the two positions, and one cannot simply blame one part for acting in bad faith, as both positions legitimize one another within the discourse. However, the therapist should still be aware of paternalistic ways and try to be reflective on his/her position, because of the positions inherent in qualified knowledge. The present study is limited in its focus on four psychodynamically-oriented therapists. Still these cases have been sufficient to explore the tensions between paternalism and autonomy as some therapists experience them.

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### Appendix 1: Final Interview Guide

Research question	Interview question
Experience with goals in therapy	<p>What is your understanding of “goals in therapy”?</p> <p>What is your general experience with goals in therapy?</p> <ul style="list-style-type: none"> <li>• Advantages – for the therapist/therapy/client?</li> <li>• Disadvantages – for the therapist/therapy/client?</li> </ul> <p>What is your basic idea when setting goals in therapy?</p> <p>Can all goals be clarified with the patient?</p> <ul style="list-style-type: none"> <li>• Are there any underlying goals that are necessary, but that the client does not benefit from knowing?</li> </ul>
Determining goals – wishes and the attainable	<p>How do you set goals for therapy?</p> <ul style="list-style-type: none"> <li>• Is it influenced by your theoretical standpoint?</li> <li>• How do you take the wishes of the client into consideration?</li> <li>• Who has the decision if you disagree?</li> </ul> <p>Who has the responsibility for goals being reached?</p> <ul style="list-style-type: none"> <li>• Why?</li> </ul> <p>Have you ever experienced a situation where you felt that the goals of the client were in conflict with the goals of therapy? Could you elaborate?</p> <p>What are the optimal goals in therapy?</p> <ul style="list-style-type: none"> <li>• What do you think personally?</li> <li>• What does your theoretical background say?</li> <li>• What is the opinion of the organization you are a part of?</li> </ul> <p>How do you know that the client is making progress?</p> <p>Do you feel that there is a connection between the goals that are set and practice?</p> <p>Are goals subject to change?</p> <ul style="list-style-type: none"> <li>• What justifies such a change?</li> </ul>
The evaluation of therapeutic goals.	<p>How do you evaluate if a goal has been reached?</p> <ul style="list-style-type: none"> <li>• Is there anything in your theoretical standpoint that says anything about this process?</li> </ul> <p>Who takes the final decision about whether or not a goal has been</p>

	<p>reached?</p> <p>Have you ever experienced that a goal was not reached?</p> <ul style="list-style-type: none"> <li>• What did you do then?</li> </ul> <p>Have you ever experienced a situation where your perception of a goal being reached, did not correspond to the perception of the client?</p> <ul style="list-style-type: none"> <li>• How did you handle this situation?</li> </ul>
Goals, time and ending therapy	<p>On what basis do you end therapy?</p> <p>Do you ever experience that therapy can be ended at a preset time?</p> <p>What can make you end therapy early?</p> <ul style="list-style-type: none"> <li>• What does this mean for the goals?</li> </ul> <p>What can make you end therapy later than originally agreed?</p> <ul style="list-style-type: none"> <li>• What does this mean for the goals?</li> </ul>
The ethical ending	<p>Have you considered any ethical problems with setting goals in therapy?</p> <ul style="list-style-type: none"> <li>• If yes, which ones – how would you describe them?</li> </ul> <p>If you are to estimate if a goal is ethically sound, do you employ your theoretical background, or some other ethical set of rules/codex?</p> <ul style="list-style-type: none"> <li>• What implications are there if you utilize a theoretical ethical standpoint for your estimation?</li> <li>• What implications are there if you use another ethical standpoint for this estimation?</li> </ul> <p>If the client does not want to continue therapy because he thinks it hurts too much, but you think that continuing is the only right thing to do, what should you do then?</p> <p>What do you do if what can help the client, clashes with your moral convictions?</p> <p>What do you do if the client does not want to set goals for therapy?</p>
Rounding	<p>We are getting near the end of this interview, is there anything you would like to add or ask?</p> <p>Do you still want to participate?</p>