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The Unbearable Implications of Setting Goals: Ethics in the World of Therapy

A Phenomenological Study

Jakob Emiliussen

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Abstract

The present study is concerned with the ethical dilemmas of setting goals in therapy. The main questions that the study is trying 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 four practitioners with different degrees of experience. These interviews were done in the period between the 28th of February 2011 and the 25th of March 2011. The interviews were conducted on the basis of an interview guide that was produced by the author of this report. The interview guide was piloted on the 11th of January 2011 and revised accordingly. The interviews lasted about an hour and were transcribed immediately after they had been carried out.

The analysis of the material from the interviews was based on the framework of the Interpretative Phenomenological Analysis (IPA), with minor changes to the procedure of categorization. The analysis revealed 19 themes whereof ten were relevant for the formulated problem of the study. These ten themes are expanded upon in the analysis section of this report and include such themes as: revision of goals, the will of the patient, termination of therapy evaluation of therapy etc.

One of the main findings of the study was based on the concept of “therapist neutrality”. Even though the therapist is meant to be neutral in his work with clients, this study shows that it is more or less impossible for the therapist to do this. Even if he/she adheres closely to a certain theory, his/her neutrality can be questioned. The implications for the study are many and far reaching; the lack of neutrality that the therapist displays is of course problematic. However, this is only because neutrality is what is demanded from the Ethical Principles of Nordic Psychologists. It is discussed to some extend if neutrality should really be the main characteristic of a therapists work. In connection to this, concerns are voiced on the problem of the therapists basing their treatment decisions on ethical principles more than theory.

The discussion centers on the “perceived neutrality” of the therapist. This notion is covered extensively and different perspectives in relation to the original problem formulation are related to this. The issues with the methodological approach are discussed in detail and

other issues are discussed as well. The results are analytically generalized using the framework of positioning theory as presented by Ron Harré (In press, 2002).

It is concluded that determining goals in therapy is a process that is based on collaboration between the therapist and the client, and the decision of whether a goal is reached is also based on collaboration between the client and the therapist. However, these do not seem to be “sterile” processes as both the client and the therapist might have different agendas when going through those processes. It seemed like the therapists that participated in this study are not fully aware of the power that is inherent in their positions as therapists. If this is neglected on purpose or if it is a result of ignorance, is never fully uncovered.

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1. Introduction

The present study is concerned with setting goals in therapy and the ethical ramifications of this. Setting goals in therapy might seem straightforward. However, dwelling into the question of setting goals quickly reveals a constellation of ethical and practical problems. The practical problems that arise when considering setting goals could be centered on the use of theory. Miller points out that: "… *generations of therapists have come to suspect that it isn't so much what they do – the theory, what model, what technique or even what medication – that helps people, but who they are and who their clients are, as well as the idiosyncratic personal fit between themselves and the people who come to see them*" (Miller 2000, p. 40 in Spinelli 2001). This quote illustrates why the therapist could be persuaded not to use any specific theory when he/she is defining the goals that should be utilized in a given therapy session. This would mean that he/she relies solely on the ethical standards on which therapy is based and his/her experience with therapeutic goals. The practical problems of setting goals then transcends into the ethical problems of setting goals.

The ethical dimension of setting goals could be defined as the issue between the client's autonomy, and the therapeutic benefit of goals. One thing is to consider the clients wishes, another is to consider these wishes and still fulfill the ethical requirements of the profession. There are some inherent difficulties in acting ethically and in doing good therapy. Sometimes, what seems best from a theoretical/therapeutic viewpoint might be unethical. For example, if the client wants one thing, but the therapist estimates that another thing is more advisable (and even if the other thing is objectively more advisable), it would still be unethical to try to force the client to do something that he/she does not want to do because of the clients right to choose freely.

As has been illustrated already, the ethical implications for setting goals are far reaching. Even if the therapist is aware of these problems, he/she might have a hard time remaining neutral because of the theories or ethical standards he does utilize (even if he/she does not adhere to one specific theory, he/she must still rely on something). And neutrality, as we shall see throughout the report, is a major concern in the practice of setting goals and maybe in therapy in general. The report sheds light on whether the therapist can and should remain neutral when setting goals. Should the therapist be true to the wishes of the client no matter what, or should he rely more on his professional opinion? The answer might

seem straightforward, but when interviewing the participants it quickly became obvious that it is not.

When talking neutrality, there is also a question of deceit. If the therapist chooses to rely more on his professional opinion, than on the wishes of the client, how is he to convey this to the client – *should* he convey this to the client? Here, the answer is not as straightforward as it might seem. The problem is, of course, that the therapist would be deceiving the client if he did not reveal that he was working form his professional opinion rather than the wishes of the client. But, the counter-therapeutic effect of revealing such ulterior motives might be of an even bigger concern.

Ethical problems as the ones stated above, are what this study is concerned with. Trying to answer or solve the ethical problems is not the goal of this study, rather it is to shed light on a dimension of therapy that seems to have evaded research, and try to bring awareness to the ethical problems of setting goals.

The present study is based upon a review of the available literature on goals and ethical considerations in connection to them. Further, the study is based on four interviews with therapists who have different experience and background. The approach to the study is phenomenological, relying on the Interpretative Phenomenological Analysis (Smith & Eatougn 2007; Storey 2007; Smith & Osborn 2008).

What follows after this introduction is a more precise definition of the problem with which this study is concerned. Following this, there will be a brief overview of the central concepts that will be utilized in the report. After a short discussion about the scientific theoretical foundation of the study, the literature-review and theoretical review will be presented. Next, the metatheoretical perspective and method of the study will be presented shortly and followed by the analysis, which takes up the main part of the report. Hereafter, a discussion of the results and their implications will be presented which will be followed by an attempt to put the report into perspective and finally a conclusion will end the report.

2. Problem formulation and expansions

As said, the present study explores the problems of setting goals in therapy. A narrowing down of the problem area is relevant here, and the problem formulation for the present study goes as follows:

Who has the responsibility for the goals of therapy, and who should decide when and how they have been fulfilled?

The problem formulation extends into different discussions. One discussion is centered on the fact that somebody has to set the goals for therapy. Is it the job of the therapist to set goals that he thinks is therapeutically sound, or is it the client who must decide? Whatever the answer would be, there might be other implications as well. If the therapist adheres to a certain theoretical standpoint, is there any intrinsic goal in this theory that should or could supersede the wishes of the client and even the therapist. Moreover, once these goals have been set, are they unchangeable, or can they be revised – if they can, is there any limit on how often or how many times they can be revised?

As a result of the above question, one must also consider the problem of when therapy is to end. Who decides if a goal has been reached? Has a goal been reached when the therapist estimates that it has been reached, based on his experience, research and theoretical knowledge, or when the client feels that he is satisfied? Further, how can the therapist ensure that he/she remains objective when estimating whether or not a goal has been reached?

Lastly there is a consideration about neutrality. Can the therapist remain neutral when goals are determined? Or even, *should* he be neutral when setting goals? The interesting part of this is whether there is some form of interference from either the ethical standards on which the therapist leans or from the theories he/she utilizes when setting goals. So, can the therapist remain neutral when he is under influence of both theories and ethical standards?

3. Clarification of concepts

In the following the main concepts of the report will be discussed and elaborated to the extent that is relevant for the present study.

3.1 Goals

Central to the focus of this study is the concept of goals. The most apparent problem when talking goals is that they seem to have different meanings on different abstract levels. The terms therapists use to define goals in therapy are very varied – they use the same term about different things and goals are often individualized for different clients (Tjeltveit 1999). Goals can be very general – indeed universal – but also more specific – localized if you will. A goal of therapy could be as general as "the client should get better" and as narrow as "when you no longer display behavior X, we can do Y" (Ibid.). This is however examples of what goals could be, and not a definition of what a goal is in and of itself. The problem of defining goals for this report is that the participants in the interviews do not use the concept in an unequivocal manner. This calls for a wide definition that encompasses all the different ways in which the participants uses the concept. One such definition could be as follows: "goals are the end which therapy wishes to attain". This definition both entails that goals are not necessarily attainable, and that they are the final "destination" for therapy. Moreover, the definition encompasses both universalistic goals and more localized goals. This definition is the one that will be utilized in the study.

3.2 Client

The participants in this study all used varying terms for referring to their clients. However, the two terms most commonly used were "patient" and "client". The literature that is reviewed in this study also uses these two terms to a varying degree. However, none of the participants or the writers seems to distinguish between the two. Rather they use them interchangeably. As to not cause any further confusion, I shall refrain from using the term patient, and only employ the term *client*. Even though the term "client" is not completely neutral (it still entails the unbalance between the parties of the therapeutic situation), it is more so than both "patient" and "analysand" (Spinelli 1994). "Patient" implies that there is something wrong in a medical and factual sense, with the person being talked about and the term "analysand" has connotations to the psycho-analytic school of thought, and could easily cause unnecessary confusion (ibid.).

3.3 Therapy

Therapy cannot be unambiguously defined, as it is an open category – not all the varying forms of therapy that are found in the category, share the same set of characteristics (Spinelli 1994). Rather, we can identify a "family resemblance", where the different similarities overlap each other. Instead it would be productive to ask "when is therapy?", as this draws focus towards the contextual properties of therapy instead of the definitional properties (Ibid.). This means that therapy occurs in a specifically designated environment (in the broadest sense of the word), and when the encounter has been labeled as therapy by an authority (for example the therapist) and/or when at least one of the participants defines the process as "therapeutic", based on the experiential features of the encounter (see Spinelli 1994 pp. 19-46, for an extensive discussion on the definition of therapy). This definition encompasses all the different kinds of therapy that the participants in this study present. However, I will narrow down my use further. Therapy is the professional relation or encounter between two parties of which one is a trained psychologist, and the other is a client seeking help with some psychological problem. Hence, therapy is the one-on-one psychological therapy session.

3.4 Therapist and psychologist

First and foremost it should be said that the present report uses the two concepts – therapist and psychologist – interchangeably. Some might argue that there is a difference between being only a therapist, and being a psychologist. However, in this report the supposed difference is irrelevant. "Therapist" and "psychologist" refer to the professional part of the therapeutic relation. It also refers to the education, research and experience that are entailed in this professionalism. The terms also refer to the person who conducts therapy. So, in sum, a therapist or a psychologist is the professional – educated and experienced – person who conducts therapy.

This concludes the clarification of concepts. The reader might think that the term of "ethics" or "ethical" has not been defined – and indeed it has not. However, this term is to be seen in connection to the Ethical Principles of Nordic Psychologists in this report, which will be covered in the review section. Moreover, the concept requires extensive clarification, which will be the point of the next section.

4. Ethics, Professional Ethics and Psychology

The following is a short introduction to the foundation of the professional ethics of the psychologist. This is to give a basic view of the grounds on which psychologists can make their decisions about ethical problems that might arise in their work. And further to give a theoretical foundation for the analysis and discussion later on. Firstly, a clarification of what professional ethics could be defined as and a brief comment on the responsibility of the profession of psychology.

Professional ethics could be said to be a framework for the professional relationships in contexts of vulnerability and dependency. Koehn (1994 according to Banks & Gallagher 2009) talks about the moral legitimacy of the professional role. "*What grounds professional ethics is the pledge professionals make to serve some higher good – that is, a good that goes beyond their own self-interest, that focuses on the good of other individuals and ultimately the public good.*" (Koehn 1994 according to Banks & Gallagher 2009, p. 21). Koehn's point is that the ends of the profession is an end desired in and of itself – i.e. good mental health, is preferable to the client but also to the society. Banks and Gallagher (2009) ask if we really can separate internal (intrinsic or personal) and external (extrinsic or societal) ends, as Koehn suggests. They answer that "*… the aims of the individual practitioners for making money or achieving high status – if these were to become the overall guiding ideals or goals of practice, then arguably the practitioner would be a morally flawed occupant of the professional role.*" (Banks & Gallagher 2009, p. 22). Spinelli (1994) extends on this and says that: "*No therapist can consistently and permanently avoid the temptation to abuse the inevitable and inherent power imbalance.* " (Spinelli 1994, p. 18). In this statement lies the assumption that the unbalanced therapeutic relation is in and of itself abusive.

This definition of professional ethics, or rather the foundation of professional ethics, requires different extensions to be applicable to the psychologist. According to Øvreeide (2002) the psychologists professional viewpoint must at all times reflect basic moral values. Professional ethics is concerned with how professional action can become ethical. The basic values are not given; they are changeable and almost invisible. This means that the professions must consider current debates about values as well as the values defines by the profession itself.

If we look to the responsibility of the profession of psychology, Øvreeide (2002) points out that the psychologist is under a demand to not only document his abilities, but also to make it visible that his work is advantageous for the client as well as the society. Psychology cannot be a black box that only the professional understands. The psychologist must master two languages – the professional language, and a language to explain the profession to non-professionals. Openness and communication ensure transparency and trustworthiness. But the risk is misuse of the professional knowledge. Self-discipline and internal criticism is an important element in the control of professional work, but not enough to ensure an ethical practice (Ibid.).

The actions of the psychologist must be expected to have consequences for others than the client (det tredje ansigt - the third face: a concept for those who have or might have an interest in or are affected by the actions of the psychologist, even though they are not themselves clients – i.e. family, friends and colleagues etc.). Ethical dilemmas occur in the tensions between different interests and constructions (Ibid.).

The fundamental issue of ethical problems in psychology (and in ethical problems in general) is that there is rarely a full description or a correct solution. There is no absolute moral authority for the unique situation, because we will always be left with a limited understanding of "the other" and "the third face", and therefore what is right to do. An action must often be carried out in a continually uncertain and never fully resolved situation.

After this brief introduction into the foundation of the professional ethics and its extensions into the psychological profession, we will take a look at the principles that are to guide the Danish (and other Nordic) psychologist in these seemingly unresolvable ethical dilemmas.

4.1 Ethical Principles for Nordic Psychologists (EPNP)

The following is a summation of the Ethical Principles for Nordic Psychologists (EPNP). This is to give an overview on the ethical regulations that guide Danish psychologists specifically in his/her work. Only the parts of the EPNP that are most relevant to this study are included and commented upon.

The Ethical Principles for Nordic Psychologists (EPNP) is a set of principles that have been agreed upon across the Nordic countries, and are based upon the "Meta-Code of Ethics" that was carried by European Federation of Psychologists' Association in 1995. These ethi-

cal principles apply to every psychologist who is a member of a psychologists association in one of the Nordic countries. The principles are not actual rules, but function as guidelines for the practitioner in ethical dilemmas. A lot of the work a psychologist does, cannot be governed by rules, and it is therefore up to the individual psychologist to act ethically (EPNP 2006-2008).

The EPNP is formulated *for* psychologists *by* psychologists. The ethics apply to the psychologists work situation, but the definition of "work situation" can vary significantly. However, the ethical principles are not meant to interfere with the private life of the psychologist (Øvreeide 2002).

Central to the subject of this report is the question of respect, which is covered in the EPNP. It is important to point out that the profession of psychology can have an implicit cultural bias and a power position where empirical knowledge, theory and methods have its own cultural limitations that should be surveyed (Øvreeide 2002). This said, we can go into the deeper aspects of respect.

> The EPNP on respect: "*The psychologist shows respect for the rights, dignity and integrity of every human being, and works to further this development. He respects the individual's right to a private life, confidence, self-determination and autonomy – in accordance with his additional work-related obligations and in accordance with existing laws*" (EPNP, 2006-2008, p. 31 – my translation).

The concept of respect includes the principle of confidentiality and secrecy. A client must know that everything he says in therapy will go no further than the psychologist and his immediate supervisors. There are certain situations where confidentiality and freedom are set aside, for example when the psychological assessment is part of a political assessment (for example a court ordered assessment). In these situations, and all other situations as well, it is important that the psychologist makes the client realize what boundaries there are, and does not give the client any false hope or illusions about voluntariness (EPNP, 2006-2008; Øvreeide 2002).

Next we turn to another important part of the EPNP, which is the part that covers the area of competence.

> The EPNP on competence: "*The psychologist strives to develop and maintain a high level of professional qualification in his work. The psychologist aims to*

> *be aware of his professional and human strengths and weaknesses, ensuring a realistic assessment of which competencies he can use for a given assignment. The psychologist only takes on the assignments, offers only the services and only uses the methods; he is qualified for through his education, training and experience.*" (EPNP, 2006-2008, p. 31-32 – my translation).

Ethic consciousness is a significant and necessary part of the competence of the psychologist. Professional psychological competence should include a continued reflection regarding ones function, prerequisites and a documentation of one's own work process and cannot rely solely on earlier exams and formal criteria. At the most basic level, the EPNP states that the whole of the psychologists' work should be scientifically supported and valid. Further a psychologist should at all times be attentive to the possibilities and limitations of a given theory. The psychologist should make sure that the theory he/she uses is the best suited for the problem at hand and not get caught up in "exiting theories" and dogmatic approaches (EPNP, 2006-2008; Øvreeide 2002).

The EPNP also considers the psychologist's responsibility. For the psychologist it is important to see the extent of his/her responsibility. First and foremost it is a question of being responsible for one's own actions in the work situation (Øvreeide 2002).

> The EPNP on responsibility: "*The psychologist is aware of the professional and scientific responsibility he has towards his clients, the organization and the society he lives and works in. The psychologist avoids doing harm and is responsible for his actions. He ensures as far as it is possible that his services are not misused.*" (EPNP, 2006-2008, p. 32 – my translation).

The basic assumption of the EPNP in relation to responsibility is the concept of "Primum non noccere", which roughly translates into "First of all. Do no harm". This has multiple implications for the profession and the psychologist: (1) an understanding that professional work can do harm (2) refusal to participate in any actions that might do harm, even though the positive consequences might outweigh the negative, however (3) some discomfort is acceptable, but should be reduced to the absolute minimum, and (4) the professional work should never be used to take advantage or manipulate the psychologist or the client (Øvreeide 2002). After this brief overview of the EPNP, we turn more specifically to the goals of therapy.

5. Goals in Therapy

The earliest identified aim of the psychoanalysis was to make the unconscious, conscious via insight and understanding (Bergmann 2001, Gabbard 2005). Bergmann (2001) suggests that there are no general goals, therapy is an individual process and the aims of it depend on the specific life situation and the value systems of both therapist and patient. However, in present day deciding what is going to be the focus of a given therapy is arguably one of the most important tasks of the clinician and agreement upon goals is the first step in planning an intervention. It is also one of the most complex tasks facing clinicians (Hawley & Weisz 2003).

There have been many different classifications of goals in therapy – some focusing on the outcomes, some on curative effect of therapy etc. Much of the literature on goals is descriptive in nature – focused primarily on relaying one's own or others view on goals (Blass 2003). Moreover, not much literature focuses on hidden values and assumptions that influence the process of identifying goals (Keenan 2010). In the next pages we will take a look at some of the issues that has been brought up in this introduction.

5.1 The contract

Hare-Mustin, Marecek, Kaplan and Liss-Levinson (1979), refers to the ethical principles that apply to both therapist and client in the therapeutic situation. The (American) ethical standards for psychologists define reciprocal roles for both client and therapist alike. By assuring clients' rights, the therapist makes them responsible for their own life. Hence, clients are expected to make rational decisions based upon the information given by the therapist.

In connection to this Hare-Mustin et. al. states that informed consent cannot occur without the client being informed properly. Informed consent refers to the process of the professional informing the client of everything pertaining to the upcoming therapy – goals, procedures, possible benefits and side effects, and alternatives. The client can then choose to participate or not. Some clients are so impaired that an autonomous choice is unthinkable (Hare-Mustin et. al. 1979; Wolman 1982; Tjeltveit 1999). Hare-Mustin et. al. extends this and identifies certain issues about informed decisions. Information should be presented dependent on the state of the client in any way possible but in coherence with the ethical standards. The disadvantage of assuring clients rights in this way could be that the client

may discontinue the treatment, if there is a premature discussion about the treatment goals and so on. However, these patients might have discontinued anyway, and an open discussion might get some of them to stay (Hare-Mustin et. al. 1979).

Wolman (1982) finds that establishing a contract is a central part to ethical therapy. The purpose of a contract is to clarify the therapeutic relationship. The contract should, among other things, specify the goals of the therapy, and when and how it could be renegotiated. The issues covered by the contract vary according to the orientation of the therapist and the inclination of the client. The more specific a contract is, the more often it will have to be renegotiated, as the client's circumstances changes and the goals of therapy evolves. However periodic reassessment is an integral part of contracting (Hare-Mustin et. al. 1979).

Hare-Mustin et. al. states that the goals of the clients should be assessed in the first interviews as to ensure that they are not in conflict with the personal moral code of the therapist. Then it is up to the individual therapist, to explain why the contract is important but in such a way that the client has the possibility of saying no (Hare-Mustin et. al. 1979).

Widiger and Rorer (1984) however, discuss the ethical principles of the American Psychologist Association (APA) which do not follow any specific set of psychological models or theories (neither does the EPNP 2006-2008), which means that some therapists might find it hard to make their therapy compatible with the ethical principles. Free choice, for example, is given in existential psychology but does not compute well with the principles of psychoanalysis or behavior modification (Idib.). Further no standard contract can be formed for all kinds of therapy (even though some try - see Handelsman & Galvin 1988). In some therapies a contract specifying all details about the treatment would be counterproductive (e.g. the psychoanalytical approach). Further informed consent is inherently incompatible with many forms of psychotherapy (Widiger & Rorer 1984).

Hence there are multiple problems with establishing and revising a contract. The therapist both has to consider the clients wishes and his own ideas, and further, there seems to be no standard he/she can really rely on when making a contract. However, the EPNP offers guidelines that the therapist can follow. These are only guidelines however, and cannot be relied on as rules. After looking into the problems on establishing contracts in therapy we now turn to how the process of setting goals might be influenced by both the therapist and the client.

5.2 The agendas and values of the client and the therapist

In this section, we take a look at the fact that the therapist and the client can have different agendas at least in the beginning of therapy (Tjeltveit 1999). The client might wish to get better, not knowing what is wrong exactly and the therapist might want to clarify more precisely what is wrong, before talking betterment. In any case, the client comes to therapy with values that are different from the therapist's. Some arrive with very wide values and goals for therapy; others come to therapy with almost no idea about what could be the goals they want to pursue (Murdin 2001). Tjeltveit (1999) and Keenan (2010) points out that psychotherapy is inconsequentially value-laden. In this connection Tjeltveit points out that: "*A central reason for the inevitability of therapy's value-ladenness is that all therapy involves value-laden goals*" (Tjeltveit 1999, p. 4).

Murdin (2001) states that all clients have a value system but it could be distorted on the basis of bad experiences, or on the basis of feelings of guilt and envy. This means that clients are not necessarily in a state that allows them to set realistic goals. However, they might think they are. Clients are often only focused on pain versus happiness and only have a criterion of success based on this focus. Then the goal of the therapist could be to make the client more conscious of the problems with only focusing on these things. However, the client might refuse this, because it can end up hurting more, causing the client to leave therapy. It is a dilemma between recognizing resistance and transference, and giving the client the autonomy to decide for him/herself (Ibid.).

In connection to this Brinkmann (2008) discusses the relationship between facts and values. He states that two premises are often taken for granted: on one hand, only statements of fact can be objectively true; on the other hand statements of values cannot be anything but subjective. Saying this, he points out that there is a logical gap between factual and evaluative statements – no descriptive statement can entail an evaluative statement. Further, moral terms cannot be subjective psychological states such as emotions or sentiments. Brinkmann proposes that people can perceive "oughtness" as part of the world. Given that norms order social life, there seems to be an inherent "factual normativity". However, human functioning cannot be understood in value neutral terms. Value-terms cannot be exorcised from the part of our vocabulary that has to do with action, thinking and feeling. Social practices are the main source for normativity – moral and otherwise (Brinkmann 2008).

Adding to Brinkmanns (2008) point, 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 therapist is that therapy will be value-free. In reality, therapy is not value-free and making an agreement without taking this into consideration is basically unethical (Tjeltveit 1999).

However, Tjeltveit (1999) also states that psychotherapy ought to be based on science, not values. It is meaningless to claim that values or ethical assertions in psychotherapy can be true or correct. "*Since there can be no truth-value attributed to ethical statements, it is cognitively meaningless to claim to understand values in therapy, or to discuss which values ought to be present… We can only say we prefer the client go towards a certain value"* (Tjeltveit 1999, p. 10). This means that there is no more epistemic weight to the goals as defined by the therapist, than those define by anybody else. Still it is hard to understand and address the values in therapy, because of definitional and conceptual differences on the meaning of the word "values" (Ibid.).

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, internal resistance and unconscious agendas might hinder or sabotage this process. Successful therapy could then be defined as therapy in which the client becomes willing to allow the process to take its time (Murdin 2001; Keenan 2010; Wollburg & Brakhaus 2010).

The difficulties occur when the two value-systems meet, and the concrete goals have to be established. In this connection we might see some form of paternalism occur. This is when the professionals' idea about what is good for a client, trump 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 goals for the client that might be tied to his theoretical orientation. Still, letting the client choose his own goals rests on a specific ethical thought – liberal individualism (Tjeltveit 2006). This principle might be accepted by the therapist (perhaps even uncritically), but not necessarily accepted by the client (Ibid.). Then we can start to identify one of the basic problems in setting goals – the differing ethical foundation of the client and the therapist.

To overcome these differences Tjeltveit (1999) and Wolman (2002) say that the client should choose goals and that the therapist is obligated to respect the choice. Hence, the therapist is the agent of the client, not the agent of society. Some goals might be inadvisable, but the therapist should try to maximize the clients' autonomy. In this connection Keenan (2010) posts that: "*… therapists need to feel confident that the goals are clinically*

sound … and that the goals are something that the therapist finds compatible with how one practices." (Keenan 2010, p. 230). This of course is somewhat counter to what Tjeltveit (1999) and Wolman (2002) suggested, as "clinically sound" is not necessarily synonymous with what the client might want.

After this discussion of the different agendas of the client and the therapist, their relation to values and the discussion of values as something societal and personal, we now turn more specifically to the problem of the therapists unethical imposing on the client.

5.3 The imposing therapist

We now turn to another concern in the therapeutic setting - the therapist's influence on the client. The point of this section is to discuss how and why the therapist might influence the client with the best intentions, but still could – maybe unwillingly – end up in an ethical scrape.

"*Certainly, 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. One should not adopt the view of the client unquestioningly. 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, which was briefly touched upon in the previous section (Ibid).

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 might be best described by Keenan (2010) in the following quote:

> "*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.*" (Keenan 2010, p. 237).

In Keenans statement above we see how the therapist could easily influence the client unwittingly. The problem is that the therapist should still work on preserving and enhancing

client autonomy, even if he is unknowingly influencing the client. According to Tjeltveit (1999) some take a Kantian perspective on preserving autonomy. Then the process (preserving autonomy) becomes more important than the outcome (effectively reaching therapy goals). This mainly western idea means that the therapist should relate to the client with a profound intimacy (Tjeltveit 1999).

"*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. Again, we see how the therapist might unknowingly influence the client because of societal or discursive influences.

Here it is relevant to return to the insight of Øvreeide (2002), who says:

> "*The psychologist has a privileged knowledge (he knows more than the client), and this knowledge is sought by the client. However it is only to a certain point that the psychologist can give the client insight in his professional actions – the rest must be based on trust in the beginning of the relation, and hereafter experience from the relation. […] Therefore the relation between psychologists and clients can never be symmetrical, but have a complementary element that implies an increased responsibility for the psychologist, a responsibility which cannot disappear via negotiation*" (Øvreeide 2002, p. 39 – my translation).

Øvreeide specifies the problem as an inherent inequality in therapy. Both the psychoanalyst and the cognitive theories assume that the therapist has superior knowledge in comparison to the client (Spinelli 1994). Therefore the therapist might be convinced that his ideas about goals and what they should be is right. This line of reasoning will eventually lead us back to the notion of paternalism that was discussed earlier. Paternalism can then be traced back to the therapists (almost) unquestioning belief in his chosen approach (Tjeltveit 1999). In this way, the unsuccessful therapeutic intervention can always be blamed on the client (psycho-analysis - "resistance" or cognitive - "unwillingness to apply the suggested instructions") (Spinelli 1994).

The problem is when observations and conclusions, based on a certain theoretical standpoint become truths or dogma. Spinelli (1994) states, that there is currently 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*" (Spinelli 1994, p. 132). Unfortunately, therapists have had a tendency to adapt the "stories" of their clients unquestioningly to the theory that they mostly apply, even though they have little evidence of the theory being based on valid or reliable evidence. Therapists should be open to alternative explanations before they convince themselves, or the client, about any particular interpretation (Spinelli 1994).

Therefore the therapist has to consider how he/she influences the clients' life. Intended and/or unintended influence is often hard to distinguish from one another, because the same processes might be used for both. But the therapists should beware not to make the client their ethical clones. Further therapists interaction might harm the family or society as a whole (Øvreeide's "third face"). Some advocate therapist neutrality, but this cannot mean that the therapist does not hold any ethical views, "*…never communicate them to clients in any way or espouse ethical relativism.*" (Tjeltveit 1999, p. 180). But neutrality could mean, as a general rule that therapists should try to minimize their influence on clients, provide a nonjudgmental environment, be flexible and open-minded, tolerate ambiguity etc. (Tjeltveit 1999).

The ideal solution is to help the client in a way that helps him/her, preserve his/her rights, and otherwise meets ethical ideals for therapy and therapists. If this is not possible, the client, therapist and other stakeholders must be aware of the dilemmas, and exercise prudence when determining the best possible balance of these ideals (Tjeltveit 1999).

After this discussion of how the therapist might unethically influence the client and clarifying that such influence might both be unintended and unconscious, we turn to the the primary goals and ideals of therapy.

5.4 Primary goals and ideals of therapy

This discussion of the primary goals and ideals is meant to show the problems and issues that arise when conducting therapy on the basis of ideal or primary goals of therapy. The discussion also sheds some light on the problem of balancing personal goals and societal goals.

Autonomy is the primary good therapists seek for their clients states Tjeltveit (1999). All theoretic schools affirm this, but humanistic and psychoanalytic psychologies stress it (Ibid.). Different ethical theories and different philosophical assumptions produce diverse

therapy ideals, and getting a concise understanding of the ethical character of therapy goals, involve clarifying and justifying the ethical theory to which therapy ideals are tied (Tjeltveit 1999). Hence, what the therapist finds as primary or executive goals is founded in certain theoretical or philosophical ideas. The problem is that the philosophical or theoretical convictions of the therapist might not be compatible with those of the client.

Even if autonomy is widely agreed on as 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. One level may not fit another. An evident and important reflection is to strike a balance between the concern for the individual and the concern for the larger group (Tjeltveit 1999, Rudnick 2002). The point is that goals set by the patient might conflict with values held by the practitioner or society at large. But still normally, the prime candidate to set goals is the client, when not mentally impaired. This means that goal setting should be done first and foremost by the client, as long as they do not involve serious danger and are arrived at competently (Rudnick 2002).

It is difficult to draw any general conclusions about goals in therapy because stakeholders use different ethical ideals. This raises the question: "*… if the goals of therapy are based on conflicting ethical sources, and therapy's effectiveness is evaluated in ways that vary with evaluators' ethical ideals, is psychotherapy (or in what sense is therapy) a coherent professional practice?*" (Tjeltveit 1999, p. 197). This is an interesting thought that goes somewhat beyond the scope of this report. For now, let's just establish that different stakeholders hold different ethical standards, and that this can influence the therapeutic session.

One solution, that has been discussed earlier, say that goals should be set as to best benefit the client. Meanwhile, Tjeltveit (2006) asks what it means to benefit the client. Not all agree that beneficence is the core duty of psychology. Some would point to nonmaleficence (not doing harm) as the main ethical commitment. Kitchener (in Tjeltveit 2006) however disagrees, as this could lead to the argument that no one should be treated as a positive outcome cannot be guaranteed – because the fear of doing harm overshadows the need for doing *something*.

Because of the many ways in which goals can be set or unconsciously pursued in therapy, each therapist has several ways of understanding desirable results of therapy. Some forms of therapy might state that there is no need for goals, and live on the basis of seeing what happens from day to day (Murdin 2001). Cunha, Gonçalves and Valsiner (2010) give anoth-

er example and say that the goal of narrative and dialogical therapy is to redefine narratives and help the client to explore new interpretations and new actions. This is done by helping the patient to adopt a metaposition from which to explore and analyze.

A simple solution to the problem of stating ultimate or primary goals for therapy might be citing such classic, universal definitions as "the goal is a reduction of symptoms" or "the goal is freedom from mental disorder". These approaches are problematic for two reasons:

> 1) All conceptions of "symptoms" and "mental disorder" have an ethical dimension – i.e. harmful dysfunction, describes something scientific (dysfunctional) and something moral (harmful). When claiming that therapy's goal is to reduce symptoms, we are in fact making an ethical judgment about the bad dimensions of the client's life (Tjeltveit 2006). Further, some may not view symptomatic improvement as an aim in its own right. Instead, they might consider symptomatic improvement a welcome side effect of the therapy (Blass, 2003).
>
> 2) Therapy moves clients in more directions than just towards freedom of symptoms. For example it moves the client towards developing in a certain valued direction (Tjeltveit 2006).

The point is that it is well-founded to be reluctant to identify ethical dimensions of goals and outcomes for all humankind. The best life for a particular person may well be different from the best life for another (Tjeltveit 2006). Clients, therapists and managed care organizations advocate certain goals, because they think that they are in some way good – this ethic dimension of the goals is masked by the terms used to define therapy goals (medical necessity, appropriate services, health needs) (Tjeltveit, 2000). The general ethical imperative (as seen for example in the APA[1] code of ethics), has no clear solution to how the psychologist is to balance his obligations towards the individual patient and his obligation towards the society.

As the discussion above show, there could easily be defined ultimate goals for therapy. However, these ultimate goals have their very own implications and issues. The point is that goals have a general component, but a single goal can ultimately not be universally defined for all clients. Now we turn to how one should go about finding out if therapy is successful.

[1] The American Psychological Association

5.5 Evaluation of therapy

The point of discussing evaluation of therapy is related to the ethical problems of ending therapy. Ending (or terminating) therapy is, as we shall see later on, riddled with ethical pitfalls and pragmatic problems in general. To end therapy however, the therapy must be evaluated in some fashion.

The evaluation of therapy consists of two steps. The first is the description of the changes, which are probably the results of the clients' participation in therapy and the second is the evaluation of these changes with reference to explicit value standards (Hiebert 1997; Tjeltveit 1999). There is, however, more to it than that.

Therapy goals vary in their level of abstraction, as we have seen earlier. Therefore evaluation of therapy goals needs a clarification of the level of abstraction. If the level of abstraction is ignored, then apparent agreements might mask underlying differences. But apparent disagreements might also disappear when parties start talking on the same level of abstraction (Tjeltveit 1999). Some stakeholders in therapy define goals and evaluate them in terms that are intended to apply universally – to everyone seeking therapy. Others tailor their goals to individual clients, and evaluate the outcomes accordingly. Most therapists do the latter (Tjeltveit 1999).

However, Hiebert (1997a) states that "*The problem is that in most cases, evaluation is treated as an afterthought, "bolted on to the side" of what counsellors do, rather than an integral part of the counselling endeavor.*" (Hiebert 1997, p. 112). Often though, people know how they are going to evaluate a process before it commences. They even have an idea of how a process is going, while it is unfolding. The criteria might not be explicit, but they are there. However counselors seldom formally evaluate their work with clients – as much as 40% of therapists in some sectors never evaluate their work (Hiebert 1997a). Thus, evaluation is not seen as an integral part of therapy.

Hiebert suggests that we ought to re-think acceptable evidence. Hiebert (1997a) states that until now acceptable evidence has been defined too narrowly. Mostly, evaluation is based on informal evidence. This informal evidence needs to be accepted as valid evidence. An informal procedure for assessment offers the counselor an alternative to standardized testing; they do not create extra work and often enhance the intervention in use. However most of these procedures have not been checked for validity or reliability. Proponents still claim however that these tools can be rigorous – especially when combined. Essentially

there need to be an agreement on what service is being offered, and what will be counted as a successful solution (Hieberts (1997a; 1996b) suggestions have been criticized and extended by Flynn 1997; Hutchinson 1997 and Young 1997).

After this brief introduction into the issues of evaluating goals, we now turn to the termination of therapy, which is closely linked to the evaluation of therapy.

5.6 The Termination of Therapy

The termination of therapy might be one of the most crucial parts of therapy (Tjeltveit 1999). Even so, not much research has been done on the matter. Further, there seems to be no agreement on what constitutes a satisfactory termination in both patient and therapist. Writers and clinicians differ on the views of who should decide when termination is appropriate, the criteria for termination readiness, and how you approach the mechanics of termination (Kramer 1986, Rice & Follette 2003). A problem with the termination of therapy is that the EPNP gives no practical guide on how and when to terminate therapy.

A look at the literature concerning termination of therapy finds that almost no information on termination is based on research findings. Mostly, the writings and studies have focused on the theoretical meaning of termination. Freud stated that "*Termination is appropriate when the instinctual drives no longer interfere with object relations.*" (Karmer 1986, p. 526). The work done after Freud has focused on particular criteria which may indicate that termination is appropriate. For example, Goodyear (1981) found that factors such as the emergence of themes of loss and/or separation, complete or partial resolution of the transference and improvement in critical aspects of ego functioning is good indicators of termination being necessary. However, this is a very loosely defined criterion which allows the therapist to decide to terminate at any time.

Wolman (1982) expands on this and points out that the termination is related to what the goals of the treatment were, and the objective criteria for attaining these goals. Further he states that the universal intrinsic goal of any psychotherapy is to make it superfluous. However the problem is the question of: Is there a natural end to an analysis, or is it even possible to conduct it to such an end? Wolman (1982) tries to define the "natural end" in this way: "*every therapist has the moral obligation to terminate his or her work as soon as further work will not bring additional and significant therapeutic gains.*" (Wolman 1982, p. 195).

5.6.1 Premature termination and forced termination

Even though it can be hard, or even impossible, to define an optimal point of termination of therapy, there is still a broad agreement that therapy can be ended prematurely. If there is a disagreement about the client's termination of the treatment, Kramer says that "*If one truly believes that the primary goal of psychotherapy is for the client to function autonomously, then his or her decision to terminate must be respected.*" (Kramer 1986, p. 529). This of course is a straightforward proposal, but there is more to premature termination than that.

Rice and Follette (2003) distinguish between forced termination, which is therapist initiated and premature termination, which is initiated by the client. Forced termination can be brought about because of extra therapeutic parameters – therapist relocation, retirement, illness or death.

Premature termination constitutes the situation when the client thinks or expresses that he wishes to discontinue the therapy despite the therapist being opposed to this. The therapist must then decide whether this decision is a mature thoughtful decision or if it is a reflection of resistance or avoidance. The APA code of ethics suggests that premature termination should lead to a discussion about the client's needs and views, and lead to counseling about the premature termination process and facilitate the clients transfer if appropriate (Bostic, Shadid and Blotsky 1996, Wolman 1982).

However, failure is often not acknowledged by therapists. Even when therapy is ended prematurely by the patient, we tell ourselves that it was because we opened up to unknown problems of the client – i.e. the therapy was too effective. Or the patients leaving might be the result of newly found strength (Murdin 2001).

5.6.2 Agreed termination

According to Rice & Follette (2003) the ideal approach to treatment termination is described as mutual agreement on termination. This, however, does not always translate into therapeutically effective termination. As mentioned Kramer (1986) found that the therapists in his study did not address termination issues directly with the clients. Rather they used vague, indirect interactions around termination and waited for the client to bring up the subject. Cognitive-behavioral therapists usually advocate an active, collaborative relationship between client and therapists in which they mutually decide upon goal setting, treatment and termination (Rice & Follette 2003, Gabbard 2005).

There is no specific hint to when therapy should be terminated in the code of ethics from APA or EPNP. However, both codes of ethics refer to "scientific knowledge based on research". Taking a utilitarian view (which is one of the ethic foundations of the codes) on this paraphrase, one would think that the specific criteria for ending therapy should be empirically tested. Pope and Vasquez (2007) also states that the APA points out that ideally, the therapist contributes his services as long as it is needed and beneficial. Another relevant question when talking ethics is not so much "when" as "how" the therapist should terminate.

5.6.3 How should the therapist terminate?

According to Kramer (1986), one should ideally have a discussion with the client about termination and the client's views and needs. There is however still a problem with the underlying ethical thought in relation to the APA code of ethics. Rice and Follette (2003) consider it to be either utilitarian or deontological. This gives two different views on how to terminate therapy. If the underlying ethic thoughts are utilitarian, then the termination of counseling should be connected to the therapeutic benefits. If the underlying theory is deontological however, a therapist need only have good intentions, for him to act in an ethically defensible manner. However, Kramer (1986) found in a study with 20 therapists, using the constant comparative method, that "*Many therapists do not have an explicitly formulated plan for concluding treatment*" (Kramer 1986 p. 528). He states that this lack of planning affects the client and adds to the complexity of termination. It seems then, that there is no definite answer to how the therapist should terminate, beyond the mutual agreement that is advocated.

5.6.4 Patient and therapist reaction to termination

There are several reactions that could come about, when the termination is eminent. Rice and Follette (2003) distinguish between client reactions and therapist reactions. These can have implications for ending therapy, and are therefore relevant to look into briefly.

Client reactions to termination might look like earlier problematic behavior (i.e. a relapse). Bostic, Shadid and Blotsky (1996) found that: *"… the more forced termination resembles a client's past losses, the more the client needs to know about the therapist's situation in order to gain some control over their transference feelings and fantasies*" (Bostic et. al. p. 350). This will help them distinguish this situation from prior, but similar, situations.

It is important to focus on the therapist's reactions as well as the client's (Goodyear 1981). If these reactions are not dealt with sufficiently it might lead to an inefficient termination. Common reactions are reported to be feelings of guilt and inefficiency. Kramer (1986) emphasizes the importance of differing between the goals of the therapist for the client, and the goals of the client.

Goodyear (1981) and Kramer (1986) describe the termination as the loss of a relationship and list some common reactions that the therapist might experience. For example anxieties about client competence, which are based on the therapist's "need to nurture", and the fact that the therapist may form overprotectiveness towards the client. Further the therapist might feel guilt, as the therapist has a "need to be adequate". This means that forced termination might make the therapist feel inadequate.

According to Holmes (1997), Howard (1986) found that, the longer a therapy went on, the greater the benefit for the client. However, it is not a linear curve; rather it is a negative logarithm, which means that the return is diminished with each successive session. Clients have different needs for long- or short-term therapy, which means that sometimes termination can be planned; in others it needs to emerge as a theme months or years before it happens.

This concludes the review of the available literature on ethics and goals. Now we turn to the present study and how it is constructed.

6. Metatheoretical foundation

In the following we will take a look at the metatheoretical grounds on which this study stands. This is both to clarify where the thoughts for the research design are based, but also to show where the limitations and possibilities of this approach are. Moreover, this section seeks some clarification of why the phenomenological approach has been chosen over other metatheoretical approaches. Firstly, we take a brief look into the phenomenological field.

Becker (2002) states, that the basic premise of phenomenology is the subjective experience of everyday events. This means that experience is viewed as a valid and fruitful source of knowledge and that our everyday world is also a valuable source of knowledge (Becker 2002). According to Giorgi (1997), the word "Phenomenon" refers to the fact of accepting that any experience is essentially individual but not "wrong" – in the sense that perceptions might differ, but are still "true" to the one perceiving it (Nöe 2007). Therefore a phenomenological analysis begins not in the objective, but in the subjective experience, which will be one of the cornerstones for this study, and the wish for attaining knowledge about the subjective experience of the everyday world, will be another.

Zahavi (2003) states that, the basic understanding in phenomenology is that the phenomenon is what the object *seems* to be. This means that the phenomenon is not the object in and of itself. This first-person perspective is important for the phenomenologist – opposite objectivists who try to eliminate the human subject from science. The first-person perspective is an unavoidable presumption not a psychological triviality. The thing is that every phenomenon, every object's appearance, is always an appearance *of* something *for* somebody (Zahavi 2003). This thought it the foundation for the chosen method of analysis, and will be elaborated on in the methodology section later on.

Turning to phenomenological research, this means that everything that can be experienced and put into words can be researched by phenomenological researchers. The phenomenological research departs from traditional social sciences because the researchers stay close to the topic itself, and try to explore it without forcing it into predetermined categories. Rather they let the topic decide the categories – i.e. our method should be determined by that which actually is, and not what is expected to be found. (Becker 2002; Lévinas 2002; Zahavi 2003). As we shall see later on, this view has a profound impact on the analysis of

this study. However, this study deviates from this formula in that a certain amount of information has been gathered on the subject at hand before conducting the interviews. This will be discussed further in the methodology section in relation to the interview guide (see p. 27).

Giorgi (1997) and Zahavi (2003) criticize the social scientists for having accepted a natural science model of research in an attempt to be accepted as a legitimate science. This model is meant to research objects that are not subjective, and that can be manipulated at will. People however, are not inanimate and cannot be manipulated at will. Rather the research situation is an interpersonal experience for the phenomenologist. The researcher and the participants create meaning together. Therefore objectivity is redefined as being aware of preconceptions. The phenomenologist does not try to eliminate the pre-understandings; rather, the phenomenologist seeks to become aware of them so that they can be set aside (this process is called Epoch) (Spinelli 1994; Becker 2002; Giorgi 1997; Giorgi & Giorgi 2008; Zahavi 2003; Phillips-Pula, Strunk & Pickler 2011, Christensen 2002). However, the idea of epoch is hotly contested. Some would argue that a full epoch is not possible, and that the risk of the full epoch, is to lose the phenomena that is to be studied because it is removed too far from the real life of the participants (Harré in Press). The reason for not choosing another metatheoretical approach is founded in this exact discussion. Hermeneutics for instance could serve the same purpose of investigating the subjective experience that the participants have. However, were the hermeneutic approach tries to embrace the pre-understandings of the researcher as an analytical tool (Christensen 2002); the phenomenological approach is much more interested in the participants interpretations and estimations of a phenomena, and tries to null the biases from the researcher. Moreover, the phenomenological approach accepts that it is impossible to get fully acquaint with someone's point of view (Christensen 2011).

An argument against the phenomenological research is that the only consciousness I have access to, is my own – the analogy argument (Zahavi 2003). Only by observing the behavior of the other, can I learn something about the other's consciousness. Only by comparing my own behavior with that of another, and inferring that the other's behavior is linked to his consciousness like my own, can I analogously understand the others behavior. However phenomenologists do reject the analogy argument. It is not true that you can only observe and infer the consciousness of others; you can also learn about it by having subject telling about their experience (Zahavi 2003, Christensen 2002).

To summarize, this investigation is founded in the phenomenological way of thinking. The reasoning behind this decision will be discussed further in the method section. However, the main reason for this choice is the wish for attaining information on the subjective experience of the phenomena of setting goals in therapy. Next we turn to the specific method for this study.

7. Method

This study is based upon four semi-structured phenomenologically oriented interviews with trained and novice psychologists. The interviews were conducted as semi structured phenomenological interviews (Kvale 1997, Tanggaard & Brinkmann 2010). The choice of interviews as the research method is founded in considerations about what resources were available and what kind of insight was sought. The interview is a common way to attain knowledge of people's opinions, life situation, attitudes and experience (Tanggaard & Brinkmann 2010). Therefore it was a fitting method of research, as this was exactly the kind of insight that was desired based on the phenomenological grounds on which this investigation stands (see metatheoretical section on p. 24ff).

The disadvantages in choosing interviews as the main method of research are many. For example you can never attain a full understanding of the participant's life world. However, this is an issue with all methods, and interviews are no guiltier of this than others. The result of an interview, as indeed with any scientific research, is an abstraction of reality. Nevertheless the goal of an interview is to get as close as possible, and formulate a coherent perspective, for example, in a report such as this one. Moreover the interview gives the opportunity to concentrate on specific individuals' understandings of events, situations of phenomena. This gives the opportunity for a detailed and intensive analysis of a limited number of people's experiences (Ibid.). The advantage of using semi-structured interviews in IPA (Interpretive Phenomenological Analysis) is that the interviewer – in real time, has the ability to follow up on interesting, important issues that come up during the interview.

Even so, you cannot attain all information by using conversation as a research method. Interviews are specifically good at shedding light on relational, conversational and narrative areas. As these areas are the main interest in this project, it seems fitting to use the interview as the research method.

7.1 Interview guide

If the semi structured interview is supposed to work, you have to make it clear what you want to know something about, before you can decide how you want to go about finding it out (Tanggaard & Brinkmann 2010). This was one of the main reasons for producing the interview guide.

Becker (1992) says that the ideal phenomenological interview uses open questions and that further questioning should only be done on the basis of what has come up during the answering of these open questions. Hence, a true phenomenological interview guide is not a useable tool for anything but a couple of startup questions. However, Kvale (1997) and Smith & Osborn (2008) states that the semi structured interview is the most preferable form of interviewing. This is also true for phenomenological research. Further, they suggest that phenomenological analysis is a viable way to analyze data from such an interview. Hence, the present study uses an interview guide, but still uses a phenomenological approach to the analysis.

A preliminary interview guide was produced after attaining some knowledge of the field. Tanggaard & Brinkmann (2010) says that no scientific interview is neutral. Therefore, the attainment of knowledge about the subject matter beforehand is not a problem. Having built an extensive knowledge about the subject, only means that you can ask the most relevant questions (Ibid.). Nevertheless, it is an unsolvable dilemma between not being biased and asking the right questions when talking phenomenological research. Choosing to gather knowledge beforehand and having a theoretical preconception, means that you have to be attentive to keep a continually open mind in the interview situation, as well as in the analysis, which is what the phenomenological approach helps to attain.

The thoughts around the preliminary interview guide were mainly concerned with the question order, asking general and open questions and making the setting casual, as to make the interview participant feel at ease. A main concern was also to make the interview seem nonjudgmental. The participant should not feel judged or evaluated, which could be particularly problematic because of the ethical nature of the topic at hand.

The preliminary interview guide was divided into five subthemes, all concerning a specific part of the research topic. The subthemes included: experience with goals in therapy; establishing goals – wishes and the attainable; evaluation of the therapeutic goals & goals, time and ending therapy (see app. 1 & 2). 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. Besides the research-related themes, the interview guide also had an information-block and an ending-block that was read out loud to inform the participant of his/her rights, obligations in connection with the project, and also get informed consent.

The preliminary interview guide was piloted on a graduate student who had worked as a therapist during an internship on the 8th semester. The preliminary interview guide was

revised following the pilot interview. New questions were added in the third and the last subtheme, as the existing questions did not produce answers that were relevant to the research topic. Some questions were deleted, on the same grounds. For a comparison between the preliminary interview guide and the final interview guide see appendix no. 1 (preliminary interview guide) and no. 2 (the final interview guide).

In the evaluation the pilot participant was asked about whether or not the participant felt judged, if there were any questions that would have been easier to answer, had they come in a different order, and if there was anything that felt uncomfortable or that the participant did not want to answer. The participant answered no to all these questions but stated that the interview had made the participant think about the moral and immoral steps in therapy.

7.2 Participants

The study consists of four interviews with two novice psychologists – Jette and Kirsten, and two experienced psychologists – Laurids and Tyra (these are all pseudonyms). The difference between the four is primarily a result of the availability of qualified participants. The two experienced psychologists were from a department of the psychiatric ward on a major Danish hospital and had between 5½ and 26 years of experience. The two novice participants had only just begun their work as therapists and had approximately two months experience as therapists. The novices were part of a program on a university that was meant to train them as clinical psychologists during their graduate-studies. The participants was somewhat known by the research beforehand. It might seem problematic that the participants were relatively close to the researcher. However, Kvale (1997) points out, along the lines 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 (for further elaboration on this issue see “Putting it into perspective” p.73).

A small sample size (N = 4) makes it impossible to think about representativeness in the form of random sampling. Instead it makes sense to go for a more closely defined group for whom the research question will be significant (Smith & Eatougn 2007; Storey 2007; Smith & Osborn 2008, Valsiner & Sato 2006).

7.3 Interviews

The interviews lasted between 45 and 60 minutes. They were recorded on a digital dictaphone. The two experienced psychologists were interviewed at their workplace in their offices, which are designed for individual therapy, and therefore well suited to interviews of this sort. The two novice participants were interviewed in a 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.

7.4 Transcription

One of the problems with interviews is the transcription. A transcription makes speech static which is counter to the real properties of speech. Speech is, in and of itself, dynamic and contextual. However, all kinds of measurements are a freezing of the properties of that which is measured. This means that transcription is, essentially, not any different from other ways to record data (Kvale 1997, Tanggaard & Brinkmann 2010). Moreover there are certain practical hurdles connected to the transcription as speech is incomplete. A certain amount of information is lost because it is not possible to transcribe body language and voice. The transcription was, as it is recommended, done by the person who had done the interview. Moreover, the transcription was done closely following the interview, which ensured that the interviewer had a fresh memory of the interview while transcribing it (Ibid.).

7.5 Method of data analysis

For the data analysis a phenomenological approach is utilized. Specifically the interpretative phenomenological analysis (IPA) will be the main focus of the analysis. Because it is well suited to exploring topics within health, clinical and social psychology, where there is a need to find out how people perceive and understand objects and events (Smith & Eatough 2007; Storey 2007; Smith & Osborn 2008). This kind of analysis is based on Husserl's idea of philosophic phenomenological analysis. It is, however, modified to fit the human sciences (Giorgi 1997)

Before I go into precisely how the IPA will be utilized in this study, there is certain issues that have to be addressed concerning the method. First of all it is the basic understanding of phenomenology that the researcher also has an active role in this kind of research; it depends on and is complicated by the researchers' understandings and biases. This means

that there is a double interpretation – the participant is trying to figure out how and what he perceives, while the researcher is trying to perceive how and what the participant perceives. Further an IPA will always be partial; it can never be the final word on the topic. This is partly because the IPA is an ideographic study, focusing on individual case-studies – i.e. it cannot be generalized in accordance with quantitative standards (Smith & Eatougn 2007; Storey 2007; Smith & Osborn 2008). However random sampling relies too heavily on assumed "randomness" in the selection of participants into samples, it overlooks by default the person-environment interaction. Sampling large amounts of participants does not ensure randomness (ibid.). Further, a person cannot be reduced to statements in a questionnaire, but has a history and social foundation as well (Valsiner & Sato 2006). Salvatore and Valsiner (2010a, 2010b) clarifies this and states that no two psychological objects can be the same because of their finite and limited traits, characteristics etc. - no matter how many are shared, the phenomenological whole will always be different. Further, they point out that induction is not the only way of generalization – hence, you can still generalize from ideographic knowledge by abductive inference. Abduction is the examining of a mass of facts and allowing these facts to suggest theory. This give us new ideas, but the reasoning is unforced (Ibid.).

Another critique could be that the IPA is not prescriptive – i.e. the "prescriptions" of the method is not fixed, but are to be considered guidelines within which some variation is allowed (which Smith & Eatougn 2007; Storey 2007; Smith & Osborn 2008 amongst others specify). If the method is non-prescriptive (in the sense that much of the IPA literature leaves room for interpretations and adaptations of the method), how is it to be controlled by others? (Giorgi 2010). The thing with qualitative research is that the process is not equivalent to the carefully prescribed procedures of quantitative research. It is the intellectual and intuitive work on each stage of the research that gives the results in qualitative research. Doing good IPA is therefore based on being good at interviewing, analysis, interpretation and writing and not on conscientious following of a procedure. This means that good IPA is as much related to the skills of the researcher, as it is to the procedure. Therefore, an actual prescription cannot be given, only guidelines can be offered (Smith 2010). This is actually where the IPA gives room to the phenomenological thought, by letting the data decide what is important in every case. And, if this is individual for every case (which is the central idea of phenomenology), then there can be no specific rules. However, the way to counter any misunderstandings is to make the method clear. This is done in the present study by including appendixes 3, 4, 5, and 6 (titled "Raw analysis material for -NAME-") ,

which shows how every category/theme has been found in the original data, and this allows the reader to check the results (Smith 2010).

Further, Giorgi (2010) has criticized the IPA for not being replicable. However, according to Smith (2010) replicability is not necessarily something that a qualitative researcher should aspire to. This kind of research is a complex, interactive, dynamic process, and it is not entirely clear what one should expect to replicate. Two interviewers cannot be expected to make the same interview. However, this does not mean that the interviews are bad or unscientific. It means that the evaluation should be done on different grounds. Moreover, ideographic studies focus on unique cases as the main way to approach psychological phenomenon and generalization is achieved through replications of ideographic analysis with different single cases. (Del Rio & Molina 2008).

Turning more specifically to the analysis multiple writers has established that there are four to six basic steps to the IPA (see Smith & Eatougn 2007; Storey 2007; Smith & Osborn 2008; Becker 2002; Kvale 1997; Phillips-Pula, Strunk & Pickler 2011; Giorgi 1997 and Giorgi & Giorgi 2008).

The four steps are generally described as follows. The first step is to read the transcripts thoroughly to gain a holistic perspective of the data. This is to secure 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 (see app. 11 for master table). Lastly a narrative account is produced based on the interplay between the interpretation of the researcher and the participants' account of their experiences. This structure is common for all the interpretations of an IPA. If a writer states that there are five or six steps, more often than not, it is a question of further splitting up the steps mentioned before or including practically oriented steps (Smith & Eatougn 2007; Storey 2007; Smith & Osborn 2008). These four steps will be used in the analysis of the interviews in the present study (see appendixes 3, 4, 5, 6 and 11). However, where the present study might differ from the guidelines, is in the condensation of categories. The present study utilizes very narrow categories, in the sense that they are very minutely described. This means that the referencing of these across the four interviews will be very minute and very accurate in their similarity.

After this extensive discussion of method we turn to the reporting of the results of the interview and the analysis in accordance to the phenomenological approach and the literature that was reviewed.

8. Analysis

After reading through the transcripts of the four interviews, refining themes and then clustering and collapsing the themes into meaningful categories it was apparent that the participants' accounts clustered around as much as 19 themes (See appendixes 3, 4, 5, 6 and 11 for an insight into the process). Hereof ten themes were chosen to be a part of this report. The ten themes that have been chosen were decided upon by determining what themes answered the original problem formulation. The remaining nine themes were in and of themselves interesting, but were either not as well supported as the ones expanded upon here or did not have anything to do with the problem formulation. Having themes that are not a direct answer to the problem formulation is of course a result of the phenomenological approach to the analysis.

8.1 The function of goals

In the interviews the participants gave accounts on what the meaning of goals are and what their function are etc. This was mostly to gain insight into how the participants viewed goals in their work. The most prevalent finding in this theme was that the goals have the ability to direct therapy. This is perhaps best underlined by Jette who says:

> J: […] jeg synes det har været utroligt hjælpsomt og have en proces hvor man ligesom afklarer "hvad er det vi skal" i den her terapi. […] fordi jeg tidligere oplevede andre metoder hvor man sådan set bare går i gang med det samme. Og ikke rigtig ved [...] hvor det skal ende henne (App. 10, l. 36-38).

Jette's account emphasizes that goals are very helpful in the therapy, as they make clear "what we are doing". Further, Jette underlines how she has experienced other methods that did not utilize goals, and that these methods did not seem to help her identify where the therapy was meant to be going. The problem with letting these goals direct therapy is that the therapist and the client potentially could have differing ideas about the goal of therapy. What is hinted at here is the danger in paternalism that is defined by Tjeltveit (2006). And even if the therapist does not want to impose his/her goals, setting goals is still unquestioningly tied to the theoretical stance of the therapist. However, as shall be discussed later on, therapy is inherently an unbalanced situation. The therapist knows more than the client, and is therefore in a privileged position. According to the EPNP, this leaves the therapist with an enhanced responsibility and he/she is required to act accordingly. This

means that he has an increased responsibility to make sure that he/she does not misuse this information.

Jette expands:

> J: […]men bare det at have et udgangspunkt det tror jeg har hjulpet begge parter også til […] at forstå hvad er det der skal ske i det her rum? […] det kan godt være man siger "okay, vi skal […] have hjulpet dig med de her ting specifikt", men det er mere det at man får talt om det på en måde som er terapeutisk, så klienten lærer hvad er det egentligt der foregår herinde. Det er det som jeg synes er det bedste ved at sætte mål […] (App. 10 l. 40-44).

Here Jette specifically goes into why the goals are good. Not only do they direct therapy, but they are also valuable in teaching the client what is going to happen in the therapy. Goals might be very specific, but the most important thing is to talk about it in a way that teaches the client the discourse of therapy. This coincides with the notion that the therapist should make the advantages of therapy visible to the client and society, which is discussed by Øvreeide (2002). Hence, setting goals is a way of ensuring that the patient can see the point (and advantages) of therapy. Moreover, it is a way to make the profession more transparent to the client and his surroundings, which is one of the main concerns of the psychologist (Ibid.).

Another finding was that goals have multiple meanings, as well as multiple functions as identified above. In the following, Laurids talks about how goals are something you work towards. The goal could both be that the client gets relief from his/her symptoms, but also that he/she gets more insight into himself:

> L: […]Målet vil altid være at, at patienten får det bedre, får en lettelse i sine symptomer, eller får lettere ved at klare dagligdagen […]Det er ligesom for mig at se målet […] Sommetider er der jo så nogen der, […]måske ikke sådan, objektivt set [får det] bedre, men så får de til gengæld en større selverkendelse og måske en større bevidsthed om deres begrænsninger, og det kan så hen ad vejen gøre at de så igen klarer tilværelsen bedre fordi [de] måske ikke i samme grad lever på nogen forestillinger som ikke eh stemmer overens med virkeligheden (App 8. l. 29-35).

Here, the multiple functions of the goals are underlined in the fact that Laurids points out that not all patients feel that they, objectively, get better, but instead they might be able to

handle their life better, because they do not live on the same assumptions about reality as they did before. Here Laurids touches upon what Rudnick (2002) has called the "ideals for the client in particular". The societal ideal for therapy might be that the patient gets "cured" in some sense; however Laurids states here that the goal of therapy might as well be teaching the client to handle their life better than before. This might be a discrepancy between the goal of the society and the goal of the therapist. Even if the society has an established goal that states that clients should be cured, Laurids states that his personal goal is to give the client an easier life – not necessarily a cure. This further supports Rucnicks (Ibid.) idea of different abstractions of goals (see review p. 17).

Lastly one of the functions of goals is to avoid misunderstandings. This is both to secure that the therapist does not get a false impression of what the clients wants from therapy, but also to ensure that the client does not misunderstand what it is possible to gain from therapy. Kirsten explains:

> K: […]jeg tror at det er en fordel […at] man kan komme udenom misforståelser. Jeg kan komme udenom at […] klient[en] forventer noget helt andet af dig end du kan tilbyde. Hvilket også er derfor vi gør[…] meget ud af på (KLINIKKEN) [at] snakke om målsætninger og forventninger også til deres forventninger til mig som terapeut. […]mange kommer og vil gerne have nogle redskaber […] det er jo ikke det vi sådan tilbyder på (KLINIKKEN) […] men sådan mere indsigtsgivende terapi […]. Så det er ikke så vejledende og guidende som det er mere og skabe indsigt og forståelse i nogle problemer de har. […] (App. 7, l. 44-51).

Here Kirsten clarifies how clients might expect one thing from therapy, and how she has to explain what she can and cannot help the client with. Therefore goals, as set in the beginning of therapy, serves as an important "first barrier" to avoiding any ethical problems in the direction of the patient expecting too much of the therapist and the therapy.

8.2 Revision of goals

So, the goals have the ability to direct therapy if we are to believe the statements above. However one of the most prevalent findings in the study was that goals are not fixed. Rather, they are fluent and can be revised for different reasons. This is seen both in the interview with Tyra, Jette and Kirsten:

> T: […]og at at de mål man sætter jo kan, ka, altså, må være lidt på hypotese-plan måske altså i forhold til at man også må kunne justerer på det […](App. 9 l. 28-29).
>
> J: […]man skal have en problemformulering som man altid måske kan sådan lige ændre ved […] (App. 10 l. 69-71).
>
> K: Nej, det tror jeg ikke det er. Jeg tænker tit godt man kan revurderer det […](App. 7 l. 277)

It seems that goals can be revised, and that it is a very common thing to happen. Almost all the participants said directly that revision is possible, and that goals are not fixed as such. Goals can apparently be revised if they appear unattainable, this is both to secure that the patient does not have a bad experience with therapy but also to give the therapy a focus that is actually attainable. Here it is made clear by Laurids:

> L: […] Sommetider må man jo også revidere målene, og det er så en anden side af sagen, ikke også, at en patient […] magter mere end man måske tror ikke også, eller en omvendt en patient magter mindre end man måske troede da man måske troede da man gik i gang. Såehh. Og det gælder, selvfølgelig, man selv har måske nogle mål og patienten har måske nogle mål, det viser sig så at de [ikke kan] indfris (App. 8, l. 52-59).

The reason to revise the goals could also be because the therapist finds that the client can handle more or less than what he/she originally thought. Moreover, the client could have an idea of being "a good client", which is what Tyra points out in the following:

> T: […] Altså jeg har været udsat for flere gange at når folk starter så må vi, så sætter vi nogle mål fordi de også gerne v, vil være gode patienter lige når vi starter, de vil gerne lyde som om det kan vi jo nok godt nå (smågriner) og så når man, arbejder videre med dem så viser det sig, at, personlighedsstrukturelt […] står det måske værre til end man lige så i udgangspunktet (App. 6, l. 270-274).

But revisions are not only made when the goals seem unattainable. The participants also stated that revisions can also occur because of the goals being fulfilled, which are pointed out by Jette:

> J: Altså det mest, forhåbningsfulde er jo at de bliver nået, og derfor ikke længere er nødvendige (App. 10, l. 214).

Here, Jette explains that it is the hope that a goal will be fulfilled, and therefore changed. Another reason to redefine a goal was mentioned by the participants. Apparently, the most common reason to revise goals is because the patient and the therapist finds a new, more relevant focus, as is underlined in the following statements from Tyra, Jette and Kirsten:

> T: Nogen gange må noget man starter med som noget man troede skulle være en indsigtsgivende terapi, jo blive til en mere støttende terapi, øh, der kan ske mange ting i deres liv undervejs, der gør at man må justerer, så, mål er for så vidt fint, det må bare ikke være det styrende, øh, alene, man kan godt have det som en ide at det er der vi prøver og arbejde os henaf, så der kommer noget retning i terapien (App. 9, l. 34-39).

> J: […] især når man går i terapi, så sker der så meget omstrukturering, så jeg er sikker på at om nogle måneder så skal vi tage vores problemformulering op til revision, og sige, er det stadig det her vi skal? (App. 10, l. 209-212)

> K: Eller sådan, at man faktisk har nået igennem det lidt mere end man havde før, så må der, så kommer der noget andet som bliver sådan mere aktuelt, som sådan faktisk først er blevet aktuelt fordi man har forstået det andet mål, hvis det giver mening. (App. 7, l. 279-282)

This means that one of the most common reasons to revise a goal is because of a change of focus, which has been brought about by new insights, which are attained by the client. This means that the exploratory process of therapy has been successful, and could even mean that therapy as a whole has been successful. However, it could also mean that the patient only now realizes how serious his problem is, and that the process of therapy has only just begun.

Lastly, one "revision" or change of focus is if the client does not want to set goals. All the participants suggest that if the client does not want to make goals for therapy, the intrinsic goal of therapy will be clarifying why the client does not want to set goals. This might not be considered a revision of goals for some, but it is however an alternative goal and not setting a goal would make the therapy "directionless" if we consider what was said earlier about the functions of goals. However, Laurids, Jette and Kirsten all pointed out that if a client did not want to set a goal, then the goal would be to find out why. Kirsten extends:

> K: Så arbejder man med hvorfor de ikke vil sætte et fokus. […] der må være en grund til at de ikke vil have det. Og så (smågriner) vil jeg tage det som fokus […] Og arbejde med hvorfor de ikke […] vil have et fokus. Hvad det så egentlig er de ønsker ud af terapien […] Er det så fordi du ikke vil være i terapi eller, hvorfor er du så kommet her? Og så vil jeg arbejde med hvorfor de ikke har et fokus, eller hvorfor de ikke tænker der er noget [..] for dem. Hvad de så forventer at jeg skal gøre. Tænker jeg, så ville det være lidt et fokus i sig selv (App. 7, l. 545-547).

Hence goals are not fixed as such. There might be an overall goal of therapy to better the client, but the goals of the individual client are not fixed in any way. However, they are still necessary to direct therapy and if the client does not want to set goals, then "getting the client to set goals" must be the goal of therapy.

This revision of goals could be seen as a result of an interpretation of the EPNP's (2006-2008) guidelines about respect. Setting goals could be, more or less, an invasive act and being open to revisions, is a way to secure that the client is still a part of the process. However, changing goals in and of itself is not an act of respectfulness. Changing goals in therapy must be done in cooperation with the patient to be truly respectful. Meanwhile this is more or less what is depicted by the participants. That the goals can be revised both in a negative and a positive direction might be the ultimate expression of respect for the client. Instead of keeping the client clinging to the illusion of being able to reach unreachable goals, the participants would rather revise them accordingly. This is of course also an expression of the EPNP's guidelines about competence. Surely, a therapist who does not revise the goals of the therapy according to his clients' capabilities and level of functioning would be viewed as incompetent. One of the main problems when talking revision of goals is making new goals when the old ones have been fulfilled. This is connected to the concept of the "never-ending" therapy, which will be discussed later in this analysis. Defining new goals upon reaching old goals is, of course, basically a good thing – working with issues that have already been covered is not necessary. However, continuous revision of goals, would keep the client in therapy indefinitely. The participants in this study worked at places that were free for the client. This resolves them of any economical accusations. However, even if the therapy is free in the economical sense of the word, surely it is not free in the social sense of the word. No matter why you enter therapy, it is always connected with some form of social stigma (Eisenberg, Downs, Golberstein & Zivin 2009). You could argue that prolonging this stigmatization by revising goals continually (and possibly keeping them in

therapy longer) is unethical, and might hurt the client more than the therapy is helping them. If this is so, there is a conflict with the guidelines of responsibility from the EPNP in that the therapist should be aware not to do any harm. This point is however pure speculation and it was not brought up by any of the participants.

8.3 The will of the patient

When talking about goals with the participants, it quickly became apparent that the client has a big part in deciding what the goals should be and how they should be defined. Goals should, according to the participants, be set in accordance with the wishes of the clients and should be based on a negotiation between the client and the patient. Tyra explains:

> T: Jamen, jeg lytter meget til eh, hvad det er folk finder vanskeligt, smerteligt, og prøver at tage udgangspunkt i det. Og […] så sørger jeg altid for at sætte det sammen, med noget af det jeg hører […] sådan at der både bliver taget udgangspunkt i det de umiddelbart kommer med, men også at jeg som professionel har en vurdering med indover. […] jeg prøver altid at få det til at hænge sammen, sådan at det giver mening for folk, […] fordi hvis jeg ikke havde det med, så tror jeg […] ikke folk ville føle sig mødte hvis jeg bare turede igennem […] med mine ideer om tingene (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 patient, the danger is that the client might feel misunderstood. This notion to listen to the client might also be based on the fact that there are no universal goals for all human beings (Tjeltveit 2006). Therefore, listening to the client is a way to identifying what the specific client finds important.

This leads us to another one of the most prevalent findings in this study. 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 statements from the four participants:

> L: Ja, så vil jeg sige så bestemmer patienten som regel, det vil jeg sige. Fordi, hvis ehm, man nu vil forsøge og trække nogle målsætninger ned over patientens hoved som patienten ikke er indforstået med så tror jeg ikke det, det er særligt befordrende for terapien […] (App. 8, l. 147-149).

> T: Jamen, jeg tænker ikke at jeg hjælper dem til at se. Fordi […] jeg stiller jo åbne spørgsmål, så det er jo dem der kommer hen til et eller andet […] Vurderende omkring det (App. 9, l. 486-487).
>
> J: Men altså, jeg holder fast i at det må være klienten der bestemmer hvornår at, at det skal være, at det skal afsluttes (App. 10, l. 283-284).
>
> K: Men klienten kan vælge sige "nu har jeg fået det bedre og nu har jeg nået det jeg ville, stop", så er det vel den der tager den endelige beslutning om han, klienten mener de nået til deres mål (App. 7, l. 343-344).

From these statements it is very apparent that the client always has the last word. This 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 therapists in this study. However, what was very prevalent was that the clients and therapists do not always share the same goal, or at least not the idea of what focus the therapy should have.

> J: [..] jeg tror ofte klienten kommer ind med en forestilling om hvad der er galt eller hvad der skal løses, og det er ikke altid man som, øh, terapeut er enig i det. [...] Så hvis man kan mødes på en eller anden måde så tror jeg at det er det bedste (App. 10, l. 26-29).
>
> K: [...] altså hende som jeg har nu altså som klient [...] hun kom med noget hun jo gerne ville arbejde med, øh, hvor vi har haft nogle forsamtaler øh, hvor jeg sammen med min supervisor også har snakket om hvad jeg skulle tilbyde som et mål også [...] som vi oplevede hendes problemstilling, var vi nødt til at have det her fokus med for at vi kunne arbejde med det hun gerne ville arbejde med (App. 7, l. 37-41).

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. However, the therapists who participated seemed to counter this problem by stating that they did not try to force the client to do anything they did not want to.

> T: Jeg er altid meget klar på at sige, det er jo ikke mig der skal vælge hvor vidt du skal være der eller ej. [...]så igen så tænker jeg at det må hele tiden blive en erfaringsdannelse over i dem, at de skal finde ud af at det, det er ikke det

> her jeg vil. Det skal ikke være mig der mener det, selvom, jeg kan jo godt sidde med tanken (App. 9, l. 474-479).
>
> J: Altså man kan, man kan ikke presse ham til noget han ikke er klar til endnu, så det er jo ham der sådan set styrer processen, og det er mig der er nødt til at skulle være nænsom [...] (App. 10, l. 137-138).

Here, the participants both state that you cannot force the clients to do anything they do not want to. They also underline the problem of the therapist having another concern than just what the client thinks it should be. Still, what is important here is that the therapists are aware that they should take care not to try and force their ideas upon the patient, even if they think they are right.

What the therapist should do is to try and give the patient the information he/she needs to make an informed choice about his/her problematic situation. Jette explains:

> J: Altså hvis jeg nu fornemmede til december at [...] han havde brug for noget ekstra tid, så ville jeg foreslå det [...] og jeg ville gøre rede for hvorfor jeg tænkte sådan. Ehm, men jeg vil lade, beslutningen [...] være op til klienten selv. Ehm, men jeg går meget ind for at [...] man skal informere klienten rigtig grundigt om hvad det er man, man tænker i terapi [...] det der med den [...] skjulte dagsorden er noget jeg, eh, tænker det er sådan lidt som en, en træls nødvendighed. Ehm. Altså brugbar men, jeg ville ønske at man bare kunne være helt åben altid og sige alting, ehm. Så [jeg'] begyndt sådan ligesom og, og forklarer grundigt hvad, jeg vurderer at du måske kunne bruge lidt mere tid, hvad siger du til det, og sådan, og så ville det så være klientens svar der afgør det (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 want to continue. To give the client a chance to decide, Jette is a proponent of giving the client all the available information about his current situation. This, in order to give the client the best possible scaffolding for making a decision that will benefit him the most. This seems in accordance with the guidelines prescribed by Hare-Mustin et. al. (1979), Wolman (1982) and Tjeltveit (1999). The therapist should aim at giving the client enough information so he/she can make his own decision. However, some clients might be so impaired that this is not possible. Moreover, there is an inherent problem of communication not being neutral. To present the client with "all the facts" might not be as

easy as it sounds at first, and the client might think of “facts” as “recommendations” or “advice”, rather than neutral information about the current situation. This will be extended upon in the discussion on page 65ff.

In all this, what seems most important to the participants is ensuring that the client maintains his or 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 recommendations of Tjeltveit (1999) and Wolman (2002). Tjeltveit and Wolman even go as far as saying that the maximization of free choice should endure even if the wishes of the client at first seem inadvisable. This, however, is where the ethical dilemma starts to occur. The question is if the will of the patient (the patient’s free choice) should supersede the therapist’s estimations? 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 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. Hence, if the inadvisable goals of the client are harmful in some way, the therapist should decline the suggestion. However, forcing the client to do anything that he/she does not want to is, of course, not an option. This is pointed out by both the participants and the EPNP. Moreover, as Murdin (2001) points out, the patient’s judgment might be impaired by his disorder. Further, he/she might be too focused on attaining happiness, instead of the pain he/she feels. This is both too narrow and too wide a definition – too narrow because it does not encompass slight improvement etc. as a goal; and too wide because “attaining happiness” is too diffuse – and is therefore unattainable.

What is unfortunately never really explored in the present study is if the participants focus on the client having the last word, is really an excuse not to make any decisions that might cause the client distress. According to the EPNP *some* distress is acceptable as long as it does not outweigh the benefit. In some situations, the client might choose a certain course of action because it seems to be less distressing than all other alternatives. Then the therapist is left with a choice – should he/she do as the client wishes, or should he/she push onwards with the more distressing alternative if he/she believes it will be more beneficial. When confronted with this alternative, it is comfortable for the therapist to rely on the “free choice” of the client. Of course, the therapist can rely on the EPNP to provide the foundation for his choice – either he/she is respectful towards the patient’s wishes or he/she is trying to act competently. But what is best for the client? Let us look at this problem forthright.

8.4 What is best for the client?

The problem that was dealt with above leads more or less directly into the next theme that appeared in the interviews. The issue of setting goals might not be as problematic if it was only dependent on the wishes of the client. However, the therapist also has to consider what is best for the client. The problem here is to discern when the therapist's ideas/goals are more beneficial to the client than what the client himself can come up with.

It was found that the therapist might employ different therapeutic "tactics", as to make the client see things the "right" way. In the following Laurids points out that forcing the client to do anything is, of course, immoral, but he also states that he hopes that the patient will see things "the right way" eventually. This idea of "the right way" is of course interesting, but is a concept of mine and not the participants. However the therapist assuming that there is a "right way", shows that he also has an idea of what this "right way" is. The therapist could also harbor another opinion on this matter. For example, he could work from the assumption that "the right way" is held by neither the therapist nor the client, but rather it is a negotiation between the two. Laurids explains his position:

> L: Fordi, hvis ehm, man nu vil forsøge og trække nogle målsætninger ned over patientens hoved som patienten ikke er indforstået med så tror jeg ikke det, det er særligt befordrende for terapien, man vil så måske prøve og se om man kan finde nogle kompromiser ikke, eller sådan, ehmm, altså, så arbejder vi på det der er dit mål [men] jeg synes nu også det er et problem […] at du drikker for meget i din fritid [men] patienten synes ikke det er et problem […] så ville det nok være taktisk uklogt og så fastholde at vi skal snakke om alkohol når patienten selv gerne vil snakke om depression eller angst ikke, så kan man jo så håbe hen af vejen at vedkommende måske kan se at, at der er en forbindelse. (App. 8, l. 159-157).

Tyra is the one in the present study that most prevalently expresses the idea that there are ways to make the client see things in a certain light. She does not express it directly though. She claims that she uses open questions when it comes to difficult situations where she is not supposed to act like a judge.

> T: Jeg forsøger og øh, stille mange åbne spørgsmål, når de kommer og fortæller hvad der sker. Og jeg forsøger at gøre det til deres projekt at finde ud af om, om det er sådan de ønsker det skal være. Jeg er altid meget klar på at

> sige, det er jo ikke mig der skal vælge hvor vidt du skal være der eller ej (App. 9, l. 470-474).

But Tyra exemplifies her supposedly open questions like the following:

> T: Og hvad er det så du vil? Skal det blive ved med at være sådan? Altså hele tiden de åbne spørgsmål ikke (App. 9, l. 524).

The first of her questions is clearly open. It leaves room for the client to expand in the way that he/she wants to without necessarily coming to any exact conclusion. The second question is however not an open question. The question "Should it continue to be like this" (my translation), is a question that can only be answered with a "yes" or a "no". Moreover, you can argue that the question is also loaded. Answering "yes" to a question like that might entail that you intend to leave everything like it already is which is hardly the point of therapy. This is, in my interpretation, "tactical" tools at work. By asking a supposedly open question, Tyra is "making sure" that the client eventually sees things "the right way". Thereby she also expresses that her idea of what is right and wrong is the "right way" to see things.

Kirsten softens the impact of the above statement by shedding some light on why the therapist would want to hide anything from the client and explains more precisely what it is that the therapist might try to make the client see the "right way".

> K: [...] Hvad er mine terapeutiske hypoteser, og hvad er mine terapeutiske mål og hvad, altså sådan, hvor meget kan jeg tillade mig og have liggende under inden for deres. […] jeg sidder jo hele tiden med en viden som de ikke bliver indviet i. Så på den måde kan man jo ikke rigtig [...]gøre så meget ved det. Så skulle jeg jo indvie dem i alt. Men det kan man jo ikke. Og det ville slet ikke være gavnligt og indvie dem i alle de hypoteser, de mål jeg tænker kunne være. Øhm, så det tænker jeg det, det kunne skade mere end det gavnede faktisk. Så derfor ville man holde det for sig selv (App. 7, l. 493-499).

Basically Kristen states that you can't initiate the patient into everything that goes on in therapy. Some of the hypotheses that the therapist is working in accordance with might even be incomprehensible for the client. Hence the therapeutic effect of telling the client everything might even be negative. This means that Kirsten thinks that "secret goals" or "hypotheses" are all right, so long as it is therapeutically sound to have them. This was ex-

panded upon in the review section. Additionally, Widiger and Rorer (1984) say that revealing all therapeutic details would be counterproductive in therapy.

The point in playing the "tactical game" of therapy is then to try and help the client in the best possible way. What might seem to be dishonest and furtive is really the therapist's attempt to help the patient see things the way they should be seen. This, however, necessitates that the therapist is and can be fully neutral and objective in his statements.

Jette states the following:

> J: Og det synes jeg selv er lidt uetisk at [...] at så har jeg en opfattelse af at, at sådan er tingene og så skal jeg bare forsøge at få ham til at se det, ehm, fordi det er jo ikke sikkert at tingene er sådan, det er bare min opfattelse af det. Såh, ehmm, det det, ja, jeg synes helt klart der ligger en masse magt i den rolle vi får, øh, som godt kan komme ind og blive et problem i rummet. (App. 10, l. 400-404).

Here Jette questions whether her convictions about what are the problems and how they should be worked with are the right ones. Just because Jette sees things one way she is not certain that this is the right way. Jette acknowledges that there is a possibility that the patients' ideas might be "just as right" or even more so, than what Jette think. Tyra is, in spite of her earlier statement, somewhat in agreement with Jette on this and says the following:

> T: Altså, jeg skal ikke bestemme hvad der skal komme ud af indsigten, men de fleste, hvis de begynder at tænke sig om, i forhold til at kæresten slog dem fordi at maden kom fem minutter for sent på bordet, kan jo godt begynde og tænke: "Okay, det er ikke helt rimeligt det her". Og, og så forsøger jeg jo altid og sammenholde det med, mange af dem har jo tidligere livserfaringer […] hvor, hvor de har måtteh, øh, altså, hvor de er blevet grænseoverskredet ogeh brugt og dit og dut og dat, altså, og så prøve og sætte det sammen med det. (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 *do* know better. What is true in this presumption is that the therapist possesses a certain kind of privileged knowledge (see Øvreeide 2002). This means that the therapeutic situation is inherently unbalanced. However, the therapist's knowledge is qualified by education, experience and research. This means that even if the situation is unbalanced, it is so with reason. The psy-

chologist should be qualified to know things about the client, that the client themselves are not aware of. Taking a phenomenological approach to this issue, you 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 problem is, if it is really 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. Before we dwell too much on this speculative idea, we must first consider Murdins (2001) aforementioned statement. Some clients are simply too impaired to make any qualified decisions. So, is Tyra doing anything wrong? Not necessarily. Assuming that the patients she works with are very impaired (and they often are, otherwise they would not attend the psychiatric ward where Tyra works), she is merely taking care that the client is seeing things in a more objective fashion in spite of the client's disorder. You could of course question the supposedly open questions as a fitting tool. Loaded questions are a valid exploratory or insight-giving device (Hill 2009). However, using loaded questions to change the opinion of the client is not alright when you consider the EPNP guidelines on respect and competence. The explanation as to why one of the participants is using loaded questions might have something to do with the inherent understanding in different theoretic schools that the therapist simply knows better (Spinelli 1994). This then, Spinelli says, is caused by the therapist relying unquestioningly on the theories to which he/she or she adheres.

8.5 The responsibilities of the therapist and the client

On asking the question about "Who has the responsibility for goals being reached?" the answers where very similar all across the board.

> T: […] det har vi jo begge hvis vi har aftalt et mål (App. 9, l. 138).
>
> K: [...]Det har vi begge to. At jeg kan ikke terapeut, gøre hele arbejdet, at det kræver også en indsats af min klient (App. 7, l. 195-196).
>
> J: Det synes jeg også er et fælles ansvar. Øh, fordi, jeg, jeg sætter nogle evner og ressourcer til rådighed for at han kan arbejde med de ting han vil, og jeg har fra starten af gjort det klart at det er ham der skal lave arbejdet, selvom jeg hjælper ham, så er det hans opgave at løse det her (App. 10, l. 146-148).

Clearly, the main part of the participants believes that reaching a goal is as much the responsibility of the client, as it is the responsibility of the therapist. The reasoning is that the client has to do some work as well and that the therapist can only offer different tools and

insights – he/she cannot do the work for the client. Nevertheless, by shifting the responsibility towards the client, the therapist can claim innocence if the goal is not reached. As Murdin (2001) states therapists are masters at turning the unsuccessful outwards. Therefore, stating that the client and therapist have a shared responsibility for reaching goals becomes a fail-safe to not being blamed for lack of success in therapy. If this is the case, it is of course an unethical practice when we consider the EPNP's guidelines on both responsibility and competence.

However, Laurids answered something entirely different to the question about who has the responsibility for reaching goals:

> L: [...] det er vel den [...] behandlende part eller den som behandlingen er uddelegeret til og det vil, i hvert fald i vores tilfælde, sige det er altid psykologen der har ansvaret (App. 8, l. 193-194).

Here it is clear that Laurids considers it the responsibility of the therapist to make sure that the goal of therapy is reached. Why Laurids is of another opinion than the other participants is not clear, and why he is disagreeing with Tyra is somewhat of a conundrum. As stated earlier, they both work in the same public psychiatric ward, and should abide by the same rules on the matter. However, that Laurids states that it is his responsibility to reach a goal does not mean, that he does not think that the client should not do any of the hard work. However, stating that it is the responsibility of the therapist to reach goals shows a somewhat different approach to the subject. Tjeltveit (1999) states that preserving autonomy, is a typical westernized approach to therapy. He states that this is a Kantian way of perceiving autonomy, which makes autonomy more important than the outcome of therapy. If we presuppose that the “shared responsibility”, that is cited by three of the participants, is a way to let the clients keep some of their autonomy in therapy, it is evident that three of the participants adhere more closely to this Kantian idea of autonomy. Does this mean that Laurids is more concerned with the outcome of therapy than the other participants? Possibly. Or maybe it is simply a question of experience. Laurids has 20+ years of experience as a psychologist, and the other participants have between two months and five years of experience. Through this experience Laurids might have learned that ultimately, it always falls back on the therapist, and therefore his answer is different from the others. His answer might also be different simply because he is more comfortable in positioning himself as a figure of authority after more than 20 years of experience.

The main reason for the participants to cite shared responsibility was that the therapist cannot do all the work. Surely, Laurids would agree on this. And there is the possibility that he interprets the question in a slightly different way that the other participants, hence giving a different answer. Instead of interpreting the question in a therapeutic direction (who should work most to reach a goal), he interprets the question in a more legal sense (who has the legal responsibility for reaching a goal).

What all the participants did agree on, is that a (Danish) therapist should always abide by the EPNP, which has been discussed earlier. Here it is exemplified by Kirsten:

> K: […] Der er jo helt klart nogle etiske vanskeligheder. Hvilket også er derfor man [...] skal oplyse om, at jeg jo er underlagt tavshedspligt, men at jeg også [...] skal følge de love og de etiske principper der er. Altså sådan, øhm, så man ikke bare lige pludselig, når de, hvis de kommer og fortæller mig, ehm, "jeg misbruger min søn" at så "Ups, det er jeg faktisk nødt til og indberette", [...] så kan jeg have handlet etisk ukorrekt ved faktisk ikke og oplyse dem om det, de troede de kunne fortælle mig alt muligt[…] Så kan det etiske godt clashe med det, det, med det man sidder i terapien med (App. 7, l. 558-566).

It is evident from the above that the therapist should always be aware that he/she is assigned to certain ethical principles. Moreover, he/she is obliged to tell the client about his duty towards these principles. Hence we have come across another responsibility of the therapist. Here Kirsten is more or less citing the EPNP. The EPNP states that the client needs to know that the things that are said in therapy will go no further. However, there are certain exceptions, which is what Kirsten is referring to here. Not telling the client about these exceptions would be as unethical as not adhering to the principle of confidentiality.

8.6 Terminating therapy

A central question in the study was the question of when to end therapy. This subject has been covered extensively in the review section of the present study. The most prevalent finding in this part of the study is that therapy is potentially never-ending. The main part of the participants all mentioned this; here it is exemplified by Laurids

> L: [...] i princippet kunne man blive ved med en patient fra nu af og ti år frem i tiden fordi, selv dem der får det bedre ville jo så altid kunne sige, jamen, så er der måske noget jeg kunne få det endnu bedre med [...] (App. 8, l. 291-293).

Hence, there is no real end to therapy. No matter how well the client ends up feeling, there is always something to work with. However, Laurids points out later on that the psychiatric ward where he works is not meant to provide solutions to psychological "life-style" problems. Laurids and his colleagues' focus are on helping the client with a psychological illness. Once this illness has been dealt with to a satisfying degree, the therapy is ended. Nevertheless the implications for the never-ending therapy are many. If there really is always something to work with, when would it be ethically sound to end therapy? Freud said that therapy should end when the instinctual drives no longer interfere with object relations. Wolman (1982) pointed out that therapy should be ended when the therapist can do no more for the client. These are both definitions that leave room for interpretation. Certainly, the participants are doing nothing wrong when they state that therapy could go on forever, if you consider these definitions. However, it seems clear that the thought of "never-ending" therapy is based on a psycho-dynamic thought. Other forms of therapy seem more limited in their temporal extension. Kramer (1986) says that the client came to therapy by themselves, and therefore they should be able to end it themselves as well. This might be true, but could it also be a way for the therapist to avoid taking any responsibility for ending therapy? It would be convenient for them to say "the client didn't want to end therapy; therefore I did not end it". Not ending therapy could be just as big an ethical problem as anything else. Laurids expands:

> L: Hvis de så begynder at sige [...] nu vil jeg gerne vente en måned ikke også så, så ved man også, dé ved det formegentlig inderst inde, og som psykolog ved man også jamen nu, nu er vi ved at nå ved vejs ende [...] og så kan det jo være man kan begynde og snakke om en afviklingssamtale. Det vil man ofte gøre. Fordi man skal jo heller ikke holde dem her længere end det er nødvendigt altså risikoen er jo også at man gør dem afhængige af en psykolog, og så vil man jo have hjulpet dem meget dårligt. […] livet jo skal leves dérude og ikke herinde (App. 8, l. 306-312).

So, holding on to a client for too long might make them dependent on the therapist, which is definitely not the goal of therapy (Hill 2009).

A concern that was aired by both Tyra and Laurids was the informal ending of therapy. They both said that the client simply not showing up was one of the most common ways to end therapy. Tyra elaborates:

> T: […] og så afslutter jeg terapi hvis folk bliver for ustabile altså at de ikke møder op til deres behandlinger […] der er økonomitænkning i vores system, [...] vi kan ikke tillade at folk bliver væk fem gange for eksempel, uden afbud og sådan noget. Så, det afslutter vi også terapi på. Og så må vi prøve og formulere for dem at det handler om hvorvidt de er motiverede i øjeblikket og at hvis deres egen læge synes at de på et senere tidspunkt kunne have nytte af behandlingen heroppe [...] så kan man jo henvise igen ikke. Men altså, det er også en måde og afslutte terapi desværre. Nogen gange. Men [...] vi kan ikke andet. Det er et vilkår. (App. 9, l. 334-341).

This informal ending of therapy is of course problematic. Here we return to the considerations about what is best for the client. It is of course impossible to treat a client that does not show up, and of course there are economic considerations that must be taken into account. However, discontinuing a client just because he/she does not show up seems problematic. The "staying away" might be a result of the disorder that the client is being treated for. If so, it is of course problematic to end therapy on this account, mostly because the therapist does not get the time to go through the normal procedures of ending therapy, which are suggested by Bostic, Shadid and Blotsky (1996).

The last finding in this part of the study was that the reason to end therapy late, was because of a wish to make sure that the client "has what he needs", by giving him a little extra. Laurids explains:

> L: [...] det kan jeg let forklare fordi […] det kan også være et personligt træk, ved mig, ikke, og, jeg vil gerne have at behandlingen er god og grundig. Det er måske lidt ligesom når jeg skal have skrevet noget, et manuskript eller sådan noget, så, så læser jeg korrektur på det tre gange for nu at være sikker på at der ikke er fejl i det. Så tænker jeg, at jeg vil ligesom give dem lidt ekstra sådan til, jeg ved ikke hvad, vedligeholdelse, til at afstive dem med. Altså, jeg vil være sikker på at de har det godt og det, det kan så medfører at, at jeg måske holder på dem for længe. (App. 8, l. 445-451).

Ending therapy later than agreed upon could then both be a result of some professional consideration, but also because of the therapist's personal trait about being thorough. The prolonging of therapy is less of a problem when it is "free" for the client, which was the case for all participants. However, when therapy is paid for by the client himself, there is a distinct ethical dilemma in prolonging the therapy beyond the original agreement. The par-

ticipants revert back to the “it's the decision of the client”, which was discussed earlier. Prolonging therapy might be connected to the common reactions that Kramer (1986) and Goodyear (1981) mentions. Reactions like guilt or feelings of inefficiency might be a central part in the therapist’s immediate reactions. This feeling is well captured when Laurids states, “I want to be sure that they are feeling well”. As Laurids describes it, prolonging therapy could very well be because of a trait of the therapist.

Other reasons to end therapy were discussed by the participants. Among others were the client attempting suicide, threats or violence towards the therapist, the client becoming unstable, and the client lacks motivation, abuse of drugs or alcohol and because of a mistake in the initial assessment of the patient (see App. 7, 8, 9 & 10).

Defining when therapy is successful, and subsequently deciding when to end it, is not straightforward. A basic assumption that was touched upon by Jette is that when the client is satisfied, so too must the therapist be.

> J: […] jeg vil [...] først finde ud af hvad siger klienten - er klienten klar til at afslutte et forløb, og er han ikke det jamen så, så er vi ikke færdige, så er der mere at tage fat i. Hvis han nu er det [...] så må jeg […] vurdere de mål vi har sat er de nået og selv hvis de ikke er det i den grad hvor jeg tænker at det vil være tilfredsstillende, så må jeg bøje mig [...]. Jeg vil altid spørge "er du sikker på det" og "der er nogle ting vi ikke er blevet færdige med hvad synes du om det" og så videre inden jeg vil afslutte et forløb [...] Altså, hvis klienten er tilfreds, øhm, så må jeg også være tilfreds, hvis jeg har spurgte ordentligt ind til grundende til at afslutte terapi (App. 10, l. 347-355).

The problem here is; again, that the disorder might limit the clients feelings of “success”. Moreover the theoretical definition of “success” from which the therapist works, might not be the same definition as the clients, which is linked to the different value-systems (Tjeltveit 1999) that was discussed in the review. Further, the therapist’s definition could also be based on some private theory, which I shall go into later on. Another problem is that the patient might consider the therapy done before it really is – either because he/she feels that he/she cannot get better than the present state, or because it is too difficult to continue. The problem is, if you truly believe that the ultimate goal of therapy is that the client gets autonomy, you cannot second-guess the client when he/she says “I'm alright now, I think we should terminate” (this without getting into the discussion of how clients might not be autonomous or neutral because of the condition they are in). Then the therapist gets

caught up in his own beliefs if he/she still thinks the client needs therapy. Hence, Jette is not consistent all the time. Sometimes, the therapist might be very unsatisfied (not having reached the goal fully) even if the client thinks he/she has reached the peak of his psychological well-being. This reaches back to the discussion of what is best for the client. Should the therapist try to hold on to the client if he/she thinks there is still work to be done, or should he/she do as the client wishes and let him go. You could argue that, as long as there is scientific justification for holding on, and a real possibility[2] of reaching a better release for the client, the therapist should hold on. That would be in full accord with the EPNP. However, as mentioned earlier social stigma, autonomy and the like should still be considered.

8.7 Evaluation of progress

On the evaluation of progress, the participants all agreed that the main device for doing evaluation was "listening and sensing". Tyra elaborates:

> T: [...] man taler jo lidt med patienterne undervejs, hvor de synes de er henne.... Og der, der er bedring jo nok det helt overordnede mål man går efter, og så er der også nogle undermål der lige sådan ligger, og så snakker man lidt om hvor man synes de er henne [...] man tjekker ind med patienten, altså, er vi enige om hvor vi er henne. (App. 9, l. 242-250).

Even if it is just "sensing and listening", there is still some theoretical foundation that some of the participants refers to when talking about evaluation.

> J: Nej, nej, det blir' på fornemmelse. Altså af hvordan han er og sidde med i lokalet, øhm jeg tror, det er også lidt den form for måling vi bruger [...] i det her teoretiske felt altså, om man kan fornemme en forandring i måden han relaterer sig til mig på, øhm, så, så det bliver jo min vurdering af, hvordan føler jeg det er at sidde med ham øh, hvilke modoverføringsreaktioner får jeg, har de ændret sig efterhånden, ehm, det tror jeg måske [...] [er det] tekniske redskab vi bruger [...](App. 10, l. 251-256).

Jette clearly sees this way of evaluation as a part of her theoretical school of thought. Her ideas about identifying transference reactions especially reveal her distinct psycho-dynamic

[2] How to estimate if there is a real possibility for a better release lies beyond the scope of this assignment. However, this must be considered when terminating therapy. If, for some reason, the therapist possesses knowledge about the de facto possibilities of a better release, he must of course react accordingly.

schooling. However, this does not make the measuring of progress any more objective. It is still a subjective method. As we shall see later on, the participants all held some form of eclectic theoretical foundation for their approach to therapy. The odd thing is that this specific way of evaluating was cited by all of them, even though they all had different viewpoints. However, in spite of being eclectic, all the participants claimed that one of their inspirations was exactly psycho-analysis. Are we to gather from this, that all therapists cite psycho-analysis when talking evaluation? It is not for this study to say. However, it is somewhat of a conundrum that this way of evaluating is so popular. Even if it is founded in theory, it seems very one-sided and somewhat uncritical.

One of the problems with the statement above is that most of the participants expressed that there was actually not any theoretical foundation for their way of evaluating. Here this is exemplified by Kirsten:

> I: Så der er ikke nogen sådan metode eller instrument til og....
>
> [...]
>
> K: Ikke hvad jeg ved af (smågriner). Ikke lige umiddelbart..... For, så skulle det jo være klientens egen vurdering, men den kan jo godt være forskellig fra terapeutens vurdering, så på den måde tror jeg ikke der er noget fast. (App. 7, l. 340-344).

Apparently, there is no theoretical foundation for the way the participants evaluate. How then, do they all manage to cite the same subjective method of evaluation? Any interpretation is valid here. Maybe there really is a theoretical foundation for the method of evaluation, but the participants somehow forgot. However, answering this is beyond the scope of this study. What is important to this study is that the participants do not cite any theory when talking evaluation.

What Kirsten also brings up in the above statement is a central part of evaluation – the difference in perception of what has been reached. This reveals a sort of double subjectivity. Not only does the therapist rely on his subjective impressions to evaluate progress, but he/she also has to make sure that the client's subjective experience somewhat resembles his own. This problem was treated by Tjeltveit (1999), who pointed out that success could be measured not only by different people (the therapist and the client), but also from different ethical principles. The problem here is that the evaluators do not necessarily share the same ethical foundation, which makes it impossible to evaluate whether a goal has

been reached. Moreover, the goals set by therapists and clients alike, might be understood at different levels of abstraction. This means that apparent agreements and disagreements might appear or disappear if you make sure that the goals are understood on the same level of abstraction (Tjeltveit 1999). The point is that some might evaluate goals on a more universal basis. If a universal level of abstraction is applied, surely some cases might look like they have not improved and vice versa.

One way to make evaluation more objective, according to Laurids and Kirsten, is to compare present abilities or skills with their level at the beginning of therapy. Laurids gives an example with a couple of youths who have had trouble maintaining an education:

> L: [...] nu har de for eksempel klaret og være i gang med ungdomsuddannelse uden at de er droppet ud. [...]nu har de faktisk gennemført mere end et semester og så vidt jeg kan se bliver det første studieår færdig her til sommer […] og somme tider har de hængt i med neglene eller har været til fraværssamtaler, men det er for mig et succeskriterium altså at de kan, kan holde ved og de laver deres lektier og de møder op til undervisningen de erh, skaffer sig måske endda nogle venner eller kammerater på skolen, og rager ikke uklar med læreren, det er faktisk også for mig et succeskriterium, ikke. (App. 8, l. 250-261).

This means that even if the therapist is not theoretically founded in his evaluation process, he/she still tries to remain objective in some sense. It might be pseudo-objectivity because of the inherent difficulties in measuring something so complex without any defined scale. However, in Laurids example it is very clear what the criteria is. If the client suddenly can handle an education, that he could not do previously, that is a clear sign of progress. These "objective" measurements can be more implicit. Kirsten expands:

> K: Mmmm, det tror jeg er de små ting. Altså det har jeg oplevet er de små ting. At det er for eksempeleh.... hvis de kommer og siger [...] de har helt vildt svært ved og mærke deres egen følelser, at så de lige pludselig kommer sådan, og giver udtryk for at de sku egentlig rigtig rigtig vrede og [...] lige pludselig giver udtryk for noget de ikke rigtig har kunnet før. Eller [...] [b]liver i stand til det. […] så mærker man der måske sker noget inde i dem også […] at de kommer i kontakt med noget de måske har lukket helt af for (App. 7, l. 263-269).

Measuring progress is not a standardized process if we are to believe the participants in this study. Even though there might be some theoretically founded and objective way of evaluating progress in therapy, the participants do not seem to be aware of it, and do not use it. However this is not an excuse. Not being aware does not relieve the therapist of the responsibility of basing his therapy on scientifically proven methods. As a matter of fact, Hiebert (1997a, 1997b) suggests multiple methods of evaluating what he/she calls informal evidence. Informal evidence, in this connection, is the evidence of progress that cannot immediately be measured with normal qualitative tools. Why the participants do not seem to be aware of these tools for measuring informal evidence is not clear. However it is clear that they are not.

8.8 The visible and invisible goals of therapy

In therapy there seems to be goals that are immediately visible for both the client and the therapist. Mainly because they usually are goals that they have agreed upon, and are working towards, which is recommended by Wolman (1982) and Hare-Mustin et. al. (1979), amongst others. 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: Nej. Og jeg tror på at der også i mange, måske alle terapiforløb, ligger en skjult dagsorden som terapeuten […] gradvist forsøger at indvie klienten i og teste om klienten er med på, ehm, og [...] måske er der nogle ting der bliver afkræftet og glider ud kan man håbe [...] der er nogle ting som er svære at formulere og som, er for for skræmmende for klienten eller for overvældende eller [...] de måske ikke helt [...] kan være med på og se [det] […] som man som terapeut kan se. Og de mål ligger jo sådan lidt latent undervejs, og bryder måske først frem sent. (App. 10, l. 77-84).

Jette states that the therapist is working from a set of hypotheses that he/she tries to test with the client and try to make the client understand how things are connected. The main reason not to reveal the goal seems to be the therapeutic consideration about not giving the client too much to think about. The problem in this is that the therapist seems to presuppose that he/she is right. This is the kind of paternalism that was discussed in the review section of this study. 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 approach to the client and the 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/she might also be in conflict with the basic opinion of the client. As Tjeltveit (2006) stated, therapy does not only move the client towards freedom of symptoms, but also develops in a certain valued direction. This, however, does not seem to be the immediate major concern for the participants in this study. But as we shall see later on it *is* a concern.

However, as Tjeltveit (1999) states, you should not adopt the views of the client unquestioningly. Often, the most important focus of therapy is not the client's view (Tjeltveit 1999). What the client deserves is the therapist's best judgment about a certain situation. This is a sound reflection, a reflection that does not seem to be a part of the argument for why the participants keep "therapeutic hypothesis" or "personal goals for the client". Rather it seems like "therapeutic hypothesis" is the standard, instead 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 therapists' therapeutic hypothesis. Kirsten explains:

> K: [...] jeg tror der er nogen ting som man ikke kan give dem indsigt i fordi det er et terapeutisk mål. Som måske ville faktisk skade lidt terapien, hvis du foreslog det som mål. [...] fordi at du også skal have en alliance op og køre med din klient så hvis du i starten fremlagde det her som et terapeutisk mål, kunne du måske risikere at de faktisk afviste terapien, men hvis du holdt det som […] et terapeutisk fokus, ved at arbejde sig frem til det og så tage det op på et tidspunkt hvor de var klar til det, og så kunne man sådan diskuterer det som sådan et yderligere mål måske, hvor jeg tænker at man hele tiden skal reviderer fokus, altså sådan vurderer det løbende, altså sådan engang imellem. (App. 7, l. 52- 55).

As pointed out in this statement, complete dismissal of therapy is a concern for the therapist. Hare-Mustin et. al. (1979) adds that a premature discussion of goals in therapy, might lead to the client discontinuing therapy. Therefore, keeping therapeutic hypotheses secret that might seem immense and threatening for the client, is a way to ensure that the client stays in therapy. This means that keeping the hypotheses secret is really a way to make therapy flow, rather than actually trying to keep secrets from the client.

Now we turn to the concern of imposing goals on the client. In the following, Tyra explains how and why the therapist should be careful not to impose certain projects on the client.

> T: [...] man skal passe på med at mål ikke bliver til at jeg får projekter på vedkommendes vejene. Ehm, som hele tiden er sådan en fin balancegang og gå. Og jeg kan jo godt have [...] en ide om at en [...] selvmordstruet patient [...] skal blive [...] ved livet ikke [...] og det kan være mit mål i sig selv, det kan jeg godt være åben og ærlig med, men [...] hvis jeg ikke formår at gøre det til deres mål, [...] så skrider det jo lidt ikke, altså, og der kan jeg jo godt nogen gange have nogle intentioner [...] med nogle emner jeg tager op [...] hvor det netop er mit projekt (smågriner) på en eller anden vis, fordi […] det er også en del af min opgave at holde dem ved livet, men, men hvor jeg ikke altid kan, altså, kan indvie i alt […] hvad jeg har gang i. For også at holde fast i at det, det skal være en lidt opdagende proces for dem, så jeg ikke serverer det hele for dem, så det kun bliver en intellektuel oplevelse, men også at man får [...] en erfaringsdannelse i gang ikke. [...] jeg synes der er der nogen ting hvor[...] man i hvert fald ikke fortæller hvor, hvor teoretisk funderet det er, det man måske har gang i (App. 9 l, 73-90).

Here Tyra is commenting on the problem of making projects on the behalf of the clients. Tyra states that it is all right to have goals for the client – also the ones they don't know about, but they should never be a project that the therapist imposes on the patient. And, these goals should never supersede what the client wants. Moreover, revealing all goals and insights to the patient might disrupt the exploratory process for the patient. Tyra states that revealing everything could make the experience more intellectual than exploratory, which is not the goal. Here the reflection that was missing in Kirsten's earlier statement is now very apparent (App. 7, l. 52-55). It is very plausible that this reflection is a result of experience. Tyra has, after all, five years of experience as a psychologist, whereas Kirsten only has a couple of months, and as Jette says in the end of her interview:

> J: Jeg synes det er rigtig vigtigt det her emne […] Især som ny [...] vil man meget gerne have nogle faste rammer for hvordan man skal gøre tingene så man kan holde sig til det. Ehh, så jeg kan godt fornemme, at min egen proces, med at sætte mål har været vigtig for mig overhovedet at forstå, hvad er det der skal foregå her. Ehm og jeg tror at det med at sætte mål, det er så-

> dan en proces der ændre sig igennem hele ens arbejdsliv. Altså, jeg tror jeg har meget andre behov om ti år. (App. 10, l. 528-533).

8.9 Not reaching goals

The point of setting goals is, inherently, to reach them. Therefore a concern of both the therapist and the client must be not reaching them. Unfortunately, not reaching goals seems to be an ordinary occurrence in the world of the participants. Laurids expands:

> I: Har du så nogensinde oplevet at et mål ikke blev nået?
>
> L: Ja, det har jeg oplevet mange gange.
>
> I: Ja, og hvad gør man så.
>
> L: […] Så konstaterer man at, at målet ikke blev nået og så, så vurderer man. Har de mennesker alligevel et behov for at snakke med en psykolog. Måske fordi de faktisk har det så skidt at de ikke engang kan realisere de mål de gerne vil og så fortsætter man med dem alligevel. Eller også kan man selvfølgelig sige på et eller andet tidspunkt, hvis det er […] mere solidt funderede individer, så vil man sige, ja, desværre, jeg kunne altså [...] ikke hjælpe dig med det der problem der, såeh, så spørgsmålet er om vi skal blive ved ikke også. […]Ja, det sker rigtig tit at man ikke når målene synes jeg. Det gør det altså. Jeg vil næsten sige at det mest almindelige det er at man når målene delvis[…] Altså, en tredjedel de får det ikke bedre, en tredjedel de får det bedre og en tredjedel de får det rigtig godt ikke også. Sådan, det tror jeg egentlig [...] i store træk [...]er det billede man ser indenfor psykiatrien i hvert fald. (App. 8, l. 340-354).

Laurids states that the most common thing is to partly reach the goals. He actually estimates that a third of the clients do not get better, another third gets better and the last third gets really good. This of course stretches into the aforementioned mutual responsibility of the client and the therapist to reach goals. In the end, the client can end therapy if he/she thinks the goal has been reached, simply because you normally can't force people into therapy. Laurids says that goals are often not reached. Sometimes, they simply can't be reached because the client is too impaired. And then you, as a therapist, have to decide whether to continue or if you should try finding another alternative. Laurids also states that this estimation relies on a talk with the client. However, the interesting part of Laurids

statement is that his first expressed thought is that if the goals have not been reached, he would consider whether the client really needed to talk to a psychologist. This could be because Laurids considers the motivation of the client to be lacking if the goals are not reached. However, as seen earlier he is also one of the proponents of revising goals while therapy is ongoing. Why Laurids' statement is characterized by this idea of dismissal is somewhat of a conundrum. It might be because Laurids experience is that not reaching goals is often a question of lacking motivation on the client's behalf. Laurids also states that he has a client in therapy that has not moved anywhere in over a year (i.e. has not reached any goals), but here it does not seem like he is considering asking whether the client really needs a psychologist:

> L: […] hvis patienten selvfølgelig selv siger, jamen nu vil jeg gerne stoppe, så, så må man jo bare accepterer det, og så må man snakke om det […] man kan næsten sige, når jeg allermest har lyst til at […] slut med en patient, så er det ligesom jeg siger nej nej, gi' det nu en chance mere ikke også, prøv og vær' tålmodig, det kan da være fristende altså […]. Ja, du, du husker jo ham der, du var inde med ikke også[3]. Det er nu et år siden ikke også og nøjagtig de samme ting, det er bare blevet værre, ikke, og det er sådan en hvor man godt kunne tænke sig at det godt nok ville være rart at slippe af med vedkommende [...] men det ville være og svigte sin pligt sin etiske ansvar […] plus, at hvor skulle han så gå hen? [...] og så håber jeg jo lidt på et mirakel eller et eller andet ikke og et eller andet sted må han jo også få noget ud af det, for han kommer jo trofast hver gang ikke, [...] og han brokker sig jo heller ikke om terapien som sådan, han brokker sig over at han har det skidt ikke også, det kan man så sige, det er så en indirekte brok over at vi gør det ikke godt nok at. […] (App. 8, l. 471-490)

Here, it is very evident that Laurids feels an obligation towards the client. No matter how much Laurids would like to terminate therapy, he tries to hold on and not give in to the notion. In this specific case, however, the client seems motivated to participate in the therapy. At least he is showing up, even though he complains about feeling bad. Laurids seems to be testing if the client is motivated. Not necessarily by challenging or accusing them, but perhaps more as a clarification that states that if the client wants to reach goals, he/she has

[3] Laurids is referring to me once observing him conducting therapy with a client diagnosed with depersonalization-derealization syndrome (ICD-10: F48.1).

to be willing to work with the problems. Laurids might even use this to motivate the client further – i.e. “if you want my help, you’ll have to work yourself”.

Moving on to another central theme in not reaching goals, we turn to the following explanation from Jette:

> J: [...] Øhm. jeg tror ikke at der kommer til at blive nogen der sådan siger, at øh, "nu er målet nået" og så er det sådan. Klienten kan godt komme og sige at, "nu vil jeg ikke mere", eller "nu føler jeg ikke at jeg har behov for mere". Og, altså, så må man jo betragte målet som, som nået fra klientens synspunkt i al fald, ehm, og må respekterer det. Men eh, jeg tror, fordi man i den her tradition arbejder med, eh, personlighed og udvikling, ehm, så vil man aldrig sige at man er færdig, altså, at det kan ikke blive bedre, man kan godt sige at nu, nu har vi gjort eh, dysfunktionelt, funktionelt, okay, men så kan vi altid tage fat på at gøre det funktionelle exceptionelt. Så der, der er altid noget man kan fortsætte med. Såeh, jeg tror det må i sidste ende være klienten der siger "nu, nu er det nok for nu" (App. 10, l. 268-277).

Jette points out that if the client believes that he/she is done with therapy then the therapist has to respect this, and must consider the goal reached – whether the therapist believes so or not – this is along the lines of what Kramer (1986) said about the client coming to therapy themselves, and that they then should be able to end it as well. However, in the tradition that Jette works with, you don't actually say, “we are done”. There is always something more that can be done, which means that therapy is essentially never-ending, which has been discussed earlier. However, Wolman (1982) points out that there might not be such a thing as a natural end to therapy. Meanwhile he also states that the intrinsic goal of therapy is to make it superfluous. This does not combine well with the participant’s conviction of therapy as a never-ending process. When taking Laurids earlier statement into consideration, you could say that ending therapy because of the goals not being reached (because of the client’s lack of motivation), is actually more along the lines of what Wolman (1982) suggests. If the client is not motivated, it might be because the clients experience tells him that it is not necessary – i.e. superfluous. What Wolman does not discuss is to whom therapy should be superfluous. Should it be superfluous to the client, the society or some other party? If it is superfluous to the client, one might think that therapy should end. However, if the client is still a hazard to himself or society, a professional estimation might say otherwise.

Further there is other things that might mean that you do not reach goals. Tyra explains:

> T: Vi har patienter hvor man må sige at de bliver ikke bedre, og så handler det om og hjælpe dem til at accepterer den tilstand de er i og få det bedst mulige ud af det. Det er jo også et mål i sig selv, ikke. Og kan skabe, […] [et] mere værdig liv [...] Og det er jo så også en bedring (App. 9, l 236-240).

Here we can see that if the goal is not reached, then the goal changes into making the client accept this. Even if a goal is not reached (and is indeed unreachable) the therapist cannot just end therapy. The therapist still has to make sure that the client has come to terms with the fact that the goals have not been reached. But is this radical changing of goals ethically defensible? Looking to the EPNP this could be considered a part of the guidelines on competency. Maintaining a strict focus on a stated goal, that is by all means unreachable, could be considered very unprofessional. Moreover, it would be a lack of respect for the client and his capabilities, which should be considered by the therapist in all aspects of therapy. Moreover, if the overall goal of therapy is attaining (or maintaining) client autonomy (Tjeltveit 1999), keeping them in therapy even though the goals cannot be reached, would undermine this overall purpose. And moreover, it would not make therapy superfluous.

8.10 The therapist

Lastly, there were findings about the therapist that were interesting. What was surprising, to this researcher at least, was that all the participants reported that they did not adhere to one specific theoretical stance. Even though most of the participants said that they were mainly inspired by psycho-dynamic and cognitive theories, they were more eclectic than just using this one theory. The best example is Laurids:

> L: Ja, så vil jeg sige at det, det er nok det integrativt eller eklektisk men eh, jeg er jo meget inspireret blandt andet af den, af den kognitive terapi ikke, men, henter jo også inspiration ved den psykodynamiske tænkning og eksistentiel tænkning og, jeg […] har også tillid til […] nogen [...] psykofarmaka, så sådan en mere biologiske model den tror jeg egentlig også på, så det, det er sådan eh, man kunne kalde det eklektisk/integrativt, det er nok mit standpunkt. (App. 8, l. 15-19).

Laurids states very clearly that he does not stick to any one theory, but has a more eclectic or integrative perspective. This issue falls under the guidelines on responsibility in the EPNP. The psychologist is responsible for choosing methods that are scientifically sound.

This eclectic view in and of itself might not be proven scientifically, but the different theories that are melted together might be. In this way, the psychologist is acting ethically sound. However, having an eclectic view makes it hard for the client (and maybe also the therapist) to find out what the therapist is really doing. As Murdin (2001) states this is a problem because the client is not effectively choosing his own treatment. However, as stated in the EPNP it is the responsibility of the psychologist to choose the theory that is best suited for the given situation. Once again the prevalent thought is that the therapist knows better than the client, and therefore the client choosing his treatment seems to take a backseat. However, the eclectic view could ensure that the psychologist does not get dogmatic about one theory or method, which is important (Spinelli 1994; Øvreeide 2002 and EPNP 2006-2008). So, being eclectic could be viewed as a way to ensure neutrality in choice of method and theory, but is problematic because of poor transparency.

While the therapist sports this eclectic view, Jette and Laurids both point out that the goals of therapy are often judged on the basis of some personal moral code:

> J: […] jeg tror det personlige er det mest fremherskende når det sådan kommer til [...] virkelighedens dag til dag terapi, øhm, jeg tror at man som psykolog har en, [...] jeg tror i hvert fald jeg har en en fornemmelse for hvornår man, hvornår man overskrider nogle grænser man ikke skal overskride, ehm, men jeg tror også at det har at gøre med at jeg har, jeg jo er trænet eller bliver trænet i de her relationelle retninger, ehm, såå [...] man kan ikke sætte noget mål sådan rent teknisk der er uetisk, øh, men man kan, man kan lave noget samspil som er uetisk (App. 10, l. 411-417).

In the above statement Jette explains that it is a personal moral code that helps the therapist decides on whether or not a goal is unethical. However, she also states that goals in and of themselves can't be unethical as such, but the interplay between the therapist and the client could potentially be unethical. This is ethical judgment in “the first degree”. 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 must be expected that the therapists follow the EPNP as best they can.

This concludes the analysis of the present study; next we will look into a more generalized discussion and summation of the findings.

9. General Discussion

In this section the findings of the study will be discussed in further detail to create an analytical generalization. Firstly, a brief summation of the main findings of the present study. Hereafter, the results will be discussed in relation to the theories that was reviewed, and sought to be analytically generalized through the use of positioning theory. The following bullet points sum up the findings of the analysis:

- Goals seem to direct therapy and help to avoid misunderstandings between therapist and client. Nevertheless goals are ambiguous in their meaning as they function on different levels of abstraction.
- Goals are not fixed but are subject to change due to different circumstances. These revisions can happen more or less fluently, but are almost destined to occur.
- The client has a big part in setting goals. In fact, the participants unanimously said that no matter what, the client always has the last word on whatever is decided during therapy.
- The participants seemed to employ different therapeutic tactics to make the patients see things "the right way". However, the point in playing the "tactical game" seems to be therapeutic.
- The client and the therapist share the responsibility for goals being reached. This conclusion was almost unanimously reached by the participants.
- Never-ending therapy seems to be a recognized alternative to actually ending therapy. This is because of the inherent ideas in for example the psycho-analytical theories which state that there is always something to work with.
- The definition of successful therapy of course has its own implications for when to end therapy. The problem is that the client's and therapist's definition might differ significantly.
- Listening and sensing was given as the main method for evaluation of progress. None of the participants seemed to be aware of the huge amount of methods for using informal evidence as a measurement of progress.
- The participants seemed to work from the assumption that "secret therapeutic hypotheses" are the foundation of any psychological work, and that they are therefore completely acceptable. The major concerns surrounding these hypotheses are the supposedly counter-therapeutic effect they might have, should they be revealed to the client.

- Commonly goals are not reached or are only partly reached. According to the participants, this is mainly because of the client's lack of motivation. However, not reaching goals could also be a result of a discrepancy between the client's and the therapist's view of when a goal is reached.
- Lastly the participants did not seem to adhere to any specific theoretical stance. This might give the clients a hard time discerning what the therapist is really doing.

In summary it seems that therapy, setting therapy goals and reaching goals are processes that include input from both therapist and client. However, it also seems that there is a question of neutrality that has to be posed. It seems that no matter what the therapist is doing, he/she is never fully neutral. Again we come back to the argument of "privileged knowledge" that was posted in the review by Øvreeide (2002), and the value-laden therapy that was proposed by Tjeltveit (1999) and to some extend by Brinkmann (2008). Øvreeide states, that therapy is a process that is based on trust. Trust from the client towards the therapist. This demands that the therapist remains as neutral as possible.

Neutrality seemed to be sought by letting the client have the ultimate say in all matters. At least, this is what the participants seemed to convey. However, as the analysis has shown, there are still some remnants of "the therapist knows better". This is, of course, problematic, because 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 very concern. Also, they don't seem to be fully aware of what their (power) position entails when it comes to affecting people. Viewing this issue through the lens of positioning theory (Harré In Press; Harré 2002; Winslade 2005 and Harré, Moghaddam, Cairnie, Rothbart & Sabat 2009), it seems that the participants are not fully aware of their position's rights – or at least not how these rights implicitly gives their statements a certain value. Further, the positioning theory states that participating in any given episode; the individual could be expected to act in accordance with their beliefs as to their position (Ibid.). Hence, the therapist might just interpret the situation in accordance with the discursively available story. Put simply, the therapist might not be aware of his paternalistic ways because he is embedded in an episode where this interpretation is the only possibility.

The question that could be posed here is if the information that is provided by a psychologist, can ever be neutral information. During the interviews it was very apparent that the participants did have different agendas, and were trying to influence the clients in a certain

direction. However, they always fell back on the “the client has the last say” and “you can't force clients to do something they don't want to” phrases. This supposedly puts the power of decision squarely in the lap of the clients. However, as studies of patient-doctor communication (for example Williams, Alderson & Farsides 2002 and Bernhardt 1997) show, information given by an authority-figure is never neutral, or at least not perceived as such. Hence, the information that the participants presents to the client, might not be perceived as mere suggestions or ideas to be considered. Rather they could be perceived as statements about the best course of action in the given situation. This dynamic could again be explained by the positioning theory (Harré In Press). According to positioning theory people are discursively infused with certain rights and duties. Hence, the client is constructing the position for the therapist, as well as other entities are. 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, according to positioning theory (Ibid.). 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.

However, if the therapist is not aware of this dynamic, he/she might think he/she is merely giving neutral suggestions. The notion of paternalism (Tjeltveit 2006) seems to come in play here. 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. However, this does not absolve the therapist from the problem of influencing the client to choose certain kinds of action. Moreover, Tjeltveit (1999) pointed out that therapy is never value-free. This might be what we are seeing in this case. The non-neutral way in, which the participants conduct therapy might be an expression of the values that influence the organization which they are a part of. This is where Øvreeides (2002) third face and Harré’s (2002, In Press) ideas of positioning theory also come into play. As well as the therapy must be affecting people around the clients, the people (or society) around the client could also affect therapy. As Tjeltveit (1999) states, people are often not aware that they are under influence from societal, cultural or discursive powers. This means that even if the therapist is aiming at being neutral, it might not be possible simply because he is embedded in a context – i.e. is assigned a certain position by the discursive practice of his organization (Harré In Press). As further confirmation of this hypothesis Brinkman (2008) stated that human functioning cannot be seen as value-free. Hence, any activity is always based on some form of value, which in turn means that a true

neutral action might not be possible. This could very well be what is illustrated by the participants in the present study.

However, when it comes to goals both Tjeltveit (1999) and Spinelli (1994) point out that therapists' might have a tendency to be too trusting of the client's version of the story. As pointed out in the review, the client's idea of what goals should be is not always the one that is preferable from a therapeutic view. Here, the EPNP might actually become a problem, especially for the participants in the present study. If the therapist is overly focused on retaining the client's autonomy – which has been stated as the overall goal of therapy by Tjeltveit (1999) – he might overlook the importance of competence. This leads us back to the discussion about paternalism. One might argue, as it was in the review, that the therapist is the one who is most qualified to judge what a fitting goal is. However, the risk is losing the interest of the patient, and the patient's autonomy (Ibid.). Therefore the therapist must consider both the guidelines about respect and competence, when he/she is to make a decision on which goals to pursue. This is without getting into the debate about the clients that are so impaired that they simply cannot make a rational decision for themselves.

The suggestion from Wolman (1982) is that if a goal is defined by the client, the therapist should always respect this. The therapist should be the agent of the client and not the society. However, the participants in the present study might not be agents of the society, but they are almost certainly agents of their own theoretical view. This means that their respect for the client's ideas might not be influenced by societal discourse, but is at least influenced by theoretical discourses – a thought derived from positioning theory (Harré 2002). 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, the participants in the present study, all utilized more or less eclectic theoretical foundations for their therapy. Therefore a clear view of the therapist's theoretical stance is more or less impossible – for the client as well as the therapist him/herself. So, the respect the therapist conveys when he accepts the goals set by the client, might be based on some of his theoretical background, but could just as well be based on something else (the EPNP for example). According to the EPNP, respect is a prerequisite for doing therapy. However, respecting the client's wishes just because the EPNP says so is qualitatively different from respecting the client's choices because of a theoretical consideration. Unfortunately it is not apparent if it is the one or the other reason that makes the participants in the present study rely so heavily on the client's self-determination. However, the risk is that the therapist is utilizing ethical considerations

before they utilize their theoretical background, which is obviously not the point of the EPNP. The EPNP are, as stated in the review, meant as guidelines not decree or law. It could be considered a major problem if the therapists start to rely more on ethical guidelines (even though Øvreeide (2002) points out that the psychologist should always be founded in basic moral values), than on their actual theoretical foundation.

But why does this "perceived neutrality" seems to be so prevalent? One could argue that the education psychologists go through might have a part in this as well as the theories that were mentioned earlier. There could be a problem at an institutional level then. Whatever the psychologist is taught about neutrality, one could ask if it is possible to practice this form of neutrality. Remaining neutral does seem to be a legitimate problem in the present study. What is just as interesting is the therapist's way of conveying that he/she is neutral and that he/she practices neutrality. In the present study, the participants continually referred to the patient's autonomy as the "ultimate" fail-safe of neutrality. This, however, is also a way to displace responsibility towards the client.This displacement or ascription of responsibility can be viewed through the lens of positioning theory (Harré In Press; Harré 2002; Winslade 2005 and Harré et. al. 2009). According to this theory, communication produces positions for the people that are communicating. This discursive practice has certain implications for the displacing of responsibility that was discussed above. When the therapist is positioning himself/herself as the "neutral therapist" via explicitly stating his/her neutrality, simultaneously he produces a certain position for the client. Winslade (2005) gives the example of liars that are not "allowed" or "expected" to tell the truth. In the same way, the client of a neutral therapist cannot/will not/may not be influenced by the therapist. Hence, the client of an implicitly or explicitly proclaimed "neutral" therapist is autonomous. This is a problematic view in that it does not encompass the problems of non-neutral communication, which has been so prevalent in this study.

As Hare-Mustin et. al. (1979) mentions, the (APA) ethical principles for psychologists, points 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. However, if these statements and recommendations are not neutral, as they do not seem to be when looking at the analysis in the present study, how is the client meant to do anything autonomous? Of course, Hare-Mustin et. al.'s position comes from an older article, and may simply be outdated. However, the remnants of the concept of the "rational patient" still rings true in the modern-day therapeutic setting. Especially

when considering the EPNP's guidelines on respect for the decisions of the client. This has great ethical implications for informed consent, which would be undermined to some degree if the therapist is not able to provide truly neutral information. However, the implications for this are be beyond the scope of this study.

As stated in the analysis and the review as well, Murdin (2001) points out that, therapists are great at pointing the dirty end of the stick outwards. In the present study it was found that the participants believe that it is not the therapist who should do all the work in the therapeutic situation. Partly because he/she simply cannot (it is the client who has the issues, not the therapist), and partly because the therapeutic effect of exploration would be lost if the therapist started providing all the answers. However, this kind of displacement of responsibility might lead to statements like “the client did not do proper work, therefore therapy was unsuccessful”. This is a legitimate statement in, for example, psycho-analysis, where it is called “resistance” (see review). However, this could lull the therapist into denying any responsibility for unsuccessful therapy. Not reaching a goal could then simply be attributed to the client not bringing the right type of material for therapy, and/or not working with it properly. Then the responsibility of successful therapy has suddenly shifted from the therapist and client in cooperation, to the client alone.

Then we come back to the argument of client autonomy. It has been stated multiple times that autonomy could be the ultimate goal of therapy. Or, put in another way the universal intrinsic goal of therapy is to make it superfluous. However, should therapists aim at autonomy at all costs? From this study it is quite obvious that they do. But should they? Taking the lens of positioning theory, you could ask if they have any other choice. Is autonomy always the most preferable outcome of therapy? The EPNP might state that autonomy is exactly what should be aimed at. A vulgar interpretation of this makes both therapy and indeed the therapist superfluous. If the client is perfectly capable of defining his own goals (Wolman 1982), and ending his own therapy (Kramer 1986), why should he/she ever need to go into therapy in the first place? This is of course a provocative statement, but bears some truth in that one should consider the implications before you advocate autonomy as an ultimate goal for therapy.

Extending on this is the idea of the never-ending therapy. As stated in the summary in the beginning of this section, the “never-ending therapy” seemed to be a valid opposite to actually ending therapy. Besides the moral implications that have already been discussed in the analysis, there are other issues with this topic. Howard (1986) stated that the longer a

therapy went on, the greater the benefit for the client. But it is not a linear curve; rather it is a negative logarithm, which means that the return is diminished with each successive session. If Howard is right, the thought of never-ending therapy is somewhat frightening. Even if the logarithm never reaches true zero, the return will be ever so small after a certain amount of time. One might argue that new issues will arise in life-long therapy and that these issues will start a new negative logarithm that has to reach true zero before therapy can be completed. However we are to understand Howard's idea of the negative logarithm, it must influence our view on the life-long/never-ending therapy. From an ethical stand-point you might argue, that the social stigmatization of going to therapy could eventually outweigh the betterment the client experiences. Then keeping the client in therapy would be unethical. If the situation is the other way around – the client does not want to quit therapy – it might as well be unethical. However, here it should depend on an estimation of why the client wants to stay, and if this reason is therapeutically sound. The root of the problem might be that the theoretical footing of the therapist has validated the idea of never-ending therapy – which would be the claim of positioning theory (Harré et. al. 2009). As all the participants cited psychoanalysis as one of their main inspirations, they all draw on the idea of long-term (potentially life-long) therapy. Hence, the position of keeping the client in therapy is partly theoretically backed – partly in the sense that all of the partici-pants were eclectic in their theoretical approach, and hence not solely founded in the psy-choanalysis. However, theoretical backing does not necessarily make for ethical actions. The theory might be wrong. I am not suggesting that practitioners terminate therapy at the first sign of a stalemate. What I do suggest is that therapists should be more attentive to the ramifications of not ending therapy – whether therapeutically backed or not.

What was concerning to this researcher was the apparent lack of a formal evaluation-method, or at least that the participants did not seem to utilize any specific method. The moral implications of this are of course far reaching. The nucleus of this discussion has been the neutrality of the therapist, how he/she is to achieve it and if it is preferable to have a neutral therapist. Whatever the conclusion would be to this discussion, surely, the way to retain neutrality is not by evaluating the client's progress by "listening and sensing". As was already pointed out in the analysis, this notion has certain theoretical ramifications and seems to be rooted in the psychoanalytical school of thought. This is perhaps not as con-cerning as the fact that none of the participants seemed to be aware of the extensive amount of methods that were summarized by for example Hiebert (1997a). If neutrality is the main characteristic that should be utilized by the therapist, one must surely expect it to

be in all aspects of therapy – even in the evaluation of progress. Letting the evaluation depend on subjective estimations of skill-improvement or ability to regulate emotions etc. seems somewhat non-neutral. Looking at this from a positioning theory perspective (Harré In Press), it might simply be because the therapist has the right to evaluate, but does not have the duty to use neutral tools. This right is both discursively stated through the interaction with the client, but also by the rules of the institution (and partly by the EPNP) of which the participants in this study is a part of. Hence, the evaluation progress seems to be in a kind of grey area between duty and right.

One of the inherent dangers in the eclectic view, is that professionals could say one thing, but do something else (Dihle, Bjølseth, & Helseth 2006; Oamo & Landau 2006). Besides the problem of the clients having a hard time discerning what the therapist is doing because of an eclectic view, there might also be a huge discrepancy between the theory and the practice of the therapist. If the therapist presents one theory, and practices therapy from an entirely different theory, he is again on shaky ground – ethically speaking. Looking at the EPNP, there could be somewhat of a discrepancy between the professional responsibility that is recommended and the real practice of the participants. Of course, nowhere in the EPNP is it stated that the therapist should adhere to only one theory. However, it is also recommended – at least by Øvreeide (2002), that the profession of psychology should not be a "black box". The profession must be transparent to a certain degree, so the client and the surrounding world can find out what is really happening.

In sum, a major issue is the neutrality of the therapist. Whether or not he/she is neutral has far reaching implications for the therapy, the client and therapist himself. Even in setting goals this issue has its implications. As has been showed repeatedly, the ideas and hypotheses of the therapist might influence the process of setting goals in multiple ways. With this statement we now turn to putting the present study into perspective.

10. Putting it into perspective

In the following, we will be taking a look at the limitations and issues of the present study. Further a suggestion to what could be expanded upon in further research, will be given as well.

One issue with this study is that the problem formulation is very concise from the beginning – verging on being too narrow. However, it became very clear that the study did not shed light on the problem formulation alone. This is probably a result of the phenomenological methodology. This illustrates however that the phenomenological research method was followed very closely. A cofounding reason for the branching results could have been the interview guide that was very expansive. Whatever the reason for this "derailment", it has produced very valuable and interesting data. However, this underlines one of the major issues with the phenomenological approach. When the material guides the categorization, you are never completely sure what could come of it. However, stating categories beforehand might have limited the present study, and most of the valuable data could have gone unnoticed. All things said and done, the concise problem formulation was counterbalanced by the phenomenological approach.

There are of course also other methodological critiques the most of which have been covered in the method-section. However, what were never fully debated were the issues with the sample. Even though the sample-size seems adequate (according to Kvale 1997), there is still the problem of the samples diversity. The participants came from two different institutions that provided very different forms of therapy, and might be hard to compare in any sense. However, as stated in the methodology section, ideographic phenomenological research is not interested in generalizability as such. Therefore, this study can only be generalized to theory – i.e. suggesting changes to existing theory or suggesting new theories, which has been done throughout the analysis and discussion.

Moreover, the participants were somewhat personally related to the researcher and interviewer – in the sense that the researcher and interviewer knew them beforehand (disclosing exactly how, would unfortunately compromise the anonymity of the participants). This might have resulted in a pleaser-effect, which means that the participants might have been more concerned about giving "good and usable answers" rather than giving the "real" answers. However, a certain amount of pleaser-effect is to be expected in all professional

relations, which were also pointed out by Tyra (App. 9, l. 281-283). And, the participants were all professional (or soon to be professional) psychologists, and well informed on the risks of pleasing for the study. Moreover, as stated in the methodology section, Kvale (1997) believes that closeness to the field that is being studied, gives the researcher a chance to ask more relevant questions and foresee what the participants might answer. Of course, the analysis might have been affected by my preconception of the participants. However, this is exactly what the phenomenological method that was chosen is meant to hinder. So, the closeness of the participants to the researcher, should be somewhat counterweighed by the chosen method and the professionalism of the participants and the researcher.

When criticizing the analysis and the discussion of this study, one might state that both was too influenced by common-sense interpretations, and not founded in theory to a satisfying degree. However, an extensive use of positioning theory was utilized in the discussion and almost all analytical points were related to theory or research that was presented in the review. Further, what might look like common-sense interpretations, are all based on the extensive phenomenological categorization that is viewable in app. 3-6 and 11.

Further research could be done on the matter of whether neutrality is the most preferable trait that should be fostered in the therapist. If so, how do we – as a profession – ensure this neutrality, both in the day-to-day work, and in the education of psychologists? Another study might look into what therapists that are more monogamous in their choice of theoretical foundation, and if their view of setting goals is any different.

A study that took a more investigative look at the codes of ethics that the psychologists are supposed to adhere to could also be interesting. The focus could be on the EPNP and looking at whether they are outdated. Further, a question could be if the psychologist adheres as closely to them as he should, and if not, what should we do then? Should we try and force the psychologists into adhering to the guidelines, or should we change the guidelines? Both these answers have multiple implications both for theory and practice of therapy. As stated in the review, the EPNP are not actual rules, but function more like guidelines. This is not only the conception of these guidelines, but what is written in the EPNP itself (EPNP 2006-2008). The reason for this was also discussed in the review, but pertains to the fact that no ethical problem has one solution, and therefore there can be no rules as rules would only pertain to a specific situations. However, stating that the EPNP are guidelines and not rules relativizes their validity – not in an ethical, but a practical sense. The “right

solution" to an ethical problem will always be a matter of interpretation. However, when relativizing the foundation on which the psychologist is to build his ethical decisions, it undermines an already uncertain process. I am not suggesting that the EPNP be made into rules, but merely pointing towards the problem of them being so relativistic. Even if the Danish psychologist has to adhere to these guidelines because of his/her membership of the Danish Psychologist Union, there is still an intrinsic problem in the EPNP because of the formulation of them as guidelines. As said, I am not suggesting that the EPNP be made into rules, neither am I suggesting that the psychologist stops taking responsibility for his/her actions by hiding behind a veil of muddy and relativistic formulations. Rather I suggest that it might be productive to look at the EPNP from the perspective of "taking responsibility" and not from the perspective of "freedom of responsibility". The EPNP might have been originally formulated with this in mind, but from the results attained in in this study it seems like the EPNP is both a shield to avoid any accusations, and way to ascribe the responsibility to others than the therapist.

The point is that it is not clear whether the participants are not neutral on purpose, or if it is because of the duties and rights of their position. A topic worth researching would then be, if there is any discrepancy between the neutrality that a therapist presents, the neutrality that he/she utilizes and the neutrality that is expected of him/her. And further, if this difference is on purpose or if it is an unconscious process.

After looking at multiple perspectives on the study and further lines of research, we now return to the original intend of the study as we venture onwards towards the conclusion.

11. Conclusion

In the following I shall try to sum up the main findings of the study and relate them to the initial problem formulation. The original problem formulation was: Who has the responsibility for the goals of therapy, and who should decide when and how they have been fulfilled? This extended into different sub-problems like: Who should set the goals of therapy? Can goals be revised? When is therapy to be terminated? And lastly, there was the question of neutrality of the therapist. These questions have been debated continuously throughout the report.

Firstly, the problems were illustrated through a review of the theories and research of the problem area. The theories and research that was reviewed all had a focus of cooperation between the therapist and the client. According to the theories the goals are the responsibility of both the client and the therapist. However, the therapist should always be mindful of the client's wishes. He should not take everything the client says as the sole truth. Instead the therapist should consider what, is sound in accordance with the theoretical and ethical guidelines he adheres to.

According to the participants of this study, the goals rely on a shared responsibility between the client and the therapist. However, it seemed like the participants were more reliant upon the client to make the final decisions, and not their theoretical background. It seems clear that there is at least a minor discrepancy between the theories and research that have been reviewed. Where the review found that it is the therapist who should have the last word (even though the therapist should respect the decisions of the client), the participants were all convinced that the last word of the client was more important than their own. However, the participants still tried to infuse the clients with certain ideals and viewpoints through different kinds of "tactical" tools of therapy. Hence, there was another discrepancy between what the participants said they did and what they actually did.

On the question of who should decide if a goal has been reached, again the reviewed theory and research suggested that this should be based upon collaboration between the client and the therapist. However, the therapist should be aware that he should try to evaluate the patient in a more objective way beside the discussion he should have with the client about the goals being reached or not. The participants of the present study however stated

that there was no real definition of how it should be decided if a goal was reached or who is responsible. The participants said they relied mainly on a combination of "sensing and listening" in their evaluation on reaching the goals of the therapy. They seemed oblivious to the multiple forms of evaluation of "informal evidence" that was found during the review in the present study. Whether this was due to intentional neglect or simple ignorance was never uncovered in this study. However, it was still found to be of some concern that the participants relied so heavily on subjective rather than objective measurements of progress. The explanation however, was that the participants viewed the human being as too complex to be captured by such an objective (and possibly quantitative) device of measurement.

Whether goals can be revised was not fully covered in the review because there was not sufficient material on the matter. However, it seemed that goals should not be fixed in the sense that they are subject to change if another, more relevant focus is found. This was also the statement that persisted throughout the interviews. According to the participants no matter what goals have been decided upon they can always be changed. In this connection it seemed that there were at least two sets of goals for the therapy. The ones that was readily visible for both the client and the therapist – mainly because they are the ones that have been agreed upon. And then there are the ones that are kept by the therapist as hypothesis. These hypotheses are what the therapist apparently really uses in his/her work.

Among other things, it is in connection with these ulterior goals that the question of neutrality shines through. If the job of the therapist is merely to provide the client with information that makes it possible for the client to make an informed decision, then he should ensure that his statements are as neutral as possible. But ensuring this and having ulterior goals at the same time seems self-contradictory. And indeed it seemed throughout the analysis that the therapists do have a hard time remaining neutral. This problem was also discussed in the review and discussion sections. The main finding here is that the theories and researchers all point out that paternalism is an inherent problem in a lot of psychological theories. However, this means that the therapist should be even more careful not to impose anything on the client, and not just accept the paternalism as an unavoidable fact.

On the question of termination of therapy, the findings were closely related to fulfillment of the goals. This seems very natural, but there are other implications than the ones that are straight forward – i.e. if a goal is reached, the therapy should be terminated. In the review it was found that there were a lot of different implications for the termination of therapy. The

main point was, as with all other answers the theories has provided, that it should be a mutual decision between the client and the therapist to end therapy. Preferably it should be on the initiative of the client, but should always rely on a discussion between the client and the therapist. However, a problematic point made by the participants in the present study, is the fact that therapy is essentially never-ending. The issue is that no matter what goals have been reached, there is always something more to work with. Even if there are no psychological disorders as such, there are still psychological life-style problems to be dealt with. Therefore the participants all stated that the termination of therapy is essentially reliant upon the client stating that he/she think enough is enough. Some of the participants stated that holding on to the client for too long was of course also a problem. This might lead to the client relying too much on the therapist, which is not the point of therapy. However, letting the client decide when enough is enough still puts a disproportionally big responsibility on the shoulders of the client – a responsibility that he/she is not necessarily equipped to carry. All things considered the therapist must be better equipped for making decisions of this sort, and should therefore be forthcoming in taking a responsibility for ending therapy when he would professionally estimate that it is time.

The overarching theme of this report has been the neutrality of the therapist. Even if the aim was to shed light on goals of therapy, their function and the problems with them, the phenomenological foundation on which this study stands, has made the study take a detour because of the inherent plasticity of the categorization process in the Interpretative Phenomenological Analysis. However, the questions of the problem formulation were answered in a fitting fashion, which concludes this study.

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The total amount of pages referenced is **2.556**, hereof **1.759** pages have not previously been part of any curriculum and **797** pages taken from previously used curriculum.

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