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The emergence and management of embodied dilemmas in psychotherapeutic interaction: a qualitative study

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ABSTRACT

Background: Ethical dilemmas are a major concern in health practices. The literature has tended to favour a more philosophical or theoretical approach, rather than taking a starting point in real-life data. **Aim**: Our aim is to demonstrate how ethical dilemmas are managed in real-time interactional data from a psychotherapeutic practice. **Methods**: We present a real-life case of ethical dilemma management in a psychotherapeutic setting. The example is taken from a large ethnographic study on psychotherapeutic interaction. We use the qualitative method of Cognitive Event Analysis to investigate the interaction in which the dilemma emerges. **Results**: Dilemma management is an interactional achievement where the therapist must contain their own uncertainty, while adapting to the affordances and constraints of the conversation. One cannot contemplate the dilemma in isolation from the therapeutic processes and the psychopathology of the patient. **Discussion**: The results point to new ways of understanding dilemma management. Rather than relying on theoretical and ethical considerations, we propose to complement such work with an embodied, bottom-up approach to applied ethics. **Conclusion**: The analytical findings pave the way for a more embodied code of ethics, which, in turn, has consequences for the theoretical assumptions that inform the guidelines for action in practice.

KEYWORDS

Cognitive Event Analysis, embodied ethics, embodied interaction, ethical dilemma management, psychotherapy

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Introduction

This article is concerned with *ethical challenges*, which are defined by Hem et al. (2014) as "occurring when there is doubt, uncertainty or disagreement about what is morally good or right." For the medical practitioner, such challenges are experienced as *ethical dilemmas* which have been defined as "a situation in which a difficult choice has to be made between two courses of action, either of which entails transgressing a moral principle."[1] One can approach ethical dilemmas from a philosophical point of view, for instance by drawing on Beauchamp and Childress' four "Principles of biomedical ethics": autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 1979). These principles are conducive for ethical reflection and debate, but practitioners rarely have the time to engage in philosophical rumination when they are faced with ethically challenging interactions. In contrast, our overall research interest is how ethical challenges emerge, develop, and are managed in embodied interaction between practitioner (in our case a psychotherapist) and patient. As such, this article contributes to an interdisciplinary dialogue between biomedical ethics (because it elucidates the situated and dynamic aspect of ethical dilemmas), multimodal interaction analysis (because we approach such dilemmas through a careful analysis of embodied interaction), and cognitive ethnography[2] (because our analysis establishes how embodied interaction gives rise to decision making in dilemmatic situations).

By emphasising the inter-bodily dynamics that constitute and characterise (the management of) ethical dilemmas, we argue that theories of applied ethics must be supplemented by empirical ethics (Musschenga, 2005) and theories on situated behaviour to overcome a logical cost-benefit analysis (Bruun et al., 2018) of dilemma management. Accordingly, we aim at linking ethical principles to real-life clinical practices in order to show how dilemmas are less about decontextualised decision making, and more about real-time reasoning constrained by inter-bodily dynamics, affect, and adaptive behaviour in situated interaction.

We showcase the emergence and management of authentic clinical dilemmas in psychotherapy by analysing a case where a therapist experiences being caught in a dilemma as she engages with a patient. This situation was mentioned by the therapist herself in a previous conversation with one of the authors. Here she highlighted the confusion she felt and how she felt vulnerable, exposed, incapable, or even incompetent, as the patient addresses a dilemma, and a decision must be reached. This prompted us to examine more closely how this situation unfolded in detail.

In the Method section, we present the empirical and methodological basis for this investigation, before turning to the analysis. In the analytical section we zoom in on (i) what happens prior to the emergence of the dilemma, (ii) what enables the emergence of the dilemma, and (iii) how the dilemma is being managed through interaction. Finally, we discuss the implications for the field of applied dilemma management and psychotherapy as well as cognitive event analysis.

Methods

The dataset used in this article derives from a largescale ethnographic study conducted at a Danish Psychiatric Hospital. The data consists of app. 650 hours of video-recordings of authentic therapeutic conversations between therapists and patients diagnosed with personality disorders, complemented with semi-structured ethnographic interviews (using structured recall) with the therapists. Further, a number of workshops were conducted with the therapists to discuss emerging issues, thematic challenges and interests. One of those workshops involved a discussion of ethical challenges. The therapists engaged in groupwork in spring 2019 and came up with narratives about ethical and interpersonal challenges they recently experienced in their therapeutic work. Through the groupwork, the therapists came up with personal records that comprised (i) descriptions of experiences where ethical challenges complicated therapeutic relations, (ii) references to actual therapy sessions recorded as part of the overall study, and (iii) narratives about their emotional experiences. We ended up with nine ethical dilemmas experienced by four female therapists, all with a background as clinical psychologists and experience with Mentalisation-Based therapy. The dilemmas centred around several themes listed in the appendix. Many of the themes overlap in actual therapy. In this article, we analyse the theme 'Fear and Fact' (cf. Appendix A) which was experienced and described by one of the female therapists in the workshop. The case she refers to was video-recorded as part of the project. The case is described and analysed in the following section by reference to both the video-recording and the therapist's narrative and interview from the workshop.

To analyse the cognitive and interactional dynamics in the situation, we draw on Cognitive Event Analysis (Steffensen, 2013; Steffensen et al., 2016; Trasmundi, 2016), which is an ecological method for investigating video recordings of interactions in order to establish how distributed cognitive systems (Giere, 2004, Hollan et al., 2000) achieve results as they rely on real-time dynamics and non-local conditions for coordination (Hutchins, 1995; Trasmundi, 2020; Steffensen, 2013; Steffensen et al., 2016; Trasmundi, 2016; Cowley, 2014; Trasmundi & Linell, 2017). A distributed cognitive system includes all components that contribute to cognitive processes and results, including people, material artefacts, environmental structures, cultural conditions, rules, etc. Results are the achievements of human actions, in this case a solution to the dilemma based on decision making. The methodological procedure of Cognitive Event Analysis consists of identifying the event under scrutiny and identifying the crucial points in the interaction that lead to phase transitions (i.e., changes in the interaction trajectory that impact the task at stake).

Cognitive Event Analysis' focus on distributed cognition involves taking into account the full array of gestures, head and body movements, gaze, and verbal utterances (Steffensen, 2013; Steffensen et al., 2016; Trasmundi, 2016; Cowley, 2014; Trasmundi & Linell, 2017). In particular, we rely on a Goodwinian approach to interaction analysis, where we focus on the cooperative, creative actions that pivots on how participants use, reuse and transform each other's embodied actions to generate joint meaningful actions (Goodwin, 1994, 2017). This method is a well-established method in the study of psychotherapeutic interaction, especially under the rubric of Conversation Analysis (Peräkylä et al., 2008).

Results

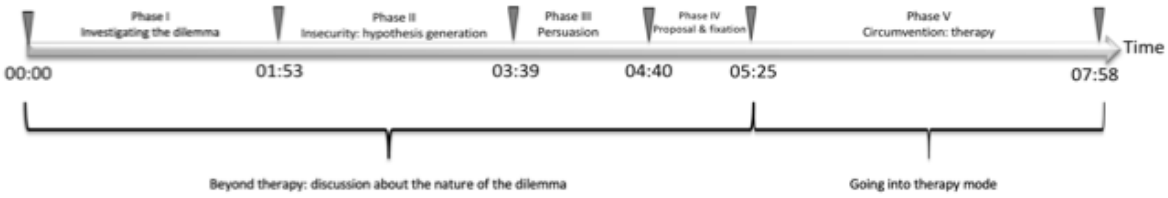
The case identified by the therapist in the workshop is a seven minute sequence where a dilemma emerges and is being managed. It involves a male patient who at the very beginning of his 13th therapy session raises a concern that relates to his and his partner's wish for adopting a child. However, as the patient's history involves being a victim of sexual abuse, he fears that opening up about how he has been sexually assaulted as a child can become a potential liability for being approved for adoption. This concern is based on his doubt about whether sensitive information is shared between the therapist and social workers in cases like his. If the department of adoption *can* get access to his files with commentaries from the therapy sessions, he considers not saying anything about the causes of many of his anxiety problems – the sexual assaults – in therapy. If he decides to open up, the patient fears it impacts his options for adoption. On the contrary, if he decides that he should remain silent when these issues are mentioned, that decision most likely suppresses psychological progression and thus affects his long-term well-being negatively.

The therapist needs to balance the principles of patient autonomy and non-maleficence (Beauchamp & Childress, 1979): From a therapeutic point of view, the patient needs to open up about sensitive topics in order to make psychological progress, but the patient has autonomy to decide what to share when. Further, there are legal and procedural aspects related to the patient's concern, which the therapist has no knowledge about. Thus, she needs to deal with both an ethical dilemma and with uncertainty and incomplete information in the situated interaction. The crucial question then becomes, how, when and who makes a decision about future procedures, and how is the ethical dilemma managed in interaction? To understand the enabling conditions for decision making as part of dilemma management, we need to zoom in on the small-scale actions in the patient-therapist interaction. That is, the overall purpose of this analysis is to show how dilemma management is related to embodied inter-bodily dynamics rather than disembodied, individual, logical analysis.

In the analysis, we show how the dilemma changes with the interaction. This embodied pattern of behaviour reflects a state of situated dilemma management, rather than logical decision making. Simply put, the therapist's stance and decision making develop as they go along in the conversation. The interaction in which the dilemma is enacted and managed reveals an interesting trajectory of moving in and out of zones of security and insecurity in ways that affect the rapport between the patient and the therapist.

This trajectory is shown in Figure 1. The interaction is divided into five phases, each characterized by its own dynamics, and each leading to a phase transition. The first four phases are characterised by a discussion about the nature of the dilemma, but as we will see, the participants do not reach a decision. Rather, they move from a dilemma-based discussion mode into a therapy mode and as such they circumvent the challenging decision making. This outcome, we argue, is a result of emerging emotional tensions between the two, which again is related to the patient's symptomatology.

***Figure 1**: Cognitive trajectory of dilemma management*



Phase 1: Investigating the dilemma

The first phase lasts for 1.53 minutes. The therapist and the patient are concerned with nuancing and clarifying the nature of the dilemma, and as such this topic is a meta-topic that does not become work material for therapy but rather becomes a topic about therapy. From a theoretical point of view, the therapist is expected to weigh the principle of patient autonomy against nonmaleficence and then decide how she wants to guide the patient in his decision-making crisis. However, in this phase we zoom in on how this dilemma management involves an interrogative phase where different perspectives – rather than decision making – are brought to the fore.[3]

1	P	my biggest wish is to have a child- it is not my eh biggest wish but I (.) I would think too that it will be great (.) .h ehm and then I kind of feel that I kind of might have been ruining that chance now (.) °by saying these things°
2	T	okay
3	P	actually so that was why I would never really have said anything in here because (.) on the other hand well yes
4	T	you were afraid of the consequences (xxx)
5	P	so I am thinking now it is probably all there in my files somewhere […] well of course I am thinking that eh once when we will sign up for adoption then it says well X has been exposed to something when he was a child
6	T	okay (xxx)

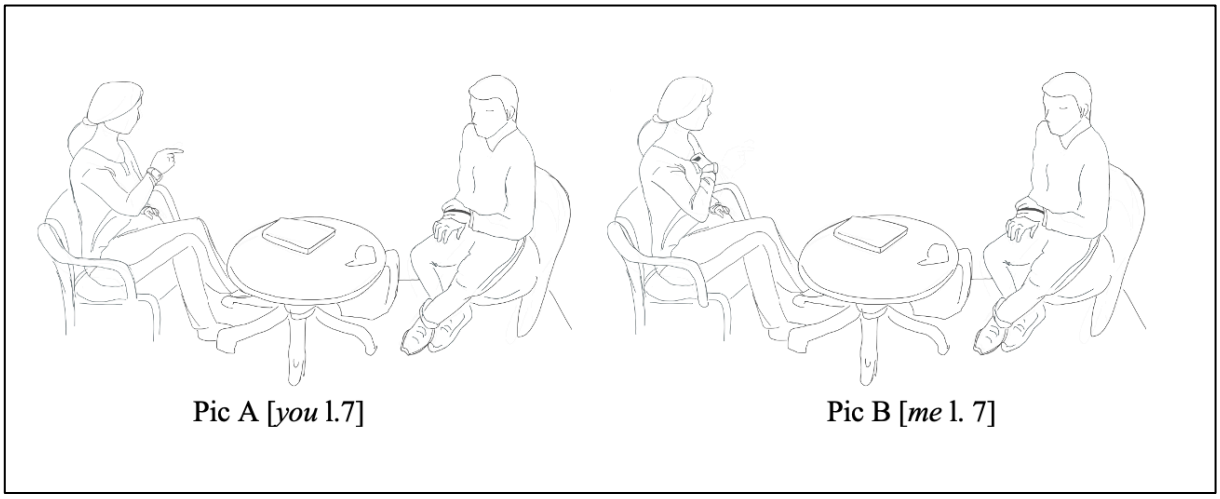


***Figure 2**: What you ask me*

7	T	.h I::: canno- I cannot im- exactly so if what you ask me is whether that ruins your chances for adoption to work with (.) your history in here
8	P	mm
9	T	and with your traumas
10	P	yes

Timecodes: l. 1-4: (00.00–00.21) & l. 5-6: (00.42–00.59) & l. 7-10: (1.40–1.53).

While the therapist cannot take a time-out, she can delay the decision-making activity. In this situation, we observe how she avoids manifesting any opinion; instead, she frames the patient's concern into a question in order to explicate what is at stake from a joint perspective of the patient and herself. This allows her to (i) postpone the decision-making process, (ii) challenge the patient's perception of the dilemma further, and (iii) gain more information about the dilemma's emerging conditions.

First, we see how the therapist transforms the patient's actions into a different outlook, so his concern is now dealt with by drawing on psychotherapeutic vocabulary. Specifically, the patient's *I might have been ruining that chance now, by saying these things* (l.1) pivots on the negative outcome of *revealing* secrets ("saying these things"). Building on this utterance, the therapist transforms this articulation into: *whether that ruins your chances for adoption to work with (.) your history in here […] and your traumas* (l. 7+9). By doing so, the therapist preserves the structure provided by the patient but at the same time she modifies this structure into something new, allowing emergent local configurations of talk to be working material for joint action (Goodwin, 1994, 2017). This transformation enables the therapist to dwell on the perspective that therapy is a matter of working with one's history and traumas, rather than revealing or hiding secrets. The therapist makes this transformation or interpretation further explicit in her whole-bodied utterances through her deictic gesturing and hypothetical thinking: She points towards the patient as she says *if you* (see Figure 2, Picture A) *ask me* (see Figure 2, Picture B) and seeks the patient's confirmation before she gives her professional opinion.

The patient confirms that the therapist's reformulation corresponds to his understanding of the dilemma (*yes* in l. 10). However, his verbal acknowledgement is uttered without any significant expressivity, which complicates the assessment of the authenticity behind his utterance. Further, he does not follow up on the therapist's utterances as he awaits her next action. This passive attitude of the patient might prompt the therapist to enact a long and ambiguous line of thinking.

Thus, in what follows, the therapist initiates an evaluation sequence where she switches between claiming that (i) working with psychological problems is always a good thing, hence a good thing for the patient, and (ii) granting that she does not know how other systems will react to information about the patient's history, and as such she partly devaluates her initial claim in this second phase. In the following we investigate these oscillations as they impact on the patient's doubt towards the therapist, which again feeds back on how the dilemma is and can be managed in situ.

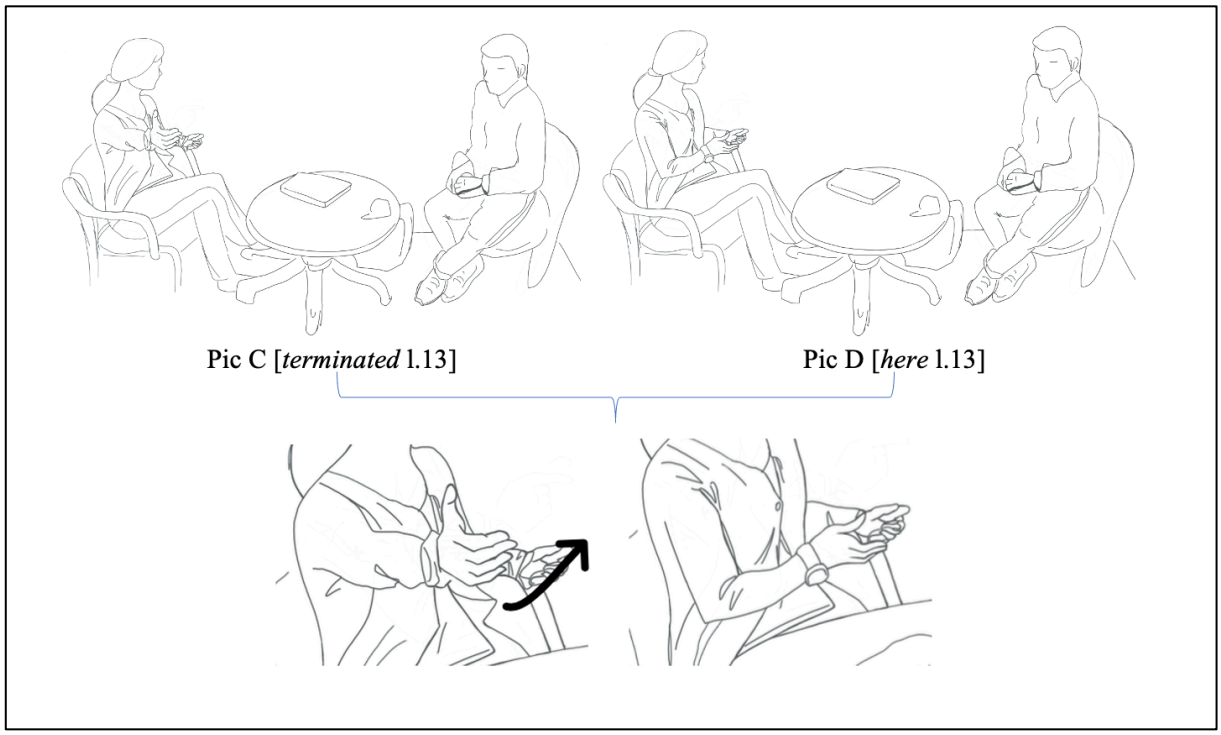
Phase II: Embodied insecurity and hypothesis generation

The therapist and the patient have now unfolded the dilemma, which enables them to make decisions about what the patient needs to do. However, the interactional pattern in the second phase changes remarkably and reflects a great deal of uncertainty on the therapist's side regarding how the municipality administration operates and on what basis they make decisions. The therapist admits that decision making is problematic at this state.

11	T	mm (sighs) (4.0) that is a question which (2.0) I cannot answer 100% correctly (.) because I do not know (.) exactly (1.0) I do not know a eh process a eh process of adoption (1.5) ehm so I do not know that system very well and I am not employed in that system and I have no experiences with it
12	P	no
13	T	ehh if I had experience with it then it would have been with some patients who have been terminated meaning I do not know what consequence it has that they have been in treatment here

Timecode: l.11-13: (1.54–2.30).

Figure 3: *Terminated from treatment here*



The therapist elaborates on the uncertainties which impact on the decision making. Specifically, she visualises how her area of competence is linked to the setting here-and-now. She compares that information with a similar reference to her lack of knowledge about a domain outside of the setting of therapy. She utters *patients who have been terminated* as her right arm moves away from her body and away from the situation (see Figure 3, Picture C), which she links with the meaning that she does not know what consequences therapy has had for them, when they are not in therapy ("*here*" – see pic D) anymore. Those deictic gestures derive their significance from their coupling the local context in which they are embedded (here) to the world beyond (the municipality). The patient remains completely

unanimated. He keeps his posture and a constant eye-contact with the therapist (see Figure 3). He reveals no emotional responses, and his facial expression is static. The rapport between the two is thus vulnerable and could even be categorised as saturated with scepticism as the patient almost stares at the therapist and awaits answers which she is unable to deliver.

Phase III: Persuasion – beneficence over autonomy

The patient's non-dialogical behaviour prompts the therapist to enact a different interactional style, one that is characterized by a more persuasive style where she relies on her expertise and argues from the point of view of a therapist in general. This implies that the therapist becomes less open to investigating the patient's specific concerns. Rather, she emphasises the value of therapy (beneficence) over the patient's autonomy, as his ability to decide the next course of action appears to be overruled by what the therapist thinks.

This third phase thus reveals the therapist's attempt to handle the dilemma by valuing therapeutic improvement of the patient over his fear of consequences. However, her guidance is not just logical, simple or one-sided, but very much affected by what and how the patient (dis)engages. Further, while the patient does not seem convinced that the positive therapeutic improvement counterbalances the fact that this improvement can be interpreted differently by social workers, the therapist initiates a row of arguments for a positive evaluation, leaving out details about the sexual assaults:

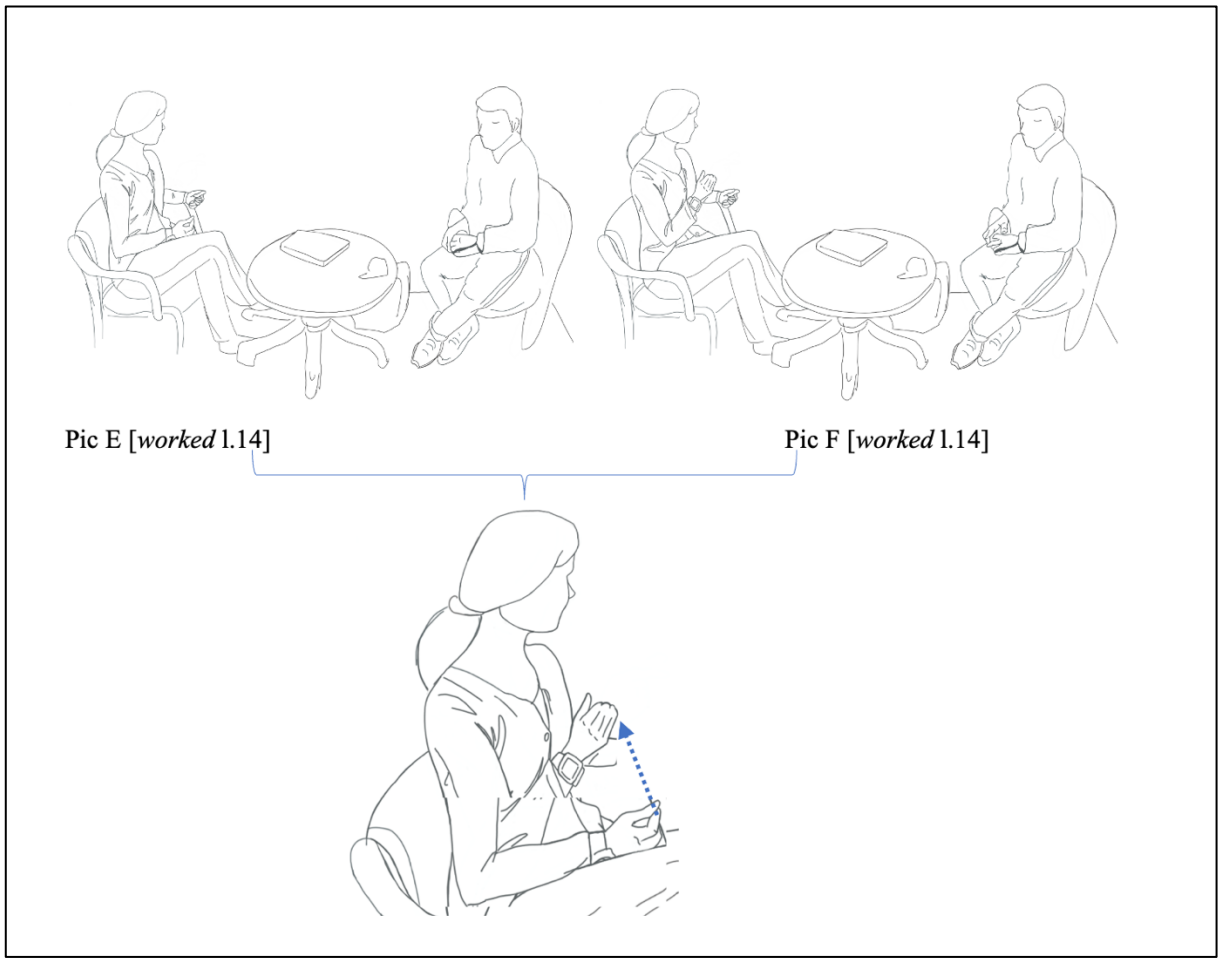


Figure 4: *Working with it*

14	T	and then one would write that you have worked with it (2.0) and then one would write (.) either that you have completed it or terminated at some point (.) and then you would write something about you fulfilled the criteria for it today you would for instance write that you have been (.) meeting regularly that would be written about you that is something they can see [that was really good
15	P	[mm
16	P	yes
17	T	one would also be able to see that you:: had worked wi::th (.) getting off your medication and managed it very well
18	P	mm
19	T	that could also be seen
20	P	mm
21	T	that is not bad either
22	P	mm
23	T	then one can see that you have had a general anxiety that is not a (.) dangerous diagnosis at all it has nothing to do with parental competency I cannot see how that e:ver should prevent you from adopting
24	P	no
25	T	e:hm and then it would say (.) whether you are feeling better in some way and is in improvement with it
26	P	yes

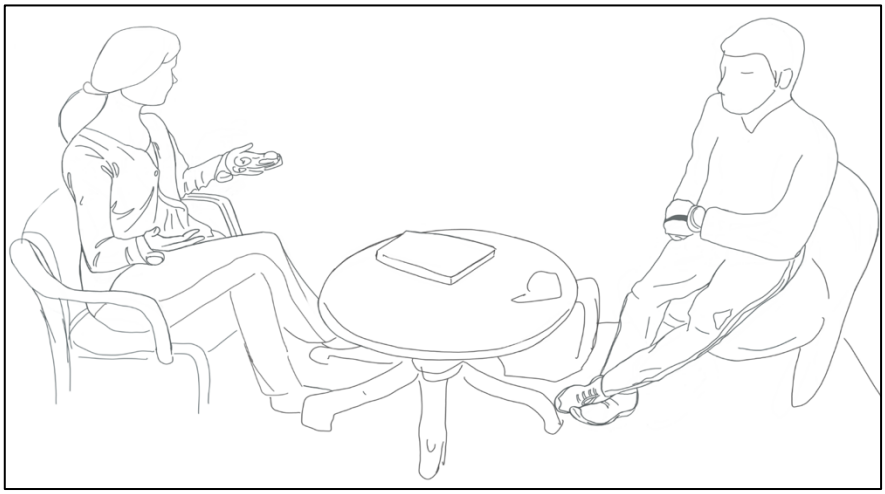
Timecode: l. 14-26: (3.40–4.24).

The therapist argues that a course of therapy is always a good thing (l. 14 and 21). We observe how the principle of beneficence is embodied in verbal and non-verbal utterances. In l. 14, the therapist utters that the patient has been "working with it" (i.e., his problems) as she makes an upward gesture to indicate the improvement from a low starting point and a positive higher endpoint after therapy (Figure 4). This positive change is emphasised later when she utters that the discharge letter will state whether the patient is in improvement (l. 25). Again, as she utters "improvement," her embodied dynamics align: her gestural upwards movement with her right hand aligns with her verbal argument for improvement. She thus emphasises that therapy lifts you up from a low starting point to a better place. The persuasive pattern of interaction is thus revealed in her certainty when she talks about how the patient in therapy develops (and how this has to be viewed as a good thing regardless of how the adoption authorities evaluate it), as well as in her rich and animated gesturing. However, this change in strategy does not correspond to a change in the patient's behaviour. The fact that she does not get any response from the patient prompts her to enact yet another strategy where she becomes more extreme with the aim of aligning with the patient.

27	T	you would **never** write in a discharge letter (.) eh a lot a lot about what it is that we have been talking about here (1.0) a discharge letter is very factual that is also the one your GP will get
28	P	mm
29	T	it will **most likely** just be that which they can see
30	P	yes
31	T	so that is not like this they will **never** get access to the overall patient record that I cannot believe
32	P	no

Timecode: l. 27-32: (4.24–4.40).

Figure 5: *The overall patient record*



Pic G [overall l. 31]

The therapist argues that what they have been talking about in detail would "never" (l. 27) appear in the discharge letter, and as she elaborates that the municipality will "never get access to the overall record" (l. 31), she opens her arms to visualise the huge amount of data (Figure 5). Again, the patient has not been changing his attitude at all throughout these three phases. The therapist stops her persuasive argumentation and suggests that others might provide them with further info before they can move on.

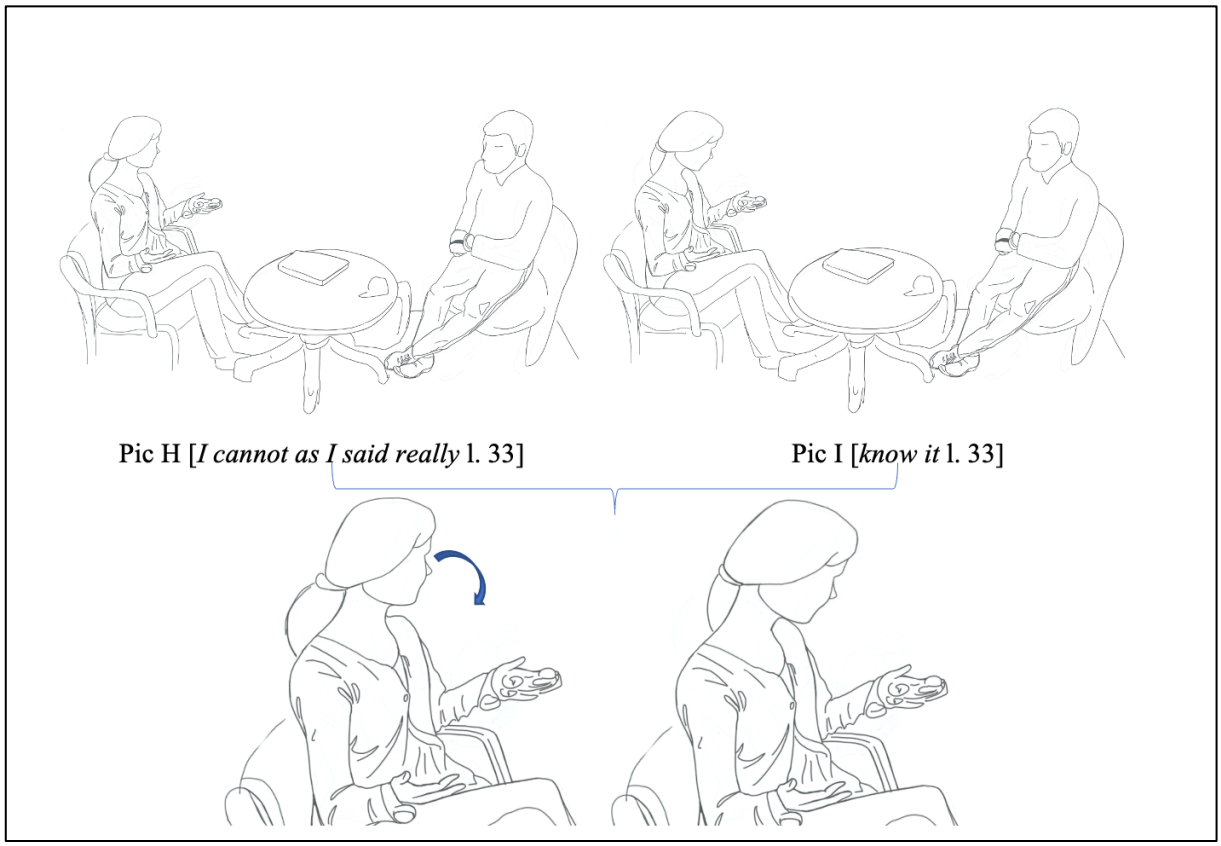
Phase IV: Proposal, fixation, and resistance

The interaction reaches a point of fixation, which prompts the practitioners to do something radically different than what they have done so far. The therapist admits that, in the end, she has no warrant for her hypothetical argumentation, and that one solution might be to postpone this discussion and ask for more information, rather than making decisions based on insufficient cost-benefit analysis:

33	T	ehm but **I cannot as I said really know it** (.) ehm (1.0) so so so that is why eh (0.5) hmm but I would (.) enquire about it if you need more answers

Timecode: l. 33: (4.41–4.55).

Figure 6: *I cannot as I said really know*



As the therapist utters that she cannot really "know it" (l.33) she leans a bit forward with her head down, which further indicates she hands over the ball to the patient (Figure 6, Picture I). So far, the more than 4 minutes discussion about this dilemma has not enabled them to get any nearer a solution to the dilemma. The therapist has tried to nuance the dilemma by emphasising the value of therapy. However, below we observe how the patient addresses the therapist's attempt to sediment improvement in therapy as a prerequisite for being able to navigate in his own life in functional terms. He, therefore, questions the overall purpose of therapy in his situation, suggesting it can entail negative consequences.

34	P	then (.) it actually <u>can</u> eh ha::ve inhibited me being in treatment in some way also wi::th regard to (.) those things one wants with one's life

Timecode: l. 34: (5.00–5.10).

The therapist has just argued for the value of therapy. The patient, in turn, reveals his distrust towards therapy as it might have been an obstacle for realising goals beyond his psychological well-being. His social life interferes with individual goals in therapy. Even now, the patient remains unanimated and does not use any gestures throughout his utterances. However, his distrust is outspoken, leaving the therapist with a difficult task of regaining trust and focus on how therapy *is* a good thing. The therapist now picks up on the patient's verbal frustration as a symptom, which enables her to move from a phase of fixating on the dilemma to a well-known therapeutic style of interaction.

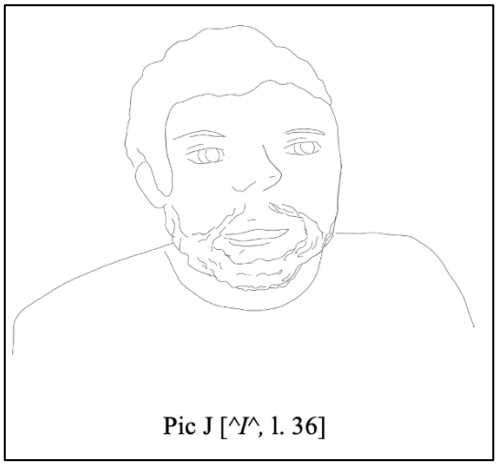
Phase V: Circumvention – back to therapy

In phase V, the therapist circumvents the decision-making process that the patient initiated by asking what he can do to improve or avoid damaging his chances for adoption. Specifically, the therapist uses the patient's reaction (fear) as re-enactment of a general anxiety for consequences. She mentions the patient's fear of consequences four times within 39 seconds, which indicates that she wants the patient to reflect on his symptoms in a more general sense. The patient resists and tries to wiggle himself out the therapist's agenda by keep questioning the therapist's arguments. Every time the therapist ignores his objections and finally, he gives in.

35	T	and to deal with your problems that I cannot see should hinder the chances
36	P	no (3.0) (*sniffles*) no (1.0) but ^I^ hope that is true

Timecode: l. 40-41: (7.14–7.25).

Figure 7: *But ^I^ hope that is true*



Pic J [^*I*^, l. 36]

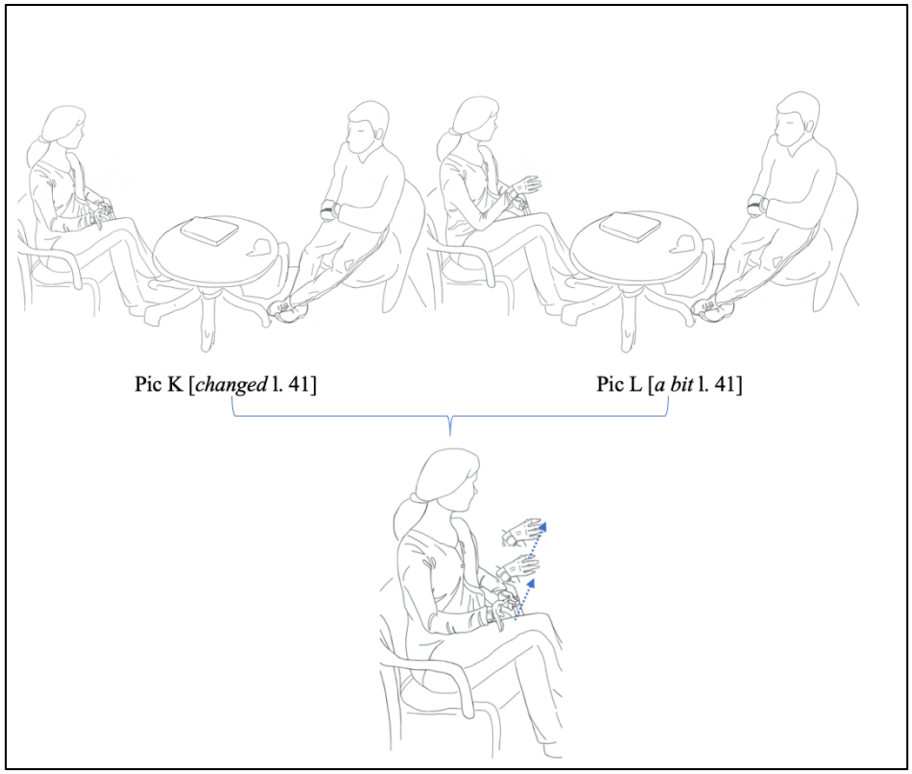
For the first time in this overall example, the patient reveals a little smile when he has uttered that he hopes that the therapist is right (l. 36, Figure 7). He embodies a defeated and ironic mood as his smile is a reaction to the therapist's argument, of which he is not fully convinced. The therapist holds on to her agenda and eventually it becomes even more clear that she moves away from a discussion about what a solution could be by enacting a therapeutic interaction style. By doing so, the therapist changes the strategy from one of discussing the consequences of the dilemma, to one that focuses on the patient's being – in her view –overly concerned with consequences. The implication of this reinterpretation is that the ethical dilemma is rather a sign of a dysfunctional emotional pattern that he re-enacts when faced with challenges.

37	T	but there is s (1.0) bu:t I also mean the thing that it feels like (.) whenever you approach the openness in relation to this topic
38	P	mm
39	T	you get scared
40	P	yea:h tha:t yes I do
41	T	of **consequences** and it might be that those consequences have changed a bit throughout your life what kind of **consequences** you fear
42	P	mm yes
43	T	but I hear anyway this thing that you get scared

44	P	yes
45	T	scared of whether you accidentally should give yourself in to therapy in a wa:y where you lose the control by telling me way too much
46	P	mm

Timecode: l. 42-51: (7.30– 7.54).

Figure 8: *Those consequences have changed a bit*



The therapist uses multiple right hand beat gestures which indicate the back and forth moves that correspond to the many kinds of consequences the patient has feared over time (Figure 8). While each beat gesture embodies a point in time where a certain consequence has emerged within the patient's life, it further illustrates that not only have they emerged repeatedly they are also diverse in nature: "those consequences they have changed a bit throughout your life" (l. 41). As such she categorises the fear of being in therapy (with possible consequences for adoption) on a par with a fear of many other consequences in general. The repetition of the word "consequence" serves as marker of the therapeutic work where the two co-operate on the goal. The patient stops questioning the therapist's utterances. The fact that the therapist uses the dilemma with its potential consequences as a re-enactment of a psychological reaction in the patient's life enables her to deal with the decision making in an indirect manner. Implicitly, she reaches a decision as she continues with the therapeutic intervention (the activity that the patient initially was reluctant towards).

This result, we argue, is enabled by the changing dynamics in the interaction trajectory, and it is indeed a result of the embodied emotionality that emerges within the system (the patient's distrust, the therapist's insecurity, and their fixation in phase IV). The app. 8 minutes of interaction undergo different interactional dynamics that reveal how the interaction oscillates between a mode of non-therapeutic practical concern regarding a dilemma and a mode of therapeutic work. Further, the therapist's expertise allows her to understand the patient's

fear of consequences as a psychological symptom of anxiety rather than a concern that should be handled in isolation. In other words, she embeds his concern in his life trajectory: "those consequences they have changed a bit throughout your life" (l. 41). Further, her professional background prompts her to prioritise beneficence over autonomy when they conflict, that is when the patient considers not wanting to be in treatment for his traumas. This expertise is not enacted without interactional challenges. The therapist struggles to make her argument coherent and convincing as she also lacks knowledge about relevant aspects. Only when she admits that she is not sure, can she transform the situation from one outside of her comfort zone and back into therapy.

What happened?

In a previous conversation with one of the authors, the therapist reported that this situation was one of her most face-threatening therapeutic experiences to date. She felt she was caught in a situation, where she simply lost the overview and felt unable to guide the patient professionally. Still, the detailed analyses in this article demonstrate how the therapist in fact contained the insecurity in the interaction and avoided jumping to any conclusions. In phase 1–3, she moved back and forth between hypothetical scenarios, and she creatively transformed the patient's utterances into richer narratives with more nuances (Goodwin, 1994, 2017). Further, she aimed at establishing a dialogical and trustful rapport with the patient by linking the dilemma to situations outside this local interaction (Goodwin, 2017). That is, she re-enacts their shared history to understand the patient's dilemma as a symptom of anxiety and a fear of consequences. Eventually, the patient's initial concerns and fear of consequences become work material for psychological intervention, and as such the therapist did convince the patient that moving on with therapy will do him well. Instead of making decisions based on insufficient grounds, the therapist thus links the patient's fear of consequences to his symptomatology and transforms the dilemma into a symptom of the patient's autobiography. The therapist's self-perception is thus not adequate for understanding the work she actually does. Managing an ethical dilemma is a temporal interactional process that cannot be done in isolation (Barnett, 2019). Dealing with a dilemma in situated interaction often requires, we claim, an ability to work in a domain of uncertainty where the therapist is not the only one responsible for the result of that work.

Discussion

In this discussion section, we address the implications for our empirical findings regarding how to deal with ethical dilemmas in theory and practice. We took an embodied, cognitive perspective on how an ethical dilemma was being managed in situated interaction. The analysis demonstrated the real-life emotional-cognitive and interpersonal challenges that therapist and patient experience when ethical dilemmas emerge. Dilemma management involves dealing with uncertainty, adapting to the affordances and constraints of the environment, and using expertise as an experiential basis for embodied perception-action in situ. These findings may add new insights to more theoretical models for dilemma management which do not work with detailed analyses of real-life data (Barnett, 2019; Knapp

et al., 2015). A dialogue between these different types of studies may, in turn, inform work on how guidelines are developed, taught, and communicated in practice.

First, the case emphasised how the patient was afraid that his openness might function as a potential threat for his own and his family's well-being. Specifically, the patient is concerned that other parties have access to patient records, which prompts the patient to be very selective in terms of what he shares in therapy. Being open in therapy is crucial for therapeutic improvement, but in the patient's perspective it is paradoxically also a constraint. Second, the case also reveals a struggle on the therapist's side. Emotionally the therapist senses that the overall weal and woe of the patient is at stake. At the same time, the therapist hesitates in her judgement of the situation because various considerations are at stake at once. There is a tendency that she urges to direct the ethical dilemma interaction into a specialist, professional domain of thinking. This insight gives the impression that the therapist is keen on getting back to her professional understanding of the problem rather than approaching it as an ethical situation. This management strategy has also been observed among medical doctors (Trasmundi, 2020). Obviously, this strategy has direct consequences for patients as their autonomy is being affected, and as the professional control biases a sensitivity towards what happens and what the patient's concern is about. In this case, the patient's concern did not relate to his own well-being but to parties outside the therapeutic setting.

Still, this study is only based on observations from a single therapeutic conversation which has obvious limitations. More work needs to be done in order to substantiate the observations and claims made in this article which, in turn, could eventually lead to a more fruitful dialogue with both academics dealing with ethical dilemmas in health care as well as health care professionals.

Conclusion

The analytical findings, we suggest, may pave the way for a more embodied code of dilemma management, which has consequences for the theoretical assumptions that inform the models and guidelines for action in practice. Most importantly, we have shown the importance of an embodied, bottom-up approach to applied ethics. Such an approach increases the tangibility and visibility of ethical aspects in real-life healthcare practices. This approach is important if the quality of ethical considerations is to be strengthened among healthcare professionals. It opens up additional opportunities to promote the consistency of the therapist's and the patient's perspectives on the situation. Further, it frames the dilemma as an embodied phenomenon that emerges in interaction, which directs the attention towards how the patient-practitioner dyad act and perceive as a result of the interaction dynamics rather than as a result of abstract reasoning. This understanding allows for more dialogical approaches to dilemma management both in terms of theory and educational practice being based more on observations from real-life situations. Eventually these results might impact on how we address, evaluate, and understand ethical dilemma management, which again can contribute to the reduction of moral distress amongst healthcare practitioners.

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Notes

1) https://en.oxforddictionaries.com/definition/ethical_dilemma
2) Cognitive ethnography is a methodological framework developed to study distributed cognition – cognitive processes distributed across persons, artefacts, and practices – in natural settings. For a more elaborate description of the approach, see (Hutchins, 1995; Trasmundi, 2020)
3) All examples are rendered in our English translation. Due to word limits, we do not render the Danish original.

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Appendix A: Themes in dilemma management

1. **Balance**: How much push/pull by therapist when the patient is suicidal?
2. **Personal opinions**: When the patient's wishes (e.g., about pregnancy) conflict with therapist's opinion
3. **Therapeutic impasse**: Therapist does not know how to proceed to engage the patient
4. **Harming or helping**: Is it the best strategy that the therapist uses?
5. **Disassociation**: When the patient exhibits violent behaviour without reason
6. **Boundaries**: How does the therapist protects her own boundaries?
7. **Fear and facts**: When the system complicates trust/alliance, for instance when the therapist must document what the patient does/says but that entails a distrust
8. **Prejudices**: How can the therapist handle prejudiced judgements?
9. **Decision making**: The therapist feels the patient forces her to make decisions on his/her behalf

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