"THE ESSAY METHOD"

A qualitative method for studying therapeutic dialogues[1]

Sverre Varvin

Corresponding author:

Sverre Varvin

Oslo Metropolitan University

Faculty of Health Sciences

PB. St.Olavs plass, N-0130 Oslo, Norway

E-mail: svvarv@oslomet.no

Telephone: 004793249669

[1] This work was developed in collaboration with Professor emeritus Bjørn Killingmo. He has been a great inspiration and the article could not have been written without his continuous participation in the process.

Abstract

This paper presents a qualitative research method for analysing therapeutic dialogues called “the essay method”. A central part of the method uses the format of the literary essay as a model. The method consists of a close monitoring of clinical material guided by an overall psychoanalytic/psychodynamic theoretical frame. It combines both clinical details and global patterns of clinical material and is especially fitted for studying relational qualities of psychotherapeutic dialogues. In this paper, the background for qualitative analysis in studying psychoanalytic material is discussed, and the procedures for using the method are demonstrated. A study of therapeutic competence in a group of student therapists is used as an example of the method in practice, demonstrating that the essay method may have potential for revising theory and establishing new concepts based on empirical findings. The essay method is compared with other qualitative methods, and it is argued that it is suitable for psychoanalytic research.

Keywords:

Qualitative method, psychotherapy research, psychoanalytic psychotherapy, analyst patient relationship, therapeutic competence

Introduction

The aim of this article is to present and to argue for a psychoanalytically grounded qualitative method for studying therapeutic dialogues. A way of writing up the dialogue inspired by the method of writing an essay, will be demonstrated. The literary essay, a way of disciplined freedom of writing, is used as a model. In the following, the term "The essay method" will be used as a shorthand for this approach. Analysis of dialogues is based in psychoanalytic object relations theory (Sandler & Sandler, 1998) that includes theory of character formation (Killingmo, 2007). This perspective implies focusing both relational aspects as well as formal/non-verbal aspects of dialogues. The method implies a close monitoring of clinical material, guided by an overall theoretical frame, making it particularly suitable for the study of relational qualities of psychotherapeutic/psychoanalytic dialogues. This will be demonstrated by material from a study of therapeutic competence in a group of student therapists (Killingmo et al., 2014).

This approach is based on general principles of qualitative studies (Frommer, 2007; Kvale, 1999) and by using the essay form, it is in line with recent developments in integration of methods and arts-based qualitative research in psychology (Butler-Kisber, 2018; Chamberlain et al., 2011; Chamberlain et al., 2018). A specific psychoanalytic way of listening to and organising material characterises the method's mode of qualitative research.

In this paper, the origin of the method will be described next; then, its use in practice will be illustrated by material from the study of student therapists. Next, the background and the context of the method is outlined. Essential aspects of the implied listening perspective are explained and how the writing of an essay is applied in the research process. The method is then evaluated and compared to other qualitative methods.

The origin of the method

The method was developed as part of a project at the Clinic of Dynamic Psychotherapy, Department of Psychology, University of XX. As experienced psychoanalysts the researchers evaluated the competence in psychoanalytic, dynamic psychotherapy of a group of student therapists (N = 21) who had completed a three-year training programme. This programme consisting of clinical seminars, practice as therapists and supervision of their clinical work (Killingmo et al., 2014).

Based on one audio-recorded session from the end of each therapy session, two researchers recruited for the project (including the author) were instructed to make separate evaluations of the competence of each student according to a set of predefined variables grouped into four main categories:

1. The therapeutic relationship as a whole,
2. The analytic attitude,
3. Transformation of understanding into concrete interventions, and
4. Interpersonal interaction skills.

Each category had a number of sub-questions. Many of these were adopted from David Tuckett's form for evaluating analytic competence in candidates in psychoanalytic training (Tuckett, 2005). After coding the material according to this manual, the researchers evaluated each therapist and reached a consensus evaluation.

In the course of the coding process, this system of variables proved difficult to apply. It was a top-down approach that necessitated fitting empirical data into a series of predefined variables; thus, it represented a limited way of using the qualitative method. In the process of analysing therapy sessions, it was found that the sub-variables were too distant to match the actual clinical material. Generally, the clinical practice of the student therapists turned out not to fit the theory-driven predefined variables. The therapists

appeared to be so “unsophisticated” (inexperienced) that it was impossible to meaningfully code the material, for example in terms of transference dynamics. The theoretical concepts of the registration manual on the one hand and the clinical material on the other were too disparate. The coding process involved further searching for partial elements in the clinical material to fit into separate predefined categories, which led to a fragmentation so that context and wholeness disappeared from the material. The relational atmosphere was lost as well. The researchers saw that a method of analysis was needed that was closer to the distinctive character of the material, implying less predefined theoretical interpretation and, at the same time, being especially directed at global and formal aspects of the session material of psychoanalytic, dynamic psychotherapy. A procedure was needed that was based on a certain preunderstanding but that nevertheless could be free enough to catch the specifics and the wholeness of the material.

This led to a change in the methodological approach in line with qualitative research methodology. Instead of searching for specific predefined and theoretically based variables (top-down approach), the researchers decided to base the approach on a psychoanalytic way of listening to the material.

The first step was to relax and just listen with an open mind to the audiotape the session without intermission. Immediately afterwards, the researchers spontaneously wrote down, in their own words, their subjective impression of the totality and relational qualities of the interaction between the two participants in the dialogue. This written impression, based on psychoanalytic listening, was inspired by the “essay” as a literary form in that it was organised and written in order to give expression to thoughts resulting from this way of listening. The essay was estimated to consist of two to three pages of typewritten text for each therapy session. This was followed by a process of hermeneutically going back and forth from the essay to the session material in order to support or disqualify a

formulation or an evaluation in the essay. In this way, the researchers reworked the essay several times and identified salient themes, and these themes were seen in the context of the whole session as manifested in the session-based essays. Further, the researchers had no information about the patients or the therapists, and in this way any predisposed perspective of listening based on knowledge of the therapist's competence or the background of the patient were abolished.

The way of listening described here has features in common with the clinical listening of the psychoanalyst. Psychoanalysts endeavour *not* to listen in prescribed directions, but to "take in" the material without intentional selection and to store it directly in the unconscious. Expressions like listening "with evenly suspended attention" (Freud, 1912) and listening "free of memory and desire" (Bion, 1967) illustrate this aim. These formulations can be viewed as instructions for a way of listening to clinical material which invite an exploration of the subjectivity of listening (Killingmo, 1999). However, the instructions do not by themselves determine the *understanding* of the material. Understanding the meaning of the material presupposes a theory and is a further step in analysing the material. The theory specifies the *content* of the listening perspective and it is by way of a theory that the observations of the psychoanalyst will appear as "psychoanalytically" distinguished from any other kind of observations.

The impact of theory is central to this method as well. This concerns how the researcher's preunderstanding influences the way the empirical material is perceived and structured when listening (Kvale, 1999), and as a psychoanalytic *theory* it acted as a common reference behind the listening perspective of the researchers. Even if they approached the material differently and with an "open mind", on a preconscious level, the same theory influenced the selection of data, how they were organized, and how they were evaluated. In contrast to the analyst at work, the researchers in the present project also had the

specific task of evaluating the competence of the students as dynamic therapists. This was the aim of this study and prepared for a certain way of specifying the direction of listening. The method that was developed has, however, a broader perspective in that it can be applied in different research contexts. The main issue is that the method can be used generally in studying dialogues in psychoanalytic therapies.

Why the name "essay" method?

In this study, an "atomistic" method was replaced by a "holistic" one. This does not mean that the holistic approach is always better suited than the atomistic one in studying and evaluating clinical dialogues.

For this procedure to qualify as a *method*, procedures had to be established. Almost spontaneously, the essay came to the fore as a possible method. An essay is associated with a particular form of written account. Compared to the ordinary scientific treatise, the essay has a short form, and while the former is subordinated to a commonly accepted code of expression, the latter has its own code. The essayist writes on behalf of him-/herself and is free to "play" with the well-known. While the author of a dissertation is expected to follow a disciplined, logical, and coherent style, the essayist can permit him-/herself to employ metaphors and popular phrases.

The essay has a long history as a literary genre. It was developed by Michel Eyquem de Montaigne (1533- 1592) who thought of it as a short form of prose dealing with even the most serious matters (Montaigne, 1910). This genre could treat every cultural issue in a surprising and unexpected way, often with an element of humour. Even if the essay allows for a more evocative way of expression, it has the hallmark of discussing a topic in a reflective way. *Essais*, or "attempts", is, in Montaigne's spirit, not a transmission of proven knowledge or of confident opinion, but a project of tentative exploration of topics. Further, it is a remedy against false, unexamined, and externally imposed notions. It is

thus a form of inquiry that may be suitable for research. It has developed as a kind of reflective inductive method (Lopate, 1994). As mentioned earlier, this is line with arts based qualitative where art is used in different aspects of the research process (gathering data, presenting results etc).

By launching this procedure as a psychological research method, an established genre of literature has been in the background. As a literary form, the essay involves similar features as a clinician's approach to clinical data. These features can be summarised as follows:

1. Compiling a huge amount of data on different levels (emotional, cognitive, relational) (Nielsen, 1995)
2. Relating to different psychological perspectives, in a short and consistent form
3. Freedom of observing, as well as reporting the observed
4. Opening for subjectivity in the process of understanding.
5. One is not looking for predefined categories
6. Aligned with descriptive aspects of the material, thereby increasing reliable communication
7. Catching predominant relational aspects of the clinical material, such as central points, continuity/fragmentation, level of communication and emotional atmosphere

The starting point was the study of therapeutic competence of student based on pre-defined categories, which then developed into a bottom-up, phenomenological study of therapeutic dialogues that examined the quality of therapy-session dialogues. A basic premise for the essay method is that the researcher has to take a kind of meta-perspective in observing the dialogue. He/she has to be "above" the content of the actual material and

instead orient his/her listening-perspective towards *the kind* of dialogue that is reflected by the material. He/she should ask him-/herself: "What kind of discourse are we listening to here? Who speaks like this to each other?"

The essay method in practice

From an atomistic to a holistic approach

The change in methodological approach also led to a change on the conceptual level from an "atomistic" to a "holistic" conception, in line with the aim of qualitative research to view parts in contexts. Based on work with the first top-down approach, it was considered more relevant to think of dynamic therapeutic competence in terms of global qualities than in terms of separate, distinctive capacities based on summation of predefined categories.

The first step in the method is listening. The listening recommended is similar to psychoanalytic listening in that any aspect of the dialogue may be focused. However, the listening will also be shaped by the perspective determined by the aim of the study. Fitting into these frames, there is an emotional listening that uses a psychoanalytic framework. The knowledge required for this type of listening is psychoanalytic theory (here, an object relational perspective that includes theory of character formation), but during the process, this knowledge will be mainly preconscious and not formulated as categories to be sought after. It is thus not free-floating attention, as in the psychoanalytic process, but a special kind of listening that opens up different perspectives and allows the listener to dwell on details and reflect on different meanings throughout the process. This special form of listening is similar to the way of listening or reading of texts in most qualitative research, but different in that it is a form that involves specific competencies; it presupposes training in psychoanalytic listening through the researchers' background in

clinical psychoanalysis. This “deep” listening also facilitates the researcher focusing his/her own state of mind while listening. The researcher may let things open in his/her mind and reflect on what happens in his/her mind while listening. It is a form of free, but disciplined, listening that allows opening up for emotional qualities within the material, the emotional effect it has on the listener, and through that, let patterns and meaning emerge in the mind of the researcher.

What appears in the mind of the listener will thus also be shaped by his/her own psychological preconceptions and states of mind. Using psychoanalytic training, countertransference reactions may be analysed, in order to examine the possibility of idiosyncratic aspects of how the material has been perceived and organised in the mind of the researcher. The aim is not to discard preunderstanding and countertransference reactions, but to use them in order to better understand the material. This represents a way of reflecting on the researcher’s preunderstanding or pre-judgement in Gadamer’s meaning (State, 2000).

The second step is writing the essay. This process will usually have several recursive stages; that is, the writer(s) go back and forth between parts and context and between different parts of the material, doing a hermeneutic reading. The first draft may be an unorganised assembly of impressions and thoughts. In the following rewritings, a more coherent picture may emerge, which then will be the basis of the essay formulated by the researcher. Each aspect, for example a dialogue sequence, has to be evaluated in the context of the whole session, in consonance with the importance of context in qualitative research. In this process, the text will be organised from a point of view which is determined by the aim of the study or the research question(s). In the study where the method was developed, it was an evaluation of therapeutic competence in beginning therapists.

The third step is working toward consensus. Each researcher writes an essay separately, which are then brought to the research group involved in the project (the research group can consist of two or more researchers). Here, it is most fruitful for each researcher's essay to be read out loud. In this way, the essence of the essay, particularly the emotional quality of the text, may be better understood. During the reading, the co-researchers listen in very much the same way as in the previous step: with an open mind, as free as possible, taking own countertransference into consideration. The ensuing dialogue is an essential part of the process:

What stands out in the different essays?

Are there common themes and where are the discrepancies, if any?

What is the meaning embedded in different ways of listening?

Are they incompatible with each other, or are there different aspects that may fit into a common understanding of the material?

This part is the *researcher-consensus* part of the process (Leuzinger-Bohleber, 2015). The question here is whether it is possible to work towards a consensus on the salient aspects of the material: This involves reflections on the different listening to and understanding the material. If consensus cannot be reached, this is noted, and one should then return to the analysis after working with several cases to see if consensus can be reached or not.

As will be demonstrated in the material from the study of student therapists described in the next part, a specification of what appeared as *significant aspects or patterns* in the material for each therapist was done. This phase in the research process implies a disciplined re-reading of the material from points of view that had appeared during the initial phases of the research process. Findings can thus be shaped in a bottom-up way based on an intense study of the material. These findings can then be formulated as

tentative concepts that in turn can be confronted with the material by a new reading from the conceptual perspectives that had been formulated.

The fourth step is theoretical in that concepts can be formulated and put in relation to present theories that may be modified or changed. In this way, the method can be theory-building as it tests, improves or extends a particular theory in psychoanalysis by systematic confrontation with empirical material, or enriches the theory by giving a deeper understanding of a phenomenon (Stiles, 2015). In the study that will be presented in the following, concepts were specified that can be tested in new researches.

Example from research on therapeutic competence of student therapists

The material consists of data from 21 therapies (16 women and 5 men, age 24 to 38) conducted by students in the final year of a six-year professional education in psychology. A single session from the last part of each therapy course was selected. During the last step of the research process, the confrontation with the material through several readings/listening and discussion between the researchers, the following three dimensions of general therapeutic competence were specified: *strategic competence*, *therapeutic attitude* and *technical competence.* On the basis of their essays, the researchers were instructed to return to the material from each *therapist* and write out their evaluation with these three aspects in mind. Below, examples will be given on how essays were used in this process.

Two research questions were formulated:

1. Did the dialogue pass on *meaning* from the point of view of psychoanalytic theory?
2. Did the dialogue express emotional *coherence* on the therapist's side?

These two criteria have in common *allusions to intentionality* in the therapist. It was assumed that this signified that the clinical practice of the therapist was anchored in psychodynamic or psychoanalytic theory, even if this was not present at the time for the therapist on a conscious level.

All dialogues were re-evaluated from the two research questions mentioned above concerning meaning and coherence. These two criteria were then used to evaluate whether the *intentionality* (even if not conscious) of the therapist was in accordance with a psychodynamic point of view.

In the first outline of essays, based on a qualitative interview analysis (Kvale, 1999), the three dimensions mentioned above (strategic competence, therapeutic attitude and technical competence) stood out as salient aspects of the therapists' ways of functioning. The sessions were then evaluated again to confirm or disconfirm whether these were meaningful relative to the aim of the study. This process involved clarifications and discussions, and work to reach consensus on these dimensions. The empirical analysis is described in a previous publication (Killingmo et al., 2014).

The three dimensions of therapeutic competence resulting from this approach will be described in the following. Examples will be given on how material from the essays where used to identify and specify the three dimensions. (Material is taken from the previously published research (Killingmo et al., 2014)).

Strategic competence referred to the ability of the therapist to reflect on therapeutic *aims* and on *means* to obtain these aims. The researchers found that it supplied the therapeutic dialogue with a quality of meaning and emotional coherence, passing on that the understanding, the attitude, and the interventions of the therapist were informed by dynamic theory.

Session material of a low- and high-level strategic competence will show how this quality was deduced from the material:

1. Low-level strategic competence:

   In this session, the therapist demonstrates several good attributes. She listens attentively, and her non-verbal utterances are made in a way that help create the necessary psychological separation between therapist and patient. The therapist's tone of voice is soft and calm, and she is able to contain the patient's grief and sense of loss when such emotions surface during the session. The therapist's most important method of intervention is asking how this or that feels or felt. This is done in a carefully considered manner.

   In spite of productive listening and the ability to establish contact, the therapist is unable, at crucial points in the dialogue, to discern key formulations in the material that might have led the process further. An example will demonstrate this: The patient has an on-going conflict with her mother. This is stated openly at the start of the session. The patient expresses a strong yearning for her mother's understanding and acceptance but experiences her only as critical and disapproving. At the same time, she emphasizes that she does not dare to "defy" her mother. The mother dominates their relationship. On one occasion during the session, the patient exclaims with intensity in her voice, "There is a battle between mother and me". This is an example of a key formulation that could have served as an entry point for addressing both the anxiety and the aggression in the patient's conflict with her mother. But the therapist fails to pick up on this formulation and does not pursue the battle scenario further. Thus, the underlying aggression and force (the potential strength) that the patient holds fail to become an open theme. Rather, the patient retains a one-sided perception of herself as the weak and feeble one.

2. High-level strategic competence:

The patient begins the session by announcing that she wishes to speak about "the weather". She would rather "dissociate" herself, be rid of the exhausting emotions, "step out" of them and maintain the façade she is so used to. At the same time, she does not know whether she can continue to do so. It is a constant inner battle, and this is what is so exhausting: "I would prefer to push these feelings away, at the same time I don't want to push them away, don't know where I stand – it's chaos." The patient states this in an emphatic voice, her words running in circles, and she is clearly bothered by uncertainty. But there is also something highly appealing in her voice. The therapist meets this outbreak very calmly. She does not allow herself to be pressured into the role of a "helper" but listens with acceptance and acknowledgement of the fact that the patient does not wish to confront what is uncomfortable. The therapist refrains from asking, reassuring or explaining. Through this attitude, the therapist allows the patient an undisturbed psychological space in which to express herself. After a while, the therapist concludes, "Now you are in the chaos – now you experience it – now you come here and talk about it. To me, it seems as if you are trying to forget what is uncomfortable whilst you are simultaneously facing it". The therapist here displays the ability to provide a summarising formulation of the two opposing attitudes in the patient. On the one hand, the urge to open up to all the feelings of bitterness, vulnerability and anger associated with childhood, and to the role she had to play at the time, the role of being good and "problem free" – the one who sorted things out, that is, the underlying latent or unconscious meaning of her behaviour. And, on the other hand, the urge to leave all the uncomfortable emotions behind, sweep them under the carpet and maintain the "lie of life" (the patient's own expression). The therapist is keenly observant and picks up on the patient's expression in a mirroring comment: "It is

precisely this 'lie of life' you have brought up which we can examine here." This shows that the therapist has the ability to bring the dialogue forward, one step at a time. The fact that the therapist uses the word "examine" also demonstrates that she invites the patient to co-operate in finding out. In addition to building a working alliance, this invites the patient to enter into an interpretative mode. The therapist's interpretation also invites the patient to delve more deeply into her emotions. The patient sees more clearly that she has always been aware of her reluctance to acknowledge her true feelings. She has created a dream world for herself since childhood. The therapist listens calmly and intently while the patient reveals her emotions. The patient expresses guilt for shattering the perfect image of childhood. She does not want to disappoint her parents. The therapist interjects, "You were the little grown-up." Here the therapist displays the ability to concentrate a complex situation into a metaphoric formulation that hits home. The last example shows a therapist that creates a productive psychological "space" and who also manages to pick up the emotional subtext, upon which she then invites the patient to reflect.

Cases with a partial strategic strategy were also identified: the therapist could keep the meaning and coherence in his/her way of relating, but then, at crucial moments, slipped out of it and for example gave advice like a friend.

There were also sessions with absence of any strategic thinking: sessions where therapist and patient were talking as friends in a café – or - when the therapist was outmanoeuvred by a demanding, dominating patient; a situation where the therapist was threatened by the underlying aggression and lacked the ability to understand and treat the patient's reaction as an expression of negative transference and was rendered passive and unable to function as a therapist.

A few sessions where labelled as anti-therapeutic as shown in the following example:

In this session the therapist seemed to have set her mind on freeing the patient from the feelings of inferiority and inadequacy that had been a constant plague to the patient in social contexts. The therapist seeks to achieve this by taking control of the relationship. Throughout the session, the therapist virtually inundates the patient with "good advice" and points of view, as if she wants to convince the patient that her feeling of defeat is unfounded. The therapist took on a role where her superior vantage point made the patient feel even more inadequate. In other words, the therapist chose a method that directly counteracted her own aim of making the patient feel less inadequate.

Therapeutic attitude refers to the therapist's more stable emotional and cognitive way of being. It came to the fore in the therapist's ability to maintain a relatively sustained quality of presence in the relationship in spite of changing levels of tension. The attitude supplied the relationship with an emotional "atmosphere" which created a frame around the concrete interventions. This professional attitude was found only in those that displayed strategic competence, which is not surprising as the ability to maintain a consistent attitude is one of the clinical characteristics that points in the direction of an underlying strategy. It was of interest to study cases where a professional attitude where *not* present as is shown in the following two examples:

1. The optimist ("Things will work out fine")

The patient has problems with her self-esteem and is involved in a difficult cohabiting relationship. The patient has also been exposed to abuse. The therapist is caring and encourages the patient to take the initiative in different areas. The therapist establishes an optimistic tone that expresses that everything will work out fine. At times, the patient takes the role of the one who ensures the therapist that it will work out fine. On one occasion, the patient talks about her mood swings: She was fine one day but next

morning she was at "rock bottom". The therapist asks what she thinks made her feel better. The patient talks about how important it is to reinforce the positive sides of life, but also mentions that she is anxious about delving into the difficult and painful subjects. This last point is not pursued. The positive is reinforced but the negative is played down. A sequence early in the session was typical: The patient talks about preparations for a journey. Therapist: "That's good!" Patient: "Yes, it will work out fine!" The patient's guilt feelings related to this journey, which are clearly present in the material, are not touched upon. It seems as if therapist and patient have entered into a mutual contract to stick to the positive, to what works well. The therapist's need to be positive and optimistic leaves the patient alone with all the doubt and guilt, and all that is "painful and difficult".

2. The normaliser ("That's perfectly normal")

The patient is anxiety-ridden and afraid of serious illness but tries to play down her difficult feelings. The therapist is friendly and wants to support her patient and help her calm down. The therapist's most important strategy is to try to neutralise the patient's fears. This becomes particularly obvious in connection with the patient's anxiety about the possibility of having been infected with HIV by a former partner. The therapist addresses this anxiety by referring to her own experiences and that of her social environment and comments that it is quite common to worry about being infected and have oneself tested. In this way, the therapist attempts to shift the patient's attention away from her strong anxiety, and the dynamic importance of this anxiety is not investigated. The patient's anxiety becomes something "perfectly normal". The therapist recognises herself in the patient. The attitude chosen by the therapist thereby acquires a dual

function. On a conscious level, it must meet the patient's needs. On an unconscious level, it will meet the therapist's needs.

Technical competence referred to the intentional interventions of the therapist, both verbal and non-verbal. The crucial point was whether the interventions were emotionally relevant to – or able to "grasp" - the material which was actualised in the relationship at every point in time. Three examples will be presented:

1. Interventions that make the patient safer

These are interventions that relate to the patient's present concerns and which are formulated so that the patient feels it is safe to continue talking. These may be nonverbal utterances, such as "hmm", said at the proper time and in the appropriate tone of voice. A quiet tone quality from the therapist may often be sufficient. The patient feels the therapist is present and listening, open and interested. Such interventions may help the patient to open up.

2. Interventions that address latent content

The therapist introduces into the dialogue feelings, wishes, or ideas that have been unconscious for the patient and was mostly seen in cases where strategic competence were present:

In one session the patient expects to be criticised and considered negatively if she "reveals" herself. She faced a dilemma where, on the one hand, she must not reveal anything, while on the other, she feels she has to "fill the time" and make sure the therapist is satisfied. This pattern emerged with full force in the session. The therapist remained calm and listened with empathy to the patient's "struggle" to fill the session without revealing too much of herself. She is ashamed of her "bad" sides and needs to hide them. The therapist was calm and gradually the patient opened up. The patient felt

more understood and revealed that she often had been very frightened when arriving at sessions. She said, "I know no disasters occur here. "But even though I see it, it's there all the time – the thought that I might be rejected if I show my bad sides". The therapist takes the initiative to examine what goes on between them in the relationship – here and now. Together they acknowledge that the patient's expectation of criticism is actually her own self-criticism.

Patient: "That's what I always expect". Therapist: "That I should think there's something wrong with you". Patient: "Yes." She adds thoughtfully, "I don't really think so. It has just as much to do with how I view myself". Therapist: "You lend a part of yourself to me". Patient: "Yes, I think I do that a lot".

Here, the therapist expresses, in slightly different words, what the patient is nearly aware of. This is an interpretative intervention, which, so to speak, puts things in place. Self-damnation, which she has been accustomed to projecting onto others, may, after good therapeutic work, be taken back as something she owns herself.

3. Interventions that are futile

These are interventions that don't bring the therapeutic dialogue into motion. The interventions don't appear in relation to the patient's material, and dialogue often ends in conventional clichés, unfocused questions meaningless comments and social "small talk". Dialogue stagnates and lacks progress:

In one session a therapist who was friendly and expectant but at the same time appeared insecure. The patient seemed to notice the therapist's insecurity and gradually assumed control of the relationship. She helped the therapist to gradually becomes better able to cope and to show her caring sides. The patient ensures the therapist that things will be fine. This gave the patient control of the situation. The therapist gradually appeared affirmative and listening but takes most of what was said at face value, brings nothing

new to the conversation, and was at times strikingly passive. Thus, the rage the patient felt towards her co-habiting partner and her GP – who did not understand her – was not addressed. Rather, it seemed as if the therapist was attempting to be someone who was not like the patient's partner and GP, i.e., someone who was considerate. Nor did the therapist dare address the patient's tendency to take on the role of a victim, the one who always takes the needs of others into account, but whose own needs are not met, and who therefore can be angry at others who "don't understand, don't help". The therapist was satisfied by ensuring the patient that "It's good that you make your own evaluations, that you can be independent".

These dimensions were not sharply separated in the material in the same way as in clinical practice. In clinical practice, they are first and foremost aspects of - and can be seen as - different perspectives on a functional totality. Having all three in mind, the researcher is able to analyse the material in a comprehensive way.

Among these three perspectives, strategy was considered to be paramount: the concept of "strategic competence" (entailing strategic thinking) was the most decisive variable in evaluating dynamic therapy competence. Strategic thinking entailed cognitive mobility and a frame of mind geared towards wholeness and connections between parts and gestalts. It also implied an understanding of the emotional tension actualised in the relationship between patient and therapist as the driving force of the therapeutic dialogue. In the clinical situation, strategic competence mostly took place on an unconscious or a preconscious level. If the dialogue between therapist and patient was actually influenced by underlying strategic competence, it was assumed that this would be marked in the manifest material, signifying that the clinical work of the therapist was based on psychoanalytic theory.

An evaluation of the method

This article's main focus is research method. To show how the method works material was presented illustrating how the three main dimensions were identified in the essays. A fuller presentation of the research and results can be seen in the original article (Killingmo et al., 2014). Here, the aim is to discuss how the essay method may function as an instrument in studying and evaluating therapeutic dialogues from different perspectives (and research questions).

As already stated, the main property of the method is that it is geared towards treating the dialogue as a gestalt. All elements of the dialogue (verbal, non-verbal, and intonation) were in the research presented here were considered from the point of view of competence. This implied a meta-position to the clinical material, which means a way of listening that highlighted both the manifest as well as the latent content of the dialogue. With this kind of listening, almost automatically, *formal* aspects of the dialogue came to the fore, raising questions such as: were we listening to two people that were speaking to each other, or were the two talking at cross purposes? Were they talking about this and that? Did the therapist talk over the patient's head? Could continuity in the discourse be identified, or did it give an all over impression of staccato and fragmentation and, if so, how was the therapist affected by the patient's fragmentation? Was there a moving tension in the interrelation between the two parts, or was it a dry and affectless conversation we are witnessing? These kinds of questions are suited for revealing whether the dialogue is meaningful from a dynamic point of view and if it expresses emotional coherence (on the part of the therapist), the two criteria of the concept of strategic thinking as the main dimension of competence.

It was shown in the analysis that through a holistic approach to the clinical material an underlying strategic competence could be identified in the manifest material. It was

argued that this showed how the clinical dialogue was informed by dynamic or psychoanalytic theory. The method was here exemplified by the study of therapeutic competence, but the method can be used and should be tested with other research questions. Further research may also relate the essay method to other measures of therapeutic competence, e.g. the competence framework developed at University College of London (UCL, 2019).

The essay method may be a way of examining the nuances and relational qualities in the clinical work of the therapist. By abstaining from coding therapist behaviour into predetermined categories and instead focusing on simple aspects of the material in a descriptive way, it was possible to demonstrate whether the therapist's understanding and his/her handling of the therapeutic dialogue actually was influenced by dynamic or psychoanalytic theory.

Clinical aspects (a background knowledge based on clinical and supervisory experience and theoretical background (Gullestad & Killingmo, 2013)), that may be visible with this method are:

The therapist lets the patient express him-/herself at the patient's own pace.

The therapist abstains from steering the course of the dialogue.

The therapist shows tolerance for pauses.

The therapist gives priority to the subjective experience of the patient.

The therapist is attentive to the actualised feeling state of the patient.

The therapist is not driven by an urgent need to help or to do something.

The therapist is not evaluating the actions, feelings or fantasies of the patient.

The therapist maintains a factual, respectful and benevolent attitude towards the patient.

These aspects of therapist behaviour reflect a quality of clinical presence. This paves the way for material, which the patient previously has not expressed, to come to the fore and can be verbalised and reflected upon in the therapeutic dialogue. Together they stand for a "silent invitation" to the patient to "let come – what comes". This kind of presence is on par with the baseline in a psychoanalytic listening perspective.

The examples above focus on *formal asp*ects of the discourse, on *how* the two parts of the dialogue communicate. This is not to say that the essay method is exclusively directed towards structural and relational aspects of personality. Formal aspects may also transmit an underlying content. The use of the simple word "but" may change a discourse from a mutually respectful one, to one of underlying aggressive fantasies, even if no trace of open criticism or scepticism can be identified in the manifest content.

This way of listening and organising material may also be useful in the clinical situation, that is, research using the essay method may be useful for the clinician. Listening to how the patient describes him-/herself or how he/she puts forward his/her points of view can give the sensitive therapist essential information about the internalised world of object relationships of the patient. By asking him-/herself, "to whom does one speak in this way?", the therapist can come closer to an understanding of the underlying scenario that is actualised in the therapeutic relationship, and what object representations that are projected onto him/her in the transference. Is the patient addressing the representation of a critical father, an impatient mother or a competitive brother?

It is argued that the orientation toward descriptive linguistic aspects of the material is a *special asset* of the essay method. From this linguistic point of view, a fruitful perspective on therapeutic dialogues would be: *Who is in conversation, in what way, about what, and on what scene?*

The essay method in relation to other qualitative methods

The essay method was developed from a study of sessions in psychodynamic psychotherapy with the purpose of evaluating therapeutic competence. In this context, three salient aspects of therapeutic competence were identified (strategic thinking, attitude and therapeutic interventions). Psychoanalytic theory was used as a perspective when approaching the material. This was the researchers' preunderstanding at work when analysing the material. The analysis of the material was phenomenological taking a critical stance towards the preunderstanding but also reflecting on how the preunderstanding influenced the analysis and understanding of the material. In contrast to the starting point with predefined variables, the essay method was developed as a phenomenological reading of the material, where salient concepts could be developed from the bottom up. This may be seen as a development of Freud's thesis on the inseparable bond between cure and research, the so-called "Junktim" approach.

> "In psychoanalysis, there has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results." (Freud, 1926) page 255)[2]

The way of reading/listening to research material that is represented in psychoanalysis is in many aspects taken up in modern qualitative research (Kvale, 1999; Varvin, 2011)

---

[2] In der Psychoanalyse bestand von Anfang ein Junktim zwischen Heilen und Forschen, die Erkenntnis brachte den Erfolg, man konnte nicht behandeln, ohne etwas Neues zu erfahren, man gewann keine Aufklärung, ohne ihre wohltätige Wirkung zu erleben (Freud, 1926/1971) page 293).

even if this has been controversial (Migdley, 2006). Nevertheless, the essay method has similarities with other approaches in qualitative research, which can only be briefly mentioned here. In grounded theory (Glaser & Strauss, 1967) concepts are developed from a thorough and systematic reading of texts by systematising salient aspects that give meaning to the text from a certain perspective (in the research presented here, from the perspective of meaning and coherence). The essay method distinguishes itself from this approach in that it demands a specific way of "listening" to the material based on psychoanalytic competence. The holistic approach implied in the writing of essays is also different from grounded theory.

Interpretative phenomenological analysis (IPA) comes closer to the essay method as it represents a combination of psychological, interpretative, and ideographic components (Smith, 2009). This method has an ideographic focus, which means that it aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon or experience. Usually these phenomena relate to experiences of some personal significance - such as a major life event, going through a developmental phase, or the development of an important relationship. IPA assumes an epistemological stance with an explicit interpretative methodology whereby it becomes possible to access an individual's cognitive inner world (Biggerstaff & Thompson, 2008). In IPA, salient themes are identified to best capture the essence of the material. In the essay method, salient themes or dimensions are also identified, but the explicit holistic approach of writing the essay produces the basis for identifying and ordering these themes.

The method of psychoanalytic expert "validation" (Leuzinger-Bohleber, 2015; Leuzinger-Bohleber et al., 2002) was developed in the frame of a large retrospective study on long-term outcome of psychoanalytic treatments. Interviews were analysed by an expert group consisting of experienced psychoanalysts and researchers. Through several sessions,

psychoanalytic listening was applied to interviews in order to understand the underlying narratives and, in that way, get a deeper understanding of what was transmitted by the interviewee. This was then formulated in salient narratives on the long-term outcomes of psychoanalytic treatments. This method has similarities with the essay method, although developed in another context, in that it uses psychoanalytic listening as a way of understanding the implicit or underlying content of a dialogue or analytic process.

In thematic analysis (Braun & Clarke, 2006), identified themes are also seen in context of the whole material. The essay method does not, however, systematise topics and themes in the same way in the process of analysis of the material as they are not identified in the original material (here the sessions) but extracted as salient aspects of the written essays.

Conclusion

Generally, the essay method can be subsumed under the tradition of ethnographic investigation of narratives derived from observation of events in natural situations (Fangen, 2011). It is an explorative method and not suitable for hypothesis testing. It concerns empirical cases but includes theoretical perspectives to determine how to organise the material in the essays. It is holistic and deals with human experience as a whole within a certain situation. This contrasts with the treatment of the human experience as isolated parts, which was the starting point in the study presented as an example here, and, which implied a study of transference, interpretations etc. isolated from the context.

In the context of psychotherapy research, the essay method as developed delves into the lifeworld of the therapist and patient within a session and aims at giving a salient narrative of what was going on in the session. Psychoanalytic inspired listening will determine how the material is perceived in the first stages of the research process and psychoanalytic

theory plays its role when organising the material and in developing theoretical categories.

The epistemology of the method acknowledges that human experience and knowledge in many areas are tacit, not articulated or not reflected upon.

It is argued that the essay method is a way to dig out this unspoken knowledge inherent in therapy sessions, interviews or similar material from real exchanges between human beings. It takes into account that parts, single observations, can only be understood in relation to the context of the wholeness of the encounter.

References:

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology, 5*(3), 214-224. doi:10.1080/14780880802314304

Bion, W. R. (1967). *Second thoughts. Selected papers on psychoanalysis*. London:: Karnac.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Butler-Kisber, L. (2018). *Qualitative Inquiry. Thematic, Narrative and Atrs-Based Perpsectives*. McGill University, Canada: Sage.

Chamberlain, K., Cain, T., Sheridan, J., & Dupuis, A. (2011). Pluralisms in Qualitative Research: From Multiple Methods to Integrated Methods. *Qualitative Research in Psychology, 8*, 151-169.

Chamberlain, K., McGuigan, K., Anstiss, D., & Marshall, K. (2018). A change of view: arts-based research and psychology. *Qualitative Research in Psychology, 15*(2-3), 131-139. doi:10.1080/14780887.2018.1456590

Fangen, K. (2011). Analyse og organisering av et stort livshistorisk materiale: Komparativt kvalitativt prosjekt (Analysis and organisation of a large material on life history: Comaparative qualitative project). In K. Fangen (Ed.), *Mange ulike metoder*. Oslo: Gyldendal Akademisk.

Freud, S. (1912). Recommendations to Physicians Practising Psycho-Analysis. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. XII, pp. 109-120). London: Hogarth.

Freud, S. (1926). The Question of Lay Analysis *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XX (1925-1926)* (Vol. XX, pp. 177-258). London: Hoghart.

Freud, S. (1926/1971). Die Frage der Laienanalyse. Unterredungen mit einem Unparteiischen. (Sigmund Freud Studienausgabe, Ergänzungsband ed., pp. 271-349). Frankfurt am Main: S. Fischer Verlag.

Frommer, J. (2007). Psychoanalytische und qualitative Sozialforschung in Konvergenz: Gibt es Möglichkeiten, voneeinander zu lernen? *Psyche, 61*, 781-803.
Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago: Aldine.
Gullestad, S., & Killingmo, B. (2013). *Underteksten. Psykoanalytisk terapi i praksis (The subtext. Psychoanalytic therapy in practice)*. Oslo: Universitetsforlaget.
Killingmo, B. (1999). A psychoanalytic listening-perspective in a time of pluralism. *Scandinavian Psychoanal Rev., 22*(2), 151-171.
Killingmo, B. (2007). Relational-Oriented Character Analysis: A Position in Contemporary Psychoanalysis. *Scand. Psychoanal. Rev., 30*, 76-83.
Killingmo, B., Varvin, S., & Strømme, H. (2014). What can we expect from beginning therapists? A study of acquisition competence in dynamic psychotherapy training. *Scandinavian Psychoanalytic Review, 37*(1), 24-35.
Kvale, S. (1999). The psychoanalytic interview as qualitative research. *Qualitative Inquiry, 5*(1), 87-113.
Leuzinger-Bohleber, M. (2015). *Finding the body in the mind. Embodied memories, trauma and depression*. London: Karnac Books.
Leuzinger-Bohleber, M., Rüger, B., Stuhr, U., & Beutel, M. (2002). *"Forschung und Heilen" in der Psychoanalyse. Ergebnisse und Berichte aus Forschung und Praxis*. Stuttgart: Kohlhammer.
Lopate, P. (1994). *The Art of the Personal Essay*. New York: Anchor Books.
Migdley, N. (2006). Psychoanalysis and qualitative psychology: complementary or contradictory paradigms? *Qualitative Research in Psychology, 2*, 213-231.
Montaigne, d. M. (1910). *Essays of Montaigne, trans. (New York: 1910). In 10 vols. 8/25/2017.* (r. b. W. C. H. Charles Cotton, Trans.). <http://oll.libertyfund.org/titles/168>: Edwin C. Hill.
Nielsen, H. B. (1995). Seductive texts with serious intentions. *Educational Researcher, 24*(1), 4-12.
Sandler, J., & Sandler, A. M. (1998). *Internal objects revisited.* London: Karnac Books.
Smith, J. (2009). *Interpretative Phenomenological Analysis*. London: Sage.
State, G. (2000). A new defence of Gadamer's hermenuetics. *Philosophy and Phenomenological Research, LX*(1), 45-65.
Stiles, W. (2015). Theory-Building, Enriching, and Fact-Gathering: Alternative Purposes of Psychotherapy Research. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy Research: Foundations, Process, and Outcome* (pp. 159-179). New York: Springer-Verlag.
Tuckett, D. (2005). Does anything go? Towards a framework for the more transparent assessment of psychoanalytic competence. *Int J Psychoanal, 86*, 31-49.
UCL. (2019). Competence Frameworks
Psychoanalytic/Psychodynamic Therapy
University College of London Psychology and language Sciences
https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-6.

Varvin, S. (2011). Phenomena or data? Qualitative and quantitative research strategies in psychoanalysis. *Scandinavian Psychoanalytic Review, 34*, 117-123.