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The theoretical basis of the Conversational Model of Therapy.

Key words

Conversational Model; Psychodynamic Interpersonal therapy; theory; forms of feeling; hypotheses

Abstract

The Conversational Model of Therapy (CM), which is also known as Psychodynamic-Interpersonal Therapy is an evidence based psychological treatment. The model has a set of distinctive therapist behaviours, which can be taught and learned in a short space of time. Although the model can be practised without an appreciation of the theory, which underpins it, the theoretical basis of the model is rooted in psychodynamic ideas, and it shares many common theoretical approaches with other psychodynamic models. In this paper, we describe the theoretical underpinnings of the model, include a description of basic model behaviours, an explanation of why these behaviours are important, and how they directly relate to and are derived from the theoretical stance. We also provide a case example, and show why the model can be practised without detailed theoretical knowledge to good effect, if its common guiding principles are followed.

Introduction

The Conversational Model of Therapy, which is also known as Psychodynamic-Interpersonal Therapy is an evidence based psychological treatment which has been evaluated in a series of randomised controlled trials and other comparative studies for a variety of conditions (Authors, 2016).

The model has a very distinctive set of behaviours, which can be taught and learnt in a very short space of time (Authors, 2016), and a detailed understanding of psychodynamic theory is not necessary in order to practice the model competently. This makes it an attractive potential alternative to main stream cognitive behavioural therapy or other more traditional psychodynamic approaches. In addition, elements of the approach can be used to enhance other therapeutic models or clinical psychiatric practice, and to develop empathic and broad-based interpersonal skills.

Although the model can be practised without an appreciation of the theory which underpins it, the theoretical basis of the model is rooted in psychodynamic ideas, and it shares many common theoretical approaches with other psychodynamic models. In this paper, we describe the theoretical underpinnings of the model, and include a description of the model behaviours, and an explanation of why these behaviours are important, and how they directly relate to and are derived from the theoretical stance. We also show why the model can be practised without detailed theoretical knowledge to good effect, using a case example.to illustrate this.

The Conversational Model was developed by Robert Hobson, a U.K. based psychiatrist and psychotherapist, in collaboration with his friend and colleague Russell Meares, formerly Professor of

Psychiatry in Sydney, Australia and now Emeritus Professor at the University of Sydney. Work began in the 1960s when Hobson was a Consultant Psychotherapist at the Bethlem Royal Hospital in London and ran a ward for patients with complex and enduring problems, many of whom would now be diagnosed as suffering from borderline personality disorder. Hobson placed much less emphasis on traditional psychodynamic interpretation and far greater emphasis on sharing feelings states by picturing and re-shaping them in the context of a human conversation. These ideas are first formulated in a paper entitled 'Imagination and amplification in psychotherapy (Hobson ,1971) and in the 'Pursuit of Intimacy' by Russell Meares (1977).

Hobson's book, 'Forms of Feeling: The Heart of Psychotherapy' was published in 1985, and in it he described the main therapeutic approach, which was subsequently elaborated by Russell Meares in a series of books published over the last 25 years (Meares, 1993; Meares, 2000; and Meares, 2016). Much of this paper draws upon Hobson's book and two of Meares's books, The Metaphor of Play (1993), and his most recent work, The Poet's Voice in the Making of the Mind (2016).

Hobson was particularly keen to avoid unnecessary complex psychodynamic jargon, and to strip theory back to its bones. He emphasised the importance of seeing therapy in action by using audiotapes and videotapes to aid supervision and teaching. He welcomed the idea of researching the model to further understand both efficacy and the therapeutic process. All these aspects of psychotherapy, may now seem common place, but were unusual and innovative, when first employed by Hobson.

The next section, which describes the theoretical underpinnings of the model is divided according to chapters in Hobson's book (Hobson,1985); experience, myself, language, and symbols. We also include a section on the notion of Hobsonian 'forms of feeling' and the 'minute particulars' of interpersonal interactions.

Key components and theoretical underpinnings of the Conversational Model

Experience

One of the early chapters in Forms of Feeling (1985) is entitled 'experience'. In this chapter Hobson lays out his ideas about the relationship between mind and body. He believed that experiencing was felt in the mind and body simultaneously and was part of the same process. In effect, he made no distinction between mind and body. Hobson was influenced by the work of the philosopher William James (1884) who stated,

> *Our natural way of thinking about these emotions is that the mental perception of some fact excites the mental affection called the emotion, and this latter state of mind gives rise to the bodily expression. My thesis on the contrary is that the bodily changes follow directly the PERCEPTION of the exciting fact and that our feeling of the same changes as they occur IS the emotion,* (James, 1884).

James' view and that of Hobson were both contrary to the accepted views of their time, which was that thoughts triggered physical responses in the body. Both their views were also formulated many years before recent neuro-scientific developments concerning the neural basis of feelings, have in part supported their position.

In neuroscientific terms emotions are complex programs of actions, which are triggered by the presence of certain stimuli (either in the outer or inner world). Feelings of emotion are perceptions of emotional action programs. The term emotion therefore refers to a specific set of actions or changes in the musculature of the viscera and the skeleton and the chemical profile of the internal milieu, whilst the term 'feelings' refers to the recognition by the self of the mental and bodily experience which is occurring (Damasio & Carvalho, 2009).

Whether feelings portray an internal state (for example, hunger or thirst) or are prompted by an external situation (for example, compassion or admiration or disgust or shame), their dominant mental contents describe a state of the body in which the condition of the viscera (e.g. heart, lungs, gut and skin) plays a key role .

So feelings are both inherently physical and mental experiences, which occur following a change in the body caused by either an external or internal stimulus. Emotions are often thought of as being irrational, but are better understood as older forms of reason, assembled by biological evolution and not by conscious deliberation. They are not the result of thinking through a problem and generating a solution, they provide the individual with an automated way to act, which may in the past have been life-saving, or conveyed other forms of advantage (Damasio, 1994; Damasio, 2003).

In 'The Poet's Voice in the Making of the Mind' (2016), Meares refers to the 'little emotions' by which he means subtle feeling experiences for which there may be no words at all, not even the crude and simplistic words we use to describe our responses to bigger emotions.

> *These feelings, which are barely contemplated in a research sense, perhaps as too minor to be given such consideration, are the feeling of life going on. Unless they have the means of some representation they will wither and sink to the bottom of consciousness, so diminishing not only an emotional range but also the differentiation in feelings, which through their expression, contribute to the connectedness among people,* (Meares 2016: 68).

Hobson described four essential components of experience. First, it is a kind of knowing, a kind of sense of something. Second, it is felt in the body, from inside. Third, experiencing is always in relation to things, persons and situations. Finally, experiencing is not static and there is a sense of flow.

Myself

Hobson believed that one of the main tasks of therapy was to try to get 'know someone', rather than know a lot of facts or information about them. What he meant by getting to know someone, was getting to know something of the person inside; the 'me'. But what is the 'me' and how is it formed?

What is meant by a sense of 'myself' has been discussed and elaborated by many philosophers, developmental psychologists, psychotherapists and neuroscientists. In his book 'The Metaphor of Play', Russell Meares drew upon the ideas of William James who described the self as an internal stream of consciousness, a sense of life going on inside us (James, 1890:239). There is both a sense of movement and simultaneously a sense of stability or what Daniel Stern referred to as a 'core self' (1985). Our thoughts are constantly in motion, but we retain a sense of who we are, which has a history as well as a present.

As we think and experience ourselves, we also note two aspects to the self, in that we are aware of both the outer world but also our inner world that we keep secret in the main. James referred to this aspect of the self as the duplex self. Not only, however, do we look outwards but we also look inwards on ourselves, as if we are split psychologically into two separate states. 'I' am monitoring 'me'.

We are not born with this sense of 'myself', but it develops over the early years of life. Many writers including most notably Winnicott (1971) and later Stern (1985), have emphasised that the self is the product of an interpersonal relationship (primarily with that of the mother or primary care giver, at least in the earliest years). It is part of accepted psychodynamic theory that a good enough relationship between caregiver and child generally results in a reasonably stable sense of self, whereby a neglectful or abusive caregiver-child relationship often results in an unstable and chaotic adult sense of self.

The conversation between 'mother' and baby begins in the first few moments of life when the 'mother' talks to the infant as if he or she understands what she is saying. As their relationship develops, the 'mother' also replies to herself as if the infant can speak. This inter-subjectivity and mirroring of the infant's emotions and experiences is seen as being crucial to the infant's development. The mother attunes to the infant, amplifying and representing, his or her feeling states with words and expressions, providing a coherence and structure to what is experienced. Meares suggests that feelings are the 'coinage of this proto-conversation' that is shared between mother and infant (Meares, 1993: 25), and that this results in an affective core to the self. In other words the self is not just a stream of thoughts in a cognitive sense, but a stream of feeling states which are beyond words. The proto-conversation does not just consist of words, but it also includes the tone of the mother's voice, the expression on her face, the gesture of her hand, and her own feelings which shine forth from her into the baby.

Meares, who draws heavily upon the work of Winnicott (1971) and Trevarthen (2004), argues that play is an essential part of personal development. In particular, he argues that it is symbolic play that enables feeling states to be captured and organised and eventually internalised to form the core of the self. If this process goes well, James suggested we experience a positive feeling within ourselves, which he termed warmth and intimacy (James, 1890:300). If the process goes less well or is traumatic, positive states are lost and the person feels a sense of alienation and estrangement from the world (Meares, 2016:19).

For the young child, play becomes possible in a space, which is both safe and fertile. It is the mother who creates this space and provides the safety and the nurturing environment. If the child is not contained, the play stops. Vygotsky used the term, 'the zone of proximal development' to describe this space and suggested that, whilst at play, the child behaves above his or her chronological age. Essentially Vygotsky was suggesting that the child develops and moves forward through play activity (Vygotsky 1978: 102-103).

The language of play in early life is not grammatical or logical. It often consists of a commentary or monologue in which the child takes on the role of different 'people' and describes what they are doing or how they are feeling. The commentary jumps about. This conversation moves by analogy, resemblance and other associations (Meares, 1993: 38). The commentary the child makes is not to communicate with others, but rather to represent or capture the child's world, and this Meares argues, 'seems necessary to the representation of self'. As the child develops further, the

conversation, processes and experiences involved in play are assimilated and become the bedrock of the internal stream of the self. What is neither outer nor inner, essentially becomes differentiated into an inner and outer world, with the capacity to reflect upon and comment upon the inner and outer states.

A key tenet of the Conversational Model is that our self grows in a relationship in which the other represents the essence of our experience by means of a 'picturing' capacity (Meares, 2016:25), and is rooted in our ability to use symbols and metaphorical play to capture and organise and internalise feeling states. The central feature of selfhood is a sense of warmth and intimacy coupled with a sense of continuity, which feels connected and cohesive. There is also a paradox in that the experience of self is constantly changing and shifting although it feels stable. Because it is a product of and develops from a relationship, the self does not have definitive boundaries, and it is constantly shaped and reformed by contact with others.

Language and symbols

Bob Hobson used the term 'feeling language' to describe a particular way of conversing with clients, which is a central component of the conversational model. This term is sometimes misunderstood as if Hobson meant the term referred to talking about emotions. In fact he was referring to much more than this, and instead was referring to a way of being with the client that in many respects parallels the play between infant and carer. This 'play' stops or does not occur if the therapy environment is not safe.

Hobson drew on the work of Vygotsky (1978) and Wittgenstein (1966) to essentially describe two different forms of language. One he termed 'jam-jar' language or discursive language and the other 'feeling language'. Jam-jar language is logical and clear. It is used to convey information and is the kind of language one uses to describe how to open a jam-jar. It is the language of science and practicality. Nearly all of psychology and psychodynamic theory is written in jam-jar language.

Feeling language is the language we use when we seek to convey how we feel. Apart from words for basic emotions such as happiness or sadness, discursive language is unable to represent how we feel inside. To do this we have to use symbolic language and metaphor. We have to liken our internal world to an image or an association of ideas that have a form beyond the basic words they represent.

In his chapter on 'Symbols' Hobson (1985) makes use of a distinction presented in the work of Suzanne Langer (1953). The distinction is between 'discursive symbols' and 'presentational symbols'. The central difference between these two forms of symbol concerns *meaning.* Discursive symbols, typically words, have fixed, stable, context invariant meanings, based on conventional definitions. New meanings are produced through the arrangement of these elements into larger forms, as in words arranged into sentences. The logic of discursive symbols is linear, mechanical and successive. Examples of the use of discursive symbols that come closest to the idealised form can be found in legal documents, scientific and philosophical papers. This type of language use is associated with a particular type of thinking, which Langer terms 'discursive thought', and as discussed, Hobson refers to as 'jam-jar' language.

We can take 'presentational symbols' to include all non-discursive symbols, comprising many subtypes. The central feature of presentational symbols is that meaning is variable according to

context, being the product of relational patterns that can only be understood through perception of the whole. While discursive symbols are linear, atomistic and fixed, presentational symbols are organic, interconnected, and fluid. Typical examples of presentational symbols in poetry, literature, drama and painting, reveal how meaning is multilayered, allusive and flexible. The characteristic form of thought associated with presentational symbols Langer termed 'imaginative thinking'.

This discussion may seem fairly abstract but is of crucial importance. The reason is emphasised by Hobson: 'If, as I believe, psychotherapy is a matter of promoting a personal dialogue, then we need to know how to receive, express, and share feeling: how to learn a *language of the heart* …' (Hobson, 1985: xiii, italics added). Elsewhere Hobson writes of 'person-talk' requiring the development of a *'common feeling-language'*. Discursive symbols and discursive thinking are very poor vehicles for the representation and expression of feeling. Whereas presentational symbols, because of the fluid and relational aspect of meaning, have a much greater capacity to represent the complex interconnected and multilayered flow of our emotional life. In particular, it is through the power of metaphor that feeling may be received, expressed, and shared. Metaphors have a unique capacity to open areas of experience and reveal previously concealed aspects of our inner world through providing a new way of seeing: 'Metaphor is a means of visualising the inner world' (Meares, 2000: 126).

Psychotherapy is often conducted entirely using discursive language as if the person is a machine that has broken down and needs to be fixed. Emotions are discussed in an abstract way and quantified in terms of scales of severity. Although, undoubtedly this way of working can be very helpful, and this kind of model has many positive features, we would argue that getting to know the inner person, getting to know the 'myself', can only be accessed using a feeling language. There is simply no other way.

Forms of Feeling

Hobson felt it was important for the person in therapy to be able to face fears or difficult experiences they may have warded off, and this should be a gradual, measured, fluid process, delicately paced by the therapist so that the client/patient did not become overwhelmed. An experience shared, in the raw, with the therapist, is usually helpful, cathartic and can be generalized to other settings. However, in the Conversational Model, the main reason for bringing feelings into the 'here and now' is that this results in a movement, and an opening up of the person's experience, and a *carrying forward*.

A 'form of feeling', in the Conversational Model, is a visual image or a symbolic representation of a feeling state (both a mental and physical experience), which has an organizing or containing quality. It also has an interpersonal dimension in that the image or symbolic representation has some interpersonal significance at some level, and it also links back in time with previous occasions when the feeling state has been experienced, rather like an image created when two mirrors face each other. Another crucial aspect is that the form of feeling can only be created from actual experiencing of the feeling state. It cannot be constructed from thinking or talking about the experience. The experience must be alive and in the person for its form to be shaped. The reality is much more complex than this simple description, as Hobson wished to convey a complex ordering of experiences, which grows and expands to reach a unique overarching form.

The notion of 'forms of feeling' is central to the therapeutic endeavour of the Conversational Model; the idea, that feelings can have a structure and a form, which is containing and stabilising. As Hobson

argued that all experience is in relation to others, forms of feeling also have a connection, or a relatedness to 'another'. Feelings can sometimes seem overwhelming, as if they are spilling out in an uncontrolled and unknowable way. Metaphor provides a way of capturing feelings in a form that can be discussed, and understood. Hobson suggested that we can use pictures in the mind to represent feelings, patterns or shapes, which enable feelings to be contained within the self, so they are no longer overwhelming, and unknowable. Hobson described this process as, 'the differentiation and integration of psychic phenomena and bodily experiences to produce a commanding form,' (Hobson, 1985: 91).

Minute Particulars

Hobson stated that an important focus for psychotherapy was,

> *how* a conversation is developed in its 'minute particulars'. Broad psychodynamic theories are all very well…..but any formulation of the problem which faces a unique person must emerge from the manner of *this conversation, here and now,* (Hobson, 1985: 165).

In other words, it was the 'how' of the conversation, as opposed to the 'what' that was important. Hobson believed that if the therapist was not able to attune to their client, then the opportunity for symbolic play would be blocked.

In 'Forms of Feeling', Hobson gives an account of a therapy, focusing on the first five minutes. He tries to capture and understand every gesture, facial expression, and utterance of the person he is seeing, right from the moment he first sees Mr. Jones in the waiting room. Hobson describes Mr. Jones as perched on a chair in a corner, huddled in a large overcoat. As Hobson approaches, Mr. Jones jumps to his feet, takes a step backward, glances at Hobson quickly, and then looks away, hesitantly holding out his hand about four inches away from Hobson's. He does not squeeze Hobson's hand, but when Hobson squeezes his, he responds by returning Hobson's grip in a half-hearted way for a second before withdrawing his arm (Hobson, 1985: 163).

This brief description provides an indication of the detailed way in which Hobson expected therapists to observe and interact with the people they were seeing. The focus is not on the bigger picture but on the tiny, nuances of feeling, subtle intimations of emotion, and words that convey a sense of movement and meaning. By focusing on these small details, Hobson believed the therapist was better able to get know the client as a person. By attending to the minute particulars of conversation, Hobson believed that there was a greater opportunity to create a safe place, where symbolic play could occur.

Key Components of the Model

The key components of the model were developed with the explicit intention of trying to promote a 'feeling language' between therapist and client. Most are very simple actions which can be learnt very quickly by people with reasonably good interpersonal skills. If things go well, a space is created in which a type of conversation which uses pictures and symbols to connect with the 'inner-person' develops. Feelings are experienced in the 'here and now' and contained and shaped using analogy and metaphor, to create a structure and degree of organisation for the internal world, and ultimately an internal sense of coherence. Some of the basic model behaviours are briefly descried below.

Statements

The first simple therapist behaviour is to ask therapists to try to shape their interactions in the form of statements rather than questions. The reason underlying this model behaviour is that questions tend to evoke a cognitive response from the person being seen. Statements encourage the person to stay with an experience or feeling rather than to question it. Although this may seem a fairly subtle point, this simple change in the therapist's interactive style has a major impact on the therapeutic milieu.

Understanding hypotheses

Once the therapist feels comfortable using statements, these statements are used in a particular way. Understanding hypotheses are statements which pick up and reflect what the client has intimated by word or gesture, but slightly deepen or extend the conversation conceptually and emotionally. This is often done using an analogy or a metaphor. They are not simply reflections.

Cue response

Listening to the client, and actually hearing what they are conveying by word and gesture is a fundamental part of the PIT model. By listening however Hobson meant something quite specific:

> *By listening I mean an active process of perceiving and paying attention to a multitude of verbal and non-verbal cues and by an imaginative act, creating possible meanings which can be tried out and modified in a conversation, or dialogue, that aims at understanding*. Hobson, 1985:208.

All therapists no matter how experienced can improve this part of their practice, and it is why it is so important to audio-record or video-record sessions.

Focus on Feelings (here and now)

Focus on Feelings in PIT implies both a staying with feeling, and as Hobson termed a carrying forward of feeling (Hobson, 1985:35). As someone talks about a past experience, they may begin to re-experience something of the feeling associated with that experience. Getting back in touch with that feeling and experiencing it 'as if it is happening now', is a crucial part of the conversational model approach. Hobson states that, 'the true voice of feeling is….not a simple emotion but a complex ordering and re-ordering of experience in growing forms,' Hobson, 1985: 93) . Hobson emphasised that this process must be stepped and gradual and each step must be the right height, not to high and not too shallow.

Symbolic attitude/metaphor

Hobson spoke of the 'healing power of the imagination', and the 'the shaping spirit'. Therapists using the model encourage their clients to stay with feelings, to see 'if anything comes to mind'. Is there a picture or a memory of some other perceptual experience which is associated in the client's mind with the feeling? Is there an image which can capture the feeling, so something of it can be expressed in words? By doing this, the therapist is trying to get to know the person inside. They are beginning to capture a 'form of feeling' rather than a pure emotional experience which is devoid of structure or meaning.

It is not just large emotions or distressing feelings that require a framework. The picturing of little emotions, half-formed complex feelings for which no specific name exists, makes real a nebulous state and creates order and coherence (Meares 2016: 82). A series of pictures or representations can come together over time to create an enlarged and enriched personal 'view'.

Mutative Change

There are many aspects of psychotherapy that lead to change, but the two most common factors are the bond between therapist and client, and the client's positive expectations of treatment (Wampold, 2015) . Although these are generic to all approaches, we would argue that these factors are centre stage in the Conversational Model, as the relationship between therapist and client is put under the microscope. A key aspect of building the 'bond' is achieved by listening to the client and developing a feeling of being understood. This empathic response is more than an emotional and cognitive process, it is beyond the grasp of words and is experienced as a 'felt' understanding.

The other, more specific, aspect of the CM approach that leads to change, is captured by Hobsons' notion of 'forms of feeling'. The idea that from a shared experience between two people, comes a re-shaping of the experience, and a developing structure, which is captured by feeling words and imagery, and elaborated into a more complex containing structure. A small building block of the self. A case example will illustrate some of these points.

Case Example

The case example is based on a real case but the factual information has been changed to protect anonymity. Certain aspects of the dream have also been slightly altered, without changing its symbolic nature. The exchanges between therapist and client are essentially unchanged. The case example shows the first 10 minutes of the first session of a brief therapy.

In the example, the therapist has warmly greeted the client in the waiting room of the clinic and has showed her up to one of the out-patient rooms. The room is sparsely furnished with two chairs, a table in the corner and a phone. There is one window, with a blind which is broken, and the carpet is stained. The therapist has noted that the client seems nervous, has avoided eye contact and has lagged behind the therapist on their way to the room, even though the therapist slowed to try to walk at a similar pace.

The therapist has brought her own small clock and places it down on the table in the corner so both she and her client can see the time.

Time (minutes & (seconds)	Person speaking	Interactions between therapist and client	Conversation Model Behaviours/other actions
0	T	Thank you again Janet for coming today. As I said my name is Jo Sellars. It's not the greatest of rooms I'm afraid. Very NHS. But we won't be disturbed and I've put a clock there, so you can see the time. We usually meet for about 50 minutes (looks at clock) so we will finish just about 11 o'clock.	Sets scene Warm, small joke.
23		Pause: Client is looking at the floor	
28	T	It's a bit strange…coming to see someone like me…..	Statement/understanding hypothesis which picks up client's anxiety and discomfort
34		The client remains looking at the floor. Pause	
40	T	We've not met before…….coming to see a stranger like me…..it's a bit unnerving I guess…..	Understanding hypothesis-staying with the client's discomfort
45		Client glances at the therapist…..then looks away again but shuffles in her seat and coughs	
52	C	I don't know what you want me to say.	
55	T	Ahh……. Well I certainly don't want to put you on the spot…..er…you seem very unsure about seeing me…..	T picks up the client may feel some kind of coercion, but stays with client's uncertainty
1-06	C	I don't know why the doctor sent me	
1-11	T	I wonder if you feel a bit pushed into coming to see me, I'm not sure	Statement, understanding hypothesis-picks up client's sense of coercion, negotiating style
		Pause	
1-25	T	Err…..	Tries to encourage client without introducing any new concepts
1-33	C	I do a bit. I mean I've had some problems, I've got some problems, but I don't see how talking about them going to help. You are not going to be able to change things.	
1-44		Umh……well I think that's entirely understandable. And a lot of people feel like that when they first come to see someone like me. I can't say that I can help at this stage. But sometimes talking with or I would say sharing something with someone can be helpful. I'd like to see if I can help you.	Negotiating style. Acknowledges reality. Suggests possibility of positive outcome of therapy.
2-01		Pause	

2-08	T	Err……but there's a difference between a shared conversation and a feeling that you have been forced to see me ….er ….perhaps……or you feel that I am in some way expecting you say something particular	Understanding hypothesis/picking up sense of coercion
2-24	C	I 've had a lot of miscarriages….and …well….. I can't have any children….you can't help with that	
2-32	T	No……very difficult for you to bear….	Statement, Understanding hypothesis-picks up client's very real distress
		Client makes eye contact for the first time-fleetingly	Bond is developing after shaky start
2-41	C	Yes …..yes ……I've had so many miscarriages…..	
2-46	T	Umh….	Encourages client to stay with flow
2-50	C	Six	
2-54	T	Six….I'm so sorry…..each one….a great loss	Statement/Understanding hypothesis- deepens conversation slightly by use of 'loss'
		pause	
3-02	C	Yes …….yes indeed	
		T moves a little closer, keeping eye contact	
3-08	T	You've lost so many ……..many babies	Statement, understanding hypothesis
3-14	C	Yes… that's how I feel……my husband doesn't think like that….	
3-24	T	I wonder……..You've been carrying this loss……alone……	Understanding hypothesis/negotiating style-slightly deepens conversation and picks up interpersonal dimension
		Client is in silent tears, but stays with the therapist	
3-34	C	I used to have such hopes….with each new pregnancy and then they'd be dashed….I'd loose the pregnancy..the baby….	
3-43	T	Terrible loss…..and there's a bit of that feeling now…	Understanding hypothesis and focus on feelings-trying to acknowledge client's current feelings
		Client nods…..lowers her head	
3-52	T	I wonder if you can stay with that feeling…..	Staying with feelings-trying to bring feelings alive in the session-so they are the focus
4-00	C	I just feel there's no point in going on…..my husband would be better with someone who could have children. I can't do that.	
4-07	T	This deep sadness…..you think about not being here…..I mean ending your life…	Staying with feelings, understanding hypothesis-deepens

			conversation and picks up client's wish to die
4-18	C	I walk along the river everyday…..everyday…..	
4-27	T	Go on….. (gently)	
4-36	C	There's just no point.	
4-41	T	You want to end your life	Understanding hypothesis-deepening
4-47	C	Well he would be better off…and this pain would stop …..this dreadful feeling	
4-55	T	I wonder if we can stay with that pain ..face it …a little bit	Focus on feelings- trying to bring feelings alive and amplify
		Client holds tummy and leans forward as if physically sick	
5-13	C	Uggghhhh	
5-21	T	Dreadful……loss…..alone…….	Staying with feelings- and linking feelings to relationship
		Client nods head……	
5-31	T	I wonder if anything comes to mind	Symbolic attitude-
		Pause	
5-44	T	A picture……..a memory…….a dream……..	trying to see if these feelings are associated for the client with images, memories or dreams or other symbolic material
		Pause	
6-03	C	I have this dream…..it's dreadful…..i'm in my kitchen at home….and I smell burning coming from the cooker and I open the door and pull out a tray of burnt fish.	
6-16	T	Well….I wonder if we can bring that dream alive……you're in your kitchen…. You smell …..	Focus on feelings in dream….bringing feelings in the dream alive in sessions
6-29	C	Burning.. an awful burning feeling…..I go to the oven……get my gloves….	
6-41	T	Umh…..as if it's happening now	Here and now
6-45	C	The tray…….they are little fishes……..but their eyes are like looking at me…although they are all burnt…….like…..like….	
7-01	T	They are……(encourages with gestures)	
7-09	C	Blaming me because I've burnt them alive……	
		Pause	
7-24	T	it's an awful feeling to loose a baby……but unbearable to feel you are to blame in someway…….	Understanding hypothesis-deepening the conversation
		Client nods	
7-44	T	This awful feeling ……as if you had …….I don't know if this is going a bit far…..but you feel a bit like	Understanding hypothesis

		you've in some way …you've been responsible for the miscarriages ….(very tentative)	Negotiating style. This intervention would only be used if the therapist is almost certain it will be acceptable to the client
7-54	C	Umh that's what I feel ……it's my fault….my fault..	
		Pause	
8-05	C	I had an abortion you see when I was 16 years old. I was still at school and it was stupid. But I think it's because of that……I keep losing them…….	
8-15	T	You feel ..some way …..in having the abortion when you were very young…….very young……..is linked to the miscarriages you've suffered ……..	
		Client nods…….	
8-30	T	Difficult to bear all this	Understanding hypothesis-tries to acknowledge enormity of client's distress
8-44	T	Alone…. I mean you've not shared this	Understanding hypothesis
		Client seems a little relieved	Bond established
8-53	C	It's not that I think…..the abortion damaged me……the doctors have told me that's not the case……but……	
8-57	T	The feelings are similar	Form of feeling developing
9-00	C	Umh……..yes……	
9-10	T	Look ……you are dealing with lots of very difficult things…..you are right…..I cannot physically change or help you have a baby….we haven't discussed what the doctors have told you about that …..but I think you are dealing with some very big…painful things…..and getting close to thinking seriously about ending your life…….all these terrible losses are difficult to bear….but your feelings run deep…….I mean ….very deep	Rationale
		Client nods	
9-41	C	Yes…….	
9-44	T	So in this talking approach……it's about helping you deal with these awful, painful feelings……and facing things with someone…..not alone…..makes them sometimes a bit more bearable	Rationale Further Building bond
		Client nods	
9-58	T	And I think that's happened a bit…already…..	Further Building bond
10-03	C	Yes..it's not what I imagined it would be….I don't know what I really imagined……but …..no ……I feel you understand	
10-07	T	So that's how this talking treatment sort of helps and also things begin to come together …..I'll need to make sure you are safe….and we need to talk a bit more about that…..but this is the kind of thing we do here…..and we usually meet weekly for 6 weeks….it usually is helpful…..and I wouldn't suggest we continued…if I didn't think that	Promoting positive Expectations of therapy based upon client's experience in the session

10-40	C	I think it makes sense….I didn't know anything about it you see….	
10-47	T	I think you felt a bit pushed into this…so it's really important, you don't feel pushed a bit by me now	Building Bond
10-53	C	I think Dr Roberts means well and was probably right……I think I needed a bit of a push	
		Both smile	Building Bond
10-58	T	Well perhaps…we can go back to your feelings about the abortion you told me about……	

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This section gives the flavour of an opening session of PIT. The interventions are very simple but are intended to develop the conversation with a focus on bringing feelings alive in the session. The process occurs rapidly but at a pace, which feels right for the client, with small, gradual steps, rather than big leaps. The process should feel like a 'heart to heart' conversation with a trusted friend.

The responses by the therapist in the above example are all 'in model' for PIT . Nearly all are statements. The responses try to focus on feelings but are not mere reflections; each one is an attempt to slightly deepen the conversation. When, and only when, the client gets in touch with an experience in the session, does the therapist gently try to see if the client can stay with that experience.

There are obviously a range of 'in-model' responses, and a variety of ways that therapists can respond to cues. In a written example, the non-verbal cues and connection between the therapist and client are harder to convey, but are as important in guiding the therapist as the spoken word.

In the above example a 'form of feeling' begins to emerge. It arises from the 'dreadful' feeling described by the client; a mental and physical experience that she experiences in her guts. The therapist encourages the client to stay with the feeling and see what comes to mind. The containing structure that develops is primarily a 'felt' experience, which is captured by an image of the burnt fish that resonates for the client, on many levels, and has a strong interpersonal dimension, that moves across time and links to earlier experience.

In PIT the 'meaning' of the dream is secondary to the process of sharing the experience of the dream, alive with the therapist, as this creates movement. Links are created by similarities in feeling states, rather than by mentally thinking about connections. The emphasis in the therapy is not about making sense of these things in a cognitive way, but being able to experience them WITH someone, and by that re-shape them.

Three key things are established in the first few minutes. First, a strong bond between the client and therapist. Second, positive expectations that the talking treatment is going to be helpful with a basic rationale of how it is going to help.

Third the client's experience of PIT in action. The client is able to share a warded off feeling with the therapist, and feel that experience move, and connect with imagery, and then re-shape and become multi-levelled. This constant re-shaping and reforming of experience in a relationship with

someone, is at the fundamental heart of the conversational model. We believe that this process together with the bond and positive expectations of help, are the key mutative aspects of the therapeutic process, and in longer therapies lead to greater stability and coherence of the self.

The bond between therapist and client of course has many levels. We believe the most important component for a positive outcome is a sense of warmth and shared endeavour between the two. However, in the above example, there is a strong sense from the client that she has been coerced by her GP into coming for help and also feels pressure from the therapist by her statement "I don't know what you want me to say." It is quite possible that the client was coerced by her GP into attending the session, but the therapist would also regard this as a cue that this may be a sensitive area for the client in terms of interpersonal relationships. These cues often happen in the very opening exchanges in therapy, and, as in any dynamic therapy, it is important to listen for them.

Although we do not explicitly refer to what would be termed transference in traditional psychodynamic models, there is an acute appreciation of the multi-layered nature of relationships.As the therapy continued with this client, a sense of coercion did indeed recur, and became linked to the form of feeling which has already been described. The client felt coerced into having an abortion when she was a teenager by both her parents, and on many complex levels felt coerced from an early age to be a 'good daughter', and then later on a good wife and mother. This understandably created a sense of frustration and anger and inevitably a sense of guilt and blame when she was unable to be a mother.

These complex links, which weave together experience and relationships, create a bigger picture, and a containing structure. The bedrock is the conversation with the therapist, and the use of a feeling language, which enables experience to flow backwards and forwards through time, constantly reforming and re-shaping. This process simply does not happen if feelings are talked about in the sessions but not experienced and shared 'alive' between two people.

NHS Practice

The 5 Year Forward View has laid out ambitious plans to treat 1.5. million patients per year via the Improving Access to Therapies Programme (IAPT). A range of therapies, in addition to cognitive behavioural therapy (CBT), will need to be available if government targets are to be met. Very few therapies have the coverage of CBT, across the country, with the possible exception of counselling.

CM is probably the most accessible of all of the dynamic models, with an evidence base demonstrating it is easy to learn and can be practiced by therapists without formal training in dynamic therapy. The basic competencies can also be taught to low intensity personal well being practitioners in the IAPT programme to improve their practice of CBT.

PIT has somewhat of a presence in the North of England with several clinical psychology courses selecting it as the second therapy trainees need to learn. Some liaison psychiatry

services also offer PIT as a treatment for self harm, and there is growing interest in training for co-morbid physical symptoms.

From a pubic and national perspective what is important is that people with mental health problems are able to access evidence based psychological treatments, delivered by competent therapists, with some degree of choice or variability in the nature of treatment offered. Dynamic therapies offer an alternative approach to CBT, and proponents of different dynamic models may need to work together to ensure meaningful levels of availability across the country, by influencing policy makers.

Summary

In summary, the Conversational Model is an evidence based psychodynamic form of psychotherapy. It shares many similarities with other psychodynamic approaches, whilst retaining a unique and characteristic set of therapist behaviours and competencies. Theoretically, there are strong similarities between the ideas, which underpin the model and general psychodynamic models. However, there is an avoidance of jargon or words that objectify people, as these may distance therapists from the people they are trying to help. Perhaps the most distinctive feature of the Conversational Model the focus on the minutiae of the conversation that develops between a therapist and the person they is trying to help, and the promotion of a 'feeling language'.

A psychodynamic training is not essential in being able to practice the model and it can be taught in a few weeks to mental health professionals with no prior therapeutic experience. Although the model is rooted in psychodynamic principles, and its very practice is driven by its theoretical stance, an appreciation of the theory is less important than the human ability to 'reach into' another and try to get to know them. The model's simplicity makes it an attractive and potentially cost effective option for NHS services.

References

Baardseth, T.P., Goldberg, S., Pace, B.T., Wislocki, A.P. , Frost N.D., Siddiqui, J.R., Lindemann, A.M., Kivlighan III, D.M., Laska, K.M., Del Re, A.C., Minami, T., & B. Wampold. (2013) Cognitive-behavioural therapy versus other therapies: redux. *Clinical Psychology Review*, **33**: 395-405.

Damasio, A. (1994) *Descartes' Error: Emotion, Reason and the Human Brain*. Penguin Group. USA.

Damasio, A. (2003) *Looking for Spinoza: Joy, Sorrow and the Feeling Brain.* Harcourt.

Damasio, A., & Carvalho, G.B. (2009) The nature of feeling: evolutionary and neurobiological origins. Neurosicence Nature Reviews **14**:143-152

Hobson, R.F. (1971) Imagination and amplification in psychotherapy, *Journal of Analytical Psychology*, **16**:79-105.

Hobson, R.F. (1985) *Forms of Feeling*. Routledge. London.

James, W . (1884) What is an emotion? *Mind* 9 **34:** 188-205 Published by Oxford Journals. Oxford University Press. England

James, W. 1890: (1950) *The Principles of Psychology* (2 vols.). Basic Books, New York.

Langer, S. K. (1953) *Feeling and Form: A Theory of Art*. Routledge & Kegan Paul. London

Meares, R.A. (1977) *The Pursuit of Intimacy: An Approach to Psychotherapy*. Melbourne: Thomas Nelson.

Meares, R.A. (1993) *The Metaphor of Play: Origin and Breakdown of Personal Being.* Howe Routledge.

Meares, R.A. (2000) *Intimacy and Alienation: Memory, Trauma and Personal Being.* Routledge.London.

Meares, R. A. (2016) *The Poet's Voice in the Making of the Mind.* Routledge. London.

Stern, D. (1985) *The Interpersonal World of the Infant : A view from Psychoanalysis and Development.* Basic Books. London

Trevarthen, C. (2004) Infancy, min in. In R.L. Gregory (ed.), The Oxford Companion to the Mind (pp455-464). Oxford University Press. Oxford. England.

Vygotsky, L.S. (1978) *Mind in Society: The Development of Higher Psychological Processes.* Harvard University Press. Cambridge, MA. USA.

Wampold, B.E. (2015) How important are the common factors in psychotherapy? An update. *World Psychiatry*, **14**: 270-277.

Winnicott, D. W. (1971) *Playing and Reality*. Routledge Classics. London.

Wittgenstein (1966) *Lectures and Conversations on Aesthetics, Psychology, and Religious Belief.* Basil Blackwell, Oxford. England.