

PSYCHODYNAMIC- INTERPERSONAL THERAPY

A CONVERSATIONAL MODEL

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Psychodynamic- Interpersonal Therapy in Context

Introduction

This book contains the essential information about a model of therapy named psychodynamic-interpersonal therapy that has been developed over the last four decades. The book draws heavily on the extensive research base for psychodynamic-interpersonal (PI) therapy, which is summarised in Chapters 2 and 3. But the overall text is designed to be a compact summary and overview of this model of therapy that will enable practitioners, in conjunction with appropriate supervision and training, to implement PI therapy. Accordingly, Chapters 4 to 9 comprise a detailed manual to allow therapists to develop their skills and tools in practice. The model can be used as a development aid to existing skills in psychological practitioners, or can be used as a stand-alone model for experienced practitioners with more complex clients.

Psychodynamic-interpersonal therapy is relatively jargon-free and easy to learn as PI practitioners use everyday language rather than technical language to describe emotional experience. There is a strong emphasis upon 'knowing a person' as opposed to knowing about a person, coupled with the development of a strong therapeutic alliance. As feelings are re-experienced, they are linked to images, thoughts or prior memories, and then to key relationships. This process of linking feelings, thoughts, symbols and relationships occurs cyclically as the therapy develops and solutions are found and tested out both in the therapy and in the client's life.

The development of the model began in the 1960s when Robert (Bob) Hobson, a consultant psychotherapist, was working at the Bethlem Royal Hospital in London. Hobson ran a ward for patients with complex and enduring problems, many of whom would now be considered to have borderline personality disturbance. Hobson discovered that the traditional psychodynamic approach of that time was not helpful and, with his colleague Russell Meares, began formulating a new approach to treatment with much less emphasis upon psychodynamic interpretation and a far greater emphasis upon 'getting to know' the person and finding solutions to problems in the context of 'a conversation'.

Their essential idea was that the client's primary fundamental disturbance was a disruption or stunting of the ordinary experience of living. They viewed 'self' not as an isolated system but as part of a larger social organism. It follows from this theoretical position that the 'conversation of therapy' should involve a reciprocal shaping or picturing of the immediate central and emotional experience of the other, coupled with a re-working and re-processing of images, ideas and feeling states to form a more coherently operating self-system.

Hobson published his thoughts about a new approach to psychotherapy in a paper entitled 'Imagination and amplification in psychotherapy' (1971), and this was followed by a preliminary account of some of the features of the model in *The Pursuit of Intimacy* by Russell Meares (1977). Hobson then published a fuller account of the therapeutic approach in his book *Forms of Feeling: The Heart of Psychotherapy* (1985), by which time there was beginning to build a body of research on the model (see Chapters 2, 3 and 10).

Meares has further elaborated and developed the theoretical underpinning of the model (Meares, 1993, 2000). And a full exposition of his work with borderline personality disorder has been published recently (Meares, 2012a). The text is accompanied by a psychotherapeutic manual specifically for delivering the model for people with borderline personality disorder (Meares, 2012b). The model was originally known as the Conversational Model of therapy and this term is still used widely and interchangeably with the term psychodynamic-interpersonal therapy (abbreviated at times to PI therapy for convenience).¹

The hallmarks of the model

This initial chapter introduces the four features that characterise the PI model of therapy. We briefly summarise them here and then amplify each of them in the subsequent sections.

1. *Conversation* – Psychodynamic-interpersonal therapy begins with the premise that personal difficulties can best be tackled within a relationship and that developing a personal relationship requires the therapist and client to 'discover a language that fits' (Hobson, 1985: 192); that is, to shape a common

¹ The term *psychodynamic-interpersonal therapy* is generally used as the name of this model, particularly in scientific discourse. The (or a) Conversational Model was the name preferred by Robert Hobson and Russell Meares. Throughout this book, the two names are used interchangeably.

- 'feeling language'. This is what Robert Hobson meant by a Conversational Model of psychotherapy. The therapist and patient engage in a creative process, a *conversation* in which shared understanding develops.
2. *Forms of feeling* – The notion of 'forms of feeling' is crucial to the PI model approach. When Hobson referred to feeling, he did not mean a faculty of emotion plus a faculty of cognition. Rather, he referred to a form of 'emotional knowing' or imaginative emotion related to an idea. This requires a different thought process to an intellectual way of thinking about problems and requires a form of creative imaginative or symbolic attitude which links together feeling states, symbols and 'analogues' to produce a sense of greater coherence. This type of analogical relationship is described by Meares as something providing a feeling of 'fit' or connectedness, showing the shape and proportions of something being described whilst not being an exact copy.
 3. *Minute particulars* – Hobson used the term 'minute particulars' to refer to the ability of the therapist to pay especially close attention to the barely noticed nuances of a conversation so that by a painstaking series of adjustments, paying attention to minimal changes in inflection or gaze, the therapist starts to share an understanding of the other's inner state through a series of tentative hypotheses. Few other models of therapy focus so intently on the micro aspects of treatment.
 4. *Research and practice* – The model has, from its inception, been grounded in a synergistic relationship between research and practice. Firstly, the PI model has a foundation in outcome research (see Chapter 2). This gives a clear answer to the question: Does it work? But, it is equally grounded in process research studying how people change in therapy – that is, research where the question is: How does it work? Our account of research on PI therapy takes the form of a developing story which progressively answers these key questions (see Chapter 3). In Chapter 10 we describe not only the research on learning this model of psychotherapy but also some suggestions about how process research methods can be used to enhance clinical practice by bringing in a different perspective of observation.

1. Conversation

A central tenet of the model is that the development of cohesion of the self depends upon a particular style of conversation, initially learned externally and then progressively internalised. This form of conversation is one that caregivers naturally adopt when bringing up young children (see Stern, 1985: 43). Some people are more naturally adept at this mode of relating than others. The process involves engaging with the child in an intimate form of 'emotional play'. It is this natural style of relating and capability to 'attune' to someone else that the model seeks to promote.

Hobson's strong belief was that it is the stories that matter – and how they are told. The skill of psychotherapists lies in their ability to learn and reflect back the language of the client and thereby create a 'mutual language' – a personal conversation. Hobson drew upon Wittgenstein's concept of 'language-games' (Hobson, 1985: 47). This is the notion that forms of language are

particular and specific to shared activities of living and Hobson argued it was central to understanding the Conversational Model. The use of a form of words in one context may have a completely different meaning in another context. The important question is: 'What is this language doing within a particular situation?' (Hobson, 1985: 47).

The idea of 'conversation' as a principle is discussed further elsewhere in this book, but in considering the personal roots of the model developed by Hobson the actual conversations with colleagues over the years have had a powerful influence. In writing *Forms of Feeling*, he acknowledges that there is an inevitable bias towards the ideas that have arisen in conversations with friends. Two contributors to the idea of 'conversation' as part of the core of psychotherapy have been Russell Meares, who gives his own account of the Conversational Model elsewhere (see Meares, 2012a), and Miller Mair (1989).

Russell Meares, in his subsequent work on child development and the idea of the 'secret' as part of the development of a sense of a separate self, has carried forward the ideas of the Conversational Model into specific theories related to infant development (Meares, 1993, 2000). Meares was also acutely aware of the risks of a therapist 'knowing too much' and hence invading the personal space of the other in a therapeutic conversation. In their work on 'The persecutory therapist' (1977), Meares and Hobson specified the characteristics of an anti-therapeutic conversation that has been crucial in developing a teachable model of psychotherapy.

The conversational and rhetorical aspects of conversation and the 'poetics of experience' have also been closely linked with Hobson's work. He begins the Introduction to *Forms of Feeling* (Hobson, 1985: xi) with a quotation from Wordsworth:

The principal object, then, which I proposed to myself ... was to choose incidents and situations from common life, and to relate or describe them throughout, as far as was possible, in a selection of language really used by men; and at the same time throw over them a certain colouring of the imagination whereby ordinary things should be presented to the mind in an unusual way ... not standing on external testimony but carried alive into the heart by passion. (Preface to the *Lyrical Ballads*, 1805)

Robert Hobson draws extensively on quotations from literature, but in a series of discussions he worked with the late Miller Mair² (1989) in elaborating a 'poetics of experience'. Quoting George Eliot in *Middlemarch*, Miller Mair points out that to be a poet:

² The late Professor Miller Mair was a clinical psychologist who became Clinical Director of Crichton Royal Hospital in Dumfries and Galloway. He worked closely with Robert Hobson in a series of training workshops during the 1970s and 1980s. He focused on the use of conversation and metaphor, and introduced the idea of a 'community of selves' with an internal conversation. These ideas and the emphasis on the poetics of experience resonated closely with the work that was developing on the Conversational Model at that time.

is to have a soul so quick to discern that no shade of quality escapes it, and so quick to feel, that discernment is but a hand playing with finely-ordered variety on the chords of emotion – a soul in which knowledge passes instantaneously into feeling and feeling flashes back as a new organ of knowledge. (Mair, 1989: xi)

As Miller Mair reminds us, Eliot notes that ‘one may have that condition by fits only’ – moments in psychotherapy – but Miller Mair, from his background in personal construct psychology, is referring to the same core principle that Robert Hobson espoused above. The emphasis on poetics of language was fundamental to Robert Hobson’s understanding of therapeutic language.

For the purposes of simplicity, Robert Hobson and Russell Meares both distinguished two basic forms of language in therapy. The first is the language used to talk about ‘things’ that Hobson referred to as ‘jam-jar language’, and the second is the language used to share personal experience, which Hobson termed ‘feeling-language’. The former is language we use to describe being in the world. It is literal and discursive and unconnected to feeling. It is the language we would use to say: ‘That is a jam-jar’. The latter is characterised by a sense of vitality, a feeling of connectedness and a sharing of emotional experience. Hobson referred to it also as ‘the language of the heart’. It is the language we use when we are talking intimately with a friend, family member, partner, or to ourselves.

Russell Meares developed this concept further by referring to ‘chronicles’ or ‘scripts’ to describe language that involves a catalogue of problems or symptoms, disconnected from the inner world. And he referred to ‘inner speech’ when describing figurative or emotional language (Meares, 2012b: 39).

Robert Hobson argued that a personal conversation, promoted in therapy, involves the development of a ‘feeling-language’. This form of language expresses, communicates and shares feeling that involves: a) an apprehension of, and staying with, immediate experiencing; and b) a process of discriminating, symbolising and ordering experiences, especially by creative expression in ‘living symbols’ (using figurative language and metaphor).

So, one of the main tasks of a therapist using PI therapy is to try to promote or facilitate and share a kind of ‘feeling-language’; in other words, to try to know and connect ‘with someone’ in therapy rather than talk about their problems or emotions. It is common for people to use ‘thing language’ to describe their feelings – ‘it’s my depression back again’ – and this should not be mistaken for ‘feeling-language’. The important distinction is between talking *with* someone as a person rather than talking *about* some experience they have had.

The work of therapy also includes owning experiences (thoughts, wishes, feelings experienced in relation to persons) in a movement from passivity to activity. This is characterised by accepting responsibility for actions and acts which had previously been disclaimed as a way of avoiding conflict.

2. Forms of feeling

The terms ‘feeling’ and ‘emotion’ are often used interchangeably. But when Hobson refers to ‘forms of feeling’ he is talking about elaborations of

presentational symbols – emotions that are connected to imaginative ideas – as a kind of emotional knowing. Staying with feelings in the ‘here and now’ in therapy often leads to images, ideas, previous experiences, dreams, memories or physical sensations. These presentational symbols or mental pictures are elaborated, shaped and processed, dissolved and re-combined to eventually produce a harmonious organization or ‘fit’.

Symbols enable people to elaborate ‘inner forms’; conceptions which can be modified, combined, re-combined in the process of thinking and solving problems. Figurative speech, which involves symbolic language and metaphor, has a sense of movement and direction: There is a sense of layered meanings and complex connections.

The model emphasises the use of metaphor as one important way of exploring creatively a relationship between hitherto unrelated ‘terms’. It is the process of exploration between two people (therapist and client) and, hence, the re-combination of meanings to create a new understanding, which is key.

Hobson was very aware that this theoretical account, at first sight at least, can seem hard to grasp, and he preferred to demonstrate the ideas in action. When asked by a trainee for a recommendation about reading about depression, he might refer to Conrad’s *Heart of Darkness* rather than a psychiatric paper, although he was very familiar with the technical language of psychiatry as shown in his MD thesis on the physical treatment for depression.

3. Minute particulars

This concept of the ‘minute particulars’ arises originally from William Blake; Hobson, (1985: 108) cites William Blake:

... he who would do good to another must do it in Minute Particulars: General Good is the plea of the scoundrel, hypocrite and flatterer, For Art and Science cannot exist but in minutely organized particulars (Jerusalem III, 55: 60–68)

A focus on the microscopic forms of therapy has been a crucial part of the psychodynamic-interpersonal model from its inception. Russell Meares, when training with Robert Hobson in the late 1960s, brought Hobson audio recordings of sessions of therapy with a young man whom he was struggling to help. Meares found he could not convey in sufficient detail to Hobson the struggles he was experiencing without audio recording the sessions. Hobson and Meares found that ‘within the minute particulars of the therapeutic conversation, systems of destruction and moments of aliveness were present in microscopic form’ (Meares, 2012a: 13). They found a great deal can happen within a very few minutes of a psychotherapy session. Hobson wrote: ‘The important focus is *how* a conversation is developed in its minute particulars. Broad psychodynamic theories are all very well: indeed, inevitably, they guide what we observe. But any formulation of the problem that faces a

unique person must emerge from the manner of this conversation, *here and now*' (Hobson, 1985: 165).

PI therapy stands apart from many other modalities in its focus on the 'micro' interactions of therapy as opposed to the 'meta' world of understanding. A crucial aspect of this process is listening. All therapists using any modality of therapy would say listening is important. However, when Hobson referred to listening he meant more than simply attending to what is conveyed. Rather, Hobson referred to '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' (1985: 208).

Therapy involves a progressive, ever-varying exchange of information conveyed by complex cycles of action and perception. The challenge for the therapist is to learn the 'language' of the client, which can only be accomplished by 'listening' to what he/she is communicating in speech, gesture and feeling. It is salutary to listen to or watch tapes of therapy and see the myriad different ways in which clients converse, only to realise that we miss most of these opportunities for conversation because we are not sufficiently attuned to what the client is trying to tell us.

Although the audio recording of therapy sessions is now commonplace, in the 1960s it was rare and many psychodynamic therapists were actively and theoretically opposed to such forms of monitoring. But, Hobson and Meares – in the same way that Carl Rogers and colleagues had done in counselling – were pioneers as they realised that it is only by replaying and reviewing recordings of therapy that therapists can improve their listening skills and begin to become aware of the *minute particulars* of therapy.

4. Research and practice

A key characteristic of PI therapy is the way it draws together research and practice as two faces of the same coin. Formal trials of whether a therapy is effective are an initial step in building a therapeutic approach, but we describe ways in which the detailed analysis of the process of change alters and updates the model itself, and also the practice of individual therapists. The methods used in teaching this model are similarly based on good research foundations. But beyond this, we also encourage those learning to practise this model to use research methods to increase their understanding of their own sessions as described in Chapter 10.

This self-reflexive approach to practice can be strengthened by regular review of progress in therapy. It is beyond the remit of this book to discuss this in detail, but there is a complementary relationship between evidence-based practice and practice-based evidence (Barkham and Margison, 2007; Margison et al., 2000). This complementarity suggests that practitioners gain from looking at their own practice and reviewing the progress of that therapy against benchmarks derived from other practitioners through using simple, well-established measures of therapeutic change.

Chapter 2 briefly summarises 30 years of research effort including evidence that PI therapy is effective in mood disorders (depression), in some psychosomatic disorders (irritable bowel syndrome and functional dyspepsia) and personality disorder (studies of borderline personality disorder). In addition, the model has also been shown to offer benefit to people who have not responded to other therapeutic approaches. Further, the PI model has been shown to be cost-effective in practice.

However, it is of limited benefit to show that a therapy works if we have no idea what might be leading to that change. There needs to be a theory of why a particular type of conversation can lead to change. We also want this model of therapy to be grounded in what therapists actually do. So, the outcome studies referred to above have been linked to qualitative and process studies from which we have distilled some key lessons about how change occurs. This work is summarised in Chapter 3 as part of an ongoing narrative about what makes psychotherapy effective.

We also report in Chapter 10 studies showing that the basics of the model can be learned quickly, that those skills persist in practice, that the training has a positive impact on therapists and that trained therapists have a distinctive style that maps onto the fundamental tenets of the model. In our view there is no purpose in developing a new therapy without the confidence that it is effective and that training can be provided that focuses on the key therapeutic skills as efficiently as possible.

The theoretical and personal foundations of psychodynamic-interpersonal therapy

Having set out the hallmarks of the psychodynamic-interpersonal model as they are realised in therapy, here we consider both the theoretical concepts that have contributed to the PI model and also the personal influences on Robert Hobson that helped shape the formation and development of the Conversational Model.

Hobson and Meares have been influenced by the ideas of Williams James (1842–1910) – an American philosopher and psychologist – and Hughlings Jackson (1835–1911) – a Yorkshire-born English neurologist – in relation to the idea of ‘self’ as being a form of a stream of consciousness. Self is understood to arise out of a relationship with others. The psychotherapist Harry Stack Sullivan (1892–1949) – an American psychoanalyst – argued that ‘a personality can never be isolated from the complex of interpersonal relationships in which the person lives and has his being’ (1940: 10). Sullivan’s model has been very influential in building an explicitly interpersonal model of the person.

However, there are areas in which Sullivan also retains a model of the unconscious even though markedly different from that proposed by Freud. He saw the contents of passion and conflict in ‘shifting and competing configurations composed of relations between the self and others, real and imagined’ (Greenberg and Mitchell, 1983: 80). This assumption that the self

is a property emerging in relationships (internal and external) underpins the psychodynamic-interpersonal model and other modern theories of psychotherapy, such as Cognitive Analytic Therapy (Ryle, 1990; Ryle and Kerr, 2002: 34–36). And both approaches draw explicitly on the work of Vygotsky (cf. Leiman, 1997; Stiles et al., 1997). For example, both models draw on the idea of a 'zone of proximal development' (ZPD; see Zonzi et al., 2014 for an example within PI therapy).

Vygotsky worked on cognitive development in children and described the ZPD as the 'distance between the actual developmental level ... and the level of potential development as determined by problem solving under adult guidance, or in collaboration with more capable peers'. In working with adults, the model is more like collaborative learning with no sense of hierarchy (see Chapter 3 for applications of ZPD in PI therapy). In addition, in PI therapy we have developed the idea of working in collaborative peer groups to extend the ZPD of trainee therapists as well as of clients (see Chapter 10 section on role-play groups).

As is common in relational approaches, PI therapy pays particular attention to the infant's development within a relationship (Meares, 1993). It is widely recognised that the infant has an intrinsic need to relate. As Sullivan pointed out, there are 'needs for tenderness' beginning with the need for bodily contact, developing into a need for an audience, and later needs for competition, co-operation and compromise. Failure to satisfy these needs at the appropriate developmental point leads to 'loneliness'. Hobson echoes this theme with his distinction between the creative state of 'aloneness/togetherness' and the terrifying state of 'loneliness' (Hobson, 1974). The theoretical underpinning for this core state has been further developed by Meares (2012a) but the detail goes beyond the scope of this book.

A complementary view of the early need for relationship is derived from attachment theory (Mace and Margison, 1997). The process of therapy is seen as an attempt to invoke an actual relationship with the therapist which is stable and responsive but within which the attachment representations can be modified to allow alternative, less maladaptive, patterns of relationship to develop (Holmes, 1996). Identifying and working with these patterns of attachment is a key underpinning of psychodynamic-interpersonal therapy. A key idea in monitoring whether these crucial conditions are being met is to consider the degree of 'attunement' between therapist and client as described by Stern (1985). Attunement is a concept widely used in counselling to mean attending closely to another person's state of mind. Here we mean something closer to the sense in which Stern refers to attunement as a form of conversation between parent and infant. The caregiver apprehends the other's affective states and responds with behaviour that corresponds with the infant's affective state, and finally the infant perceives a connection between the caregiver's statement and his or her own emotional state. This may be verbal or could be in the form of vocalisation or non-verbal gesture leading to a state of affective attunement. Stern conceptualised these states as the foundation for recognising that inner states are shareable.

Between adults, the same emotional exchange can occur and this experience is crucial in PI therapy. In some cases a longer period of therapy may be needed, as the belief that emotional states can be shared or even experienced directly has never been developed. With reference to the practice of PI therapy, Stern's description of 'amodal properties' (Stern, 1985) are especially helpful as they describe textural properties of a conversation such as intensity, rhythm, shape and cadence which are part of the 'minute particulars' discussed earlier.

PI therapy also draws on Jungian principles and Robert Hobson acknowledged the particular importance of Jungian psychology in developing his ideas. Hobson's own basic training as a psychotherapist was in analytical psychology and there are many resonances of the Jungian tradition in his writing. He acknowledges the influence of Fordham (1979), in particular his work on the Self. But the most important links are with Jung himself, and particularly Jung's approach to the practical aspects of therapy.

A profound personal influence on Hobson was his personal meetings with Carl Jung during the 1950s. Although by then a senior analytical psychologist and President of the Society of Analytical Psychology, Hobson admits to being surprised by the simplicity of some of the core elements of Jung's actual clinical work. Hobson distilled these principles and incorporated them into his own model. Many casual observers pay most attention to Jung's work with archetypes and myth, which are, of course, important in their own right. However, the central elements that Hobson drew from his conversations with Jung have much in common with current models of brief therapy.

There are three that are particularly pertinent. First, Jung emphasised the importance of a 'symbolical attitude' even in the briefest therapies and this principle has clearly been carried forward in the centrality of metaphor in the Conversational Model, and hence PI therapy. Second, Jung also used the immediate present, the 'here and now', in a particular way which focused the session in a, sometimes, challenging way. And third, Hobson's central idea of the 'conversation' was drawn from Jung's concept of the 'dialectical meeting': thesis, antithesis and the synthesis embodied in the conversation itself.

For Hobson, this emphasis, drawn originally from Jung, has strong resonance with the ideas of Harry Stack Sullivan (1953). Sullivan developed Interpersonal Psychoanalysis. He saw the contents of passion and conflict in 'shifting and competing configurations composed of relations between the self and others, real and imagined' (Greenberg and Mitchell, 1983: 80). This approach, which underpins the original Conversational Model, is fundamentally dialogical. This assumption that the self is a property emerging in relationships (internal and external) underpins other modern theories of psychotherapy drawing on the work of Vygotsky and Bakhtin.

Core values

All of the elements of theory presented above are embedded in the notions of a conversation, as described by Hobson and Meares. Hobson also invoked some core values that need to be upheld by the psychotherapist. Hobson returns frequently to the theme that psychotherapy is about 'persons' involved in a mutual

conversation. '[S]ix qualities of a personal relationship ... are at the heart of conversational therapy: it happens between experiencing subjects, it can only be known from "within", it is mutual, it involves aloneness-togetherness, its language is a disclosure of private "information", and it is shared "here and now"' (Hobson, 1985: 25). This approach is central to Hobson's approach to therapy. In those six qualities he sums up some of the key principles of practice that we will expand in the subsequent chapters of this book.

A key paper from Meares and Hobson (1997; 'The persecutory therapist') shows how even well-intentioned therapists can be experienced as damaging and so the model of psychotherapy developed here is explicit not just about what *should* occur in a therapy but also what is unhelpful. These unhelpful aspects prevent the development of a therapeutic conversation.

Psychodynamic-interpersonal therapy as an integrative model

Psychodynamic-interpersonal therapy, as the name implies, can be seen to draw on several traditions within psychotherapy and can be seen as an 'integrative' model (Margison, 2002; Martin and Margison, 2000). One particular aspect of integration that was developed alongside the research programme described later is the *assimilation model* (Stiles et al., 1990; see Chapter 3). This illustrates how different approaches by PI therapy and cognitive behaviour therapy (CBT) can both aim to increase the assimilation of problematic experiences. However, as described later, the way that assimilation occurs shows key differences between an integrative relational approach like PI therapy and other models of therapy. Integration suggests that the elements are part of one combined approach to theory and practice, as opposed to eclecticism, which draws ad hoc from several approaches in the approach to a particular case (Hollanders, 2000).

The diverse range of influences involved in PI therapy as an integrative model have been discussed elsewhere (see Margison, 2002). In addition to psychologists such as William James, Rogers' person-centred counselling, self-psychology of Kohut, systems theory and Bowlby's attachment theory, Robert Hobson was influenced by literary figures including Shakespeare, Wordsworth and Coleridge in his approach to developing a 'feeling language'. He was heavily influenced by philosophers, especially Wittgenstein on language games, Christian writers including Martin Buber on the 'I-Thou' relationship and phenomenology through Rollo May on the experience of the self. These influences are explored further in *Forms of Feeling*, especially in the Notes and Note on Sources (Hobson, 1985: 283–99) where the breadth of influence becomes apparent.

Conclusions

This chapter has outlined the main background to the development of the Conversational Model and subsequently this model of psychodynamic-interpersonal therapy. It has complex foundations but now represents a distinctive tradition within psychodynamic-interpersonal therapies. The psychodynamic

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tradition is represented in the detailed attention to shifting states of mind, the tendency to ward off painful or threatening experiences, the underlying drive to form attachments and in the focus on disturbances of the self.

The interpersonal aspects are seen in the fundamentally dialogical approach and the emphasis on repetitive relationship themes. Both of these are in a context that draws on an explicit focus on optimising the therapeutic relationship and facilitative conditions (Rogers, 1951). The model of psychotherapy has been heavily influenced by the research that we, and others, have carried out and this work is summarised in the next two chapters. We look at the evidence that this approach is effective and also at the evidence that supports our model of the change process.