The Conversational Model: An Outline

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This paper gives a brief outline of the Conversational Model which is among the best validated of currently employed psychotherapies. The theory is built around the idea that the central task of psychotherapy is to potentiate the emergence and amplification of that dualistic form of consciousness that William James called self. However, this state of mind cannot be acted upon as if it existed in isolation. Rather, it is part of an ecology that includes the form of relatedness that underpins it. No element of the ecology can change unless the other elements also change. Seen in this way, the form of relatedness is transformational. It is necessarily mediated by conversation consisting of more than its content, the simple transmission of information. The main point of the paper is that the form of the conversation manifests and constitutes not only a form of consciousness but also a form of relatedness. This conception provides a means of testing hypotheses of therapeutic action since it suggests that syntactical structuring, together with the other major elements of language, lexicon, and phonology, allow us to chart the waxings and wanings of personal being in the therapeutic conversation.

THE BACKGROUND

The Conversational Model is the name Robert Hobson (1920-1999) gave, in 1985 (1) an approach to psychotherapy that grew out of work with patients who had failed other treatment and who, in the language of the time, were "unanalysable." Many of these people would now be called "borderline." Although the approach arose out of experiences with severely damaged people, it has a general application. The purpose of this paper is to give a brief outline of the model in order to introduce it to American therapists who, because of its Anglo-Australian origins, may not be familiar with it.

The work began in 1965 with a focus on the "minute particulars" (1), through the use of audiotapes to study the therapeutic conversation. Here could be found in microscopic form not only systems of destruction of the sense of personal being but also "moments of aliveness," that are the germs

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of self. These data provided an important basis to the theory that Hobson and myself have struggled to grasp and formulate over the last three decades.

The project was launched, in publication terms, in 1971, when Hobson put forward certain of the main ideas of what he hoped would be a "testable model of psychotherapy" (2). Fostering a form of relatedness Hobson called "aloneness-togetherness" was seen as a central aim of therapy. This aim was additional to, and beyond, that of correcting distortions of habitual maladaptive forms of relatedness. Its purpose was the generation of self, which was understood as a dynamism, a process, arising in conversation as a third thing, *between* people (2, p. 97).

This paper outlines the subsequent elaboration of these original nuclear ideas. Self is conceived much as William James had done (3, 4). It has a core of "value" that can be damaged (5). Attacks upon this feeling are a major source of psychological trauma (6). Symbolic play provides a metaphor for the development of self (7), which cannot be generated by a "linear" form of language (8). Rather, therapy is directed towards a jointly created imaginative narrative arising out of play - like, non - linear mental activity (1, 2, 4, 6, 7, 8). Therapeutic interventions directed at "insight" and the "unconscious" risk invalidation and the creation of dependence (3, 9). Descriptions of the theory and method are given in Hobson (1) Meares (6, 7).

The model is one of the best validated of all currently employed psychotherapies. An abbreviated version of the model has been manualized as "psychodynamic-interpersonal" (PI) psychotherapy (10, 11). PI has shown to be effective in depression (12, 13, 14) in certain psychosomatic disorders (15) and to be cost-effective in treating repeated users of clinic services (16). A brief form of PI is useful in reducing repeated episodes of self-harm (17). The Conversational Model produces beneficial effect and is cost-effective in the treatment of borderline personality disorder (18-21).

THE ACTION OF BEING

An old definition of the word "conversation," provided by the Oxford English Dictionary, conveys the essence of the Conversational Model. It is: "The action of living or having one's being *in* a place or *among* persons." It tells us that conversation both *constitutes* and *manifests* a form of personal being. A focus upon the shifts, the movements, the waxings, and wanings of this experience is at the core of the therapeutic approach.

Each mental illness involves a specific disturbance of the ordinary ongoing sense of personal existence, an experience we might call "self." This statement is almost tautological yet it is necessary to begin in this way

since, although the observation is fundamental, the basic idea is sometimes lost in a focus upon symptoms and behavior. The Conversational Model is built around the idea that psychotherapy is directed towards the restoration of a disrupted sense of personal being, or self. Each mental illness will involve a particular kind of disturbance of the sense of personal being.

The development of a scientific theory that underpins this approach must begin with what we mean by self. According to William James, self is defined as a process—something like his "stream of consciousness" (3, 6, 7). Using James's description (22), we can identify at least 12 main characteristics of self. Of great significance is the feeling associated with the movements of inner life. It involves the sense of aliveness, of vitality. This is allied to a feeling of well-being, a background tone of positive affect of which we are not always consciously aware. Another notable characteristic of self is duality, a doubleness created by the reflective awareness of inner events.

A perusal of the main characteristics of the Jamesian self (see table I) suggests the complexity that follows a disruption of this experience. Furthermore, the list is not exhaustive.

It is likely that each individual's presentation to a therapist reveals a unique "profile", comprising these various features, some being relatively preserved, others lost, stunted, or deformed. Although the profile for each individual will be his or her own, specific general patterns of disturbance can be identified. For example, an attenuation of the concept of boundedness is prominent in obsessive-compulsive disorder (23, 24); the senses of agency and ownership are ill-developed in anorexia nervosa.

The Conversational Model arose out of the aridness of the positivist-behaviorist era of the twentieth century in which the notion of inner life, the heart of humanity, was disregarded, derided, or even denied in the dominant trends of psychological and philosophical thought. The overt reasons for the banishment of self from these and related disciplines

Table I. MAIN CHARACTERISTICS OF JAMESIAN SELF

1. Duality (i.e., reflective awareness)	7. Temporality
2. Movement (sense of vitality)	8. Spatiality
3. Positive feeling (warmth & intimacy)	9. Content beyond immediate present (i.e., of the possible, the imagined, the remembered)
4. Non-linearity	10. Ownership
5. Coherence	11. Boundedness
6. Continuity	12. Agency

included the criticism that, because it could not be seen and measured, it was beyond the pale of scientific inquiry. However, in attempting to create a model of therapy that was "humanistic" (1, p. 228), and that gave value to the feeling of inner life, we did not want to lose the emphasis upon the scientific ideal that underpinned much of the intellectual endeavor of the twentieth century. It is essential that therapeutic methods do not depend merely upon such influences as tradition, authoritative texts, or even the idea that a particular procedure seems to make sense. Therapeutic procedures must be testable.

If our work is to have a scientific basis, we must be able, as it were, to view changes in self as the experience waxes and wanes during the therapeutic process. This can be done linguistically. Fluctuations in the state of self as displayed in shifts in its various characteristics are manifest in the language of the therapeutic conversation.

The study of language here refers not simply to the *content* of language. Conversation is not merely a vehicle for the transmission of pieces of information conceived as necessary to the therapeutic process. Of central import is the *form* of the language, the way that words are used. This usage includes the tone of voice. Language consists of phonology, lexicon, and syntax. Phonology is the fundamental language since it is all that the baby can use for the first 18 months or so of life. Syntax is the last element to emerge. Syntax not only suggests a form of self, it also depicts and constructs a form of relatedness. This leads to the notion that every form of consciousness is underpinned by a particular form of relatedness.

SELF AS DYNAMISM: THE FIRST THERAPEUTIC FOCUS

The Jamesian self is only one of a number of different forms of consciousness. Its identifying feature is duality. This unified experience is "duplex," made up of one pole of awareness and another pole of inner events. Consciousness is not always in this form. For example, when we are alarmed, reflective awareness is lost and attention is directed towards the source of the threat. This kind of consciousness is "adualistic." The characteristic consciousness of those people damaged by the impacts of the social environment takes this form. The aim of therapy is to restore, generate, and potentiate that particular kind of consciousness that we are calling self. However, this state of mind cannot be approached as if it existed by itself.

Just as Winnicott said of a baby, we can say that *there is no such thing as a self.* It does not exist in the absence of an environment. Particular states of consciousness cannot be conceived in isolation. They arise in the

context of particular forms of relatedness, which are necessarily mediated by conversation. The idea that self is part of a dynamism, or ecology, is summarized in Table II.

The proposal that particular forms of conversation both manifest and create a form of relatedness and a form of consciousness can be illustrated by considering a particular example. If a person with whom we are talking says something beginning with "It looks like. . . . . " when referring to inner events, he or she shows not only a duality of consciousness but also a form of relatedness. It involves a curious kind of at-oneness in which both partners feel a sense of connectedness and a shared understanding, but their orientation is not directed at themselves but at something else, a third thing which, as it were, arises between them. This third thing we might call self.

The kind of relationship illustrated here has the elements of Robert Hobson's called "aloneness-togetherness" (1, 2, 25). In a literal sense, this is an "intimate" relationship since it involves the sharing of inner experience. It is important that intimacy, understood in this way, does not necessarily include sexuality, and is not equivalent to confession.

Hobson's "aloneness-togetherness" is a state in which, while with another, one's own world is retained, and while alone, one is not afflicted with the pain of isolation. He contrasted this state with another dyadic state, a principal feature of which is isolation and alienation. The first aim of therapy is to establish that form of relatedness in which the experience of self emerges. Hobson wrote: "Much of the work of psychotherapy is

Table II. THE DYNAMISM OF SELF

1. Self is a particular kind of consciousness
2. Every state of consciousness arises out of the brain's interplay with the sensory environment
3. The most important part of the sensory environment, in terms of the experience of self, is the social environment
4. Following 3, we can restate 2 as follows: That state of consciousness we call self arises in the context of a particular form of relatedness
5. Since relatedness depends upon language we can enlarge 4 to say that a particular state of consciousness, manifest in language, arises in the context of a particular form of relatedness, mediated by conversation
6. Any change in one of the components of this system (or ecology) causes a change in all the other components
7. Conversely, a state of consciousness cannot alter unless the other components of the dynamism also alter

concerned with establishing the state of aloneness-togetherness, by resolution of an idealized fantasy of fusion that goes together with social isolation" (2, p. 97). Fusion is not intimacy. Indeed, it can be seen as a kind of defence, a desperate attempt to fill, with the figure of the other, the emptiness left by the absence of self.

FELLOW FEELING AND THE DOUBLE

The experience of the other in the state of "aloneness-togetherness" is one of fellow-feeling. A "fellow" according to the Oxford English Dictionary, is "One of a pair; the mate, marrow; a counterpart, match." The "marrow," the same dictionary tells us, is "the inmost part; the vital part; the essence; the goodness." These words convey something of the affective tone that "fellow-feeling" implies. It is a consequence of a complex matching arising out of an interplay that resonates between two people. Out of this feeling of resonance between my inner, essential, and highly valued experience and the responses of the other, there emerges the sense of myself. Hobson in his characteristically condensed, and almost gnomic way, wrote: "I can only find myself in and between me and my fellows in a human conversation" (1, p. 135). ("Me" in this statement refers to "identity" and is distinguished from both "I" and "Myself").

The experience of the other in this state of connectedness is not adequately expressed by any word in the English language. "Fellow" is an approximation, as is Kohut's "selfobject." The latter term conveys the notion that this form of relatedness, in which self elements adhere to the object, is to be distinguished from the "subject-object" form. However, a literal understanding (or, in my view, misunderstanding) of Kohut's definition, which concerns the other's "functions in shoring up our sense of self" (26, p. 49) leads to the danger of addiction to certain responses of the other, and so to impediments to the emergence of self.

The cardinal feature of "fellow-feeling" (that might also be called "intimate relatedness"), is that of "doubling." The other portrays, or represents, in tone of voice, facial expression, the use of words, or all of these, something of my own, "vital," experience. My likeness, as it were, is embodied in the other or in his or her expressions. This process of "doubling" is essential to the development of self (6).

The double consciousness self is not experienced by the child until about 4, 5 or 6 years of age when he or she discovers the experience of the "stream of consciousness" (27) and the concept of "innerness" is formed (28). Before this milestone is achieved, consciousness is largely adualistic. However, the achievement is not an inevitable part of an immutable

biological program. Rather, particular responses are required of the soeial environment. The caregiver, at least at first, plays out the role of the double, so that the *double consciousness of the mature adult first appears, in elementary form, not as an intrapsychic experience, but in the world between the baby as "I," and the other whose responses "match" the baby's positive emotional state.* In this behavior, the mother who is double, a me-other, does not simply mimic her baby. Her responses include *amplification, coupling* and *representation*, the characteristics of a self-organizing system (6).

The sense of at-oneness with the other is slowly internalized as summarized in Table III. The table makes clear that the internalization takes place in the context of play and involves conversation that, at first, depends upon phonology.

The developmental process provides principles for important aspects of the therapeutic approach, particularly in those cases where the caregiving environment has failed to provide appropriate responsiveness, i.e., a constantly changing series of "attuned" or empathic representations. In these cases, since the internalization of the sense of being with the other has not taken place, the "aloneness-togetherness" form of relatedness is not possible. Nor is the experience of the "stream of consciousness" developed, leaving the individual afflicted with inner emptiness. His or her

Table III. A DEVELOPMENTAL SCHEMA OF "DOUBLING" IN PLAY

Birth	Conversational Play —mother doubles as the child
2–3 months	Proto-Conversation —mother (i.e. caregiver) as the other who is a double
10–12 months	Imitation —child now creates the double by means of the body
18 months–4/5 years	Symbolic Play —child creates an abstract or illusory double to whom he/she talks (condensation of experience of the other as double and projection of the child himself or herself) —the transitional field
4–5 years	Inner Conversation —the double is now internal

conversation has the style of a "chronicle" (29). A further understanding of this state can be gained by a consideration of the scene of symbolic play.

TWO KINDS OF HUMAN LANGUAGE

Symbolic play, in which the child plays with toys, or other things, in an apparently solitary way, is a feature of that period of life before the child's discovery of the stream of consciousness at the ages of four to six. It shows the embryonic features of this inner experience going on in the outer world.

In this kind of play, although the child appears to be ignoring those around him or her, he or she is not alone. The activity is suffused with the sense of the presence of the other during those occasions in the past when at-oneness was experienced. The scene has a strange reality that both Piaget (30, 31) and Winnicott (32) identified. It is neither inner nor outer but both. It is "transitional," to use Winnicott's term.

While the child plays, he or she chatters, using a curious language described by Vygotsky (33). It is nonlinear, associative, and apparently purposeless. It jumps, and is, at times, so condensed that it cannot be understood, leading Vygotsky to conclude that its function is not communicative. Rather, I suggest, it is necessary for the representation, and so, the bringing into being, of self (34, 7). The child engaged in symbolic play, has taken on for himself or herself the representing role of the other as double.

The child's language during symbolic play (e.g., "See, he's going up. He's clever isn't he?"), suggests that a curious kind of conversation is going on. Since this activity is, I suggest, the necessary forerunner to the "stream of consciousness," and the earlier form of the later, inner experience, we infer that the stream of consciousness can be conceived as something like an inner conversation. Vygotsky had a very similar idea, believing that

Table IV. THE TWO HUMAN LANGUAGES

Inner Speech	Social Speech
1. Nonlinear	1. Linear
2. Nongrammatical	2. Grammatical
3. Analogical, associative	3. Logical
4. Positive affect	4. Variable affect
5. Noncommunicative	5. Communicative
6. Inner-directed	6. Outer directed
7. Intimate	7. Nonintimate
8. Self-related	8. Identity-related

when the strange kind of speech used in symbolic play disappears between the ages of four to six, it is internalized to become "inner speech." The form of relatedness in which the sense of self is emerging shows the "shape" of this language.

Symbolic play is enveloped by the atmosphere of implicit intimate relatedness. The orientation is embryonically inner and focuses on the child's personal concerns, aspirations, imaginings and so forth. The activity, in its most typical form, consists in the telling of a story that, in a symbolic way, gives them representation. These small stories are the atoms out of which that larger organism, the individual's own symbolically told "narrative of self," is, eventually, made. This process goes on, in a more interior way, throughout life.

The child, however, is only engaged in this play for a small amount of time, as we are only lost in thought for brief periods of the day. For most of the day, the child uses a second language. It is the language of ordinary communication. It is logical, linear, and clearly purposeful. In adult life, the two main forms of language are found in pure form only in rare circumstances. Inner speech is the basis of some forms of poetry. The linear form of language, lacking symbolic qualities, is found in legal and political documents.

When an inner life is discovered at the ages of four to six, these two language forms become coordinated and mingled. Most conversations now consist of social speech in which is embedded the elements of the other, inner, speech. Increasing amounts of this latter language are associated with intimacy, and also with that form of dual consciousness we are calling self. Conversely, inner speech is lacking in those whose development has been disrupted. Their language is linear, seeming to reflect a "stimulus entrapment" (7, 35) It seems as if they are neurophysiologically unable to "turn off" the effect of stimuli (36). The conversation has the form of a "chronicle."

This kind of conversation, which consists of a catalogue of internal events as they have impacted upon the subject, is characteristic of those deprived of that form of relatedness that underpins the experience of self. In this state of relative alienation, they are forced to orient towards the world rather than towards those experiences that might become the basis of inner life.

TRAUMA: THE SECOND THERAPEUTIC FOCUS

The experience of self as it appears in the therapeutic conversation is, from time to time, overthrown by another form of consciousness that is more

limited, adualistic and of traumatic origin. This repetitive irruption blocks further development in the sphere of self. A second therapeutic aim is to identify these intrusions of traumatic memory in order to integrate them into the ordinary ongoing dualistic consciousness.

It is important to note that integration of this kind is only possible if the process of self is established. This, therefore, must be the primary aim of therapy. It will depend to a large extent on the therapist's imaginative and sensitive capacity to make, in a fluid and natural way, empathic representations of the patient's nebulous, half glimpsed, but emergent inner states (37).

The traumatic impacts upon the self system, inflicted in the past, may affect any one or several of the various features of self, e.g., the senses of agency, ownership or boundedness. However, perhaps the most important impact is upon the central *feeling* of self, that positive tone that William James likened to "warmth and intimacy." This feeling gives "value," providing for the individual his or her sense of personal worth (7, 38). Damage to this central core through what might be called "attacks upon value" are among the more debilitating of cumulative traumata. They take various forms, including shaming, ridiculing, and simple invalidation. However, "attacks upon value" go beyond emotional abuse, extending to apparently benign remarks, such as the repeated injunction to "be careful", sometimes creating for the individual the unpleasant feeling of loss of personal agency.

Traumatic memory is a form of psychic life different from dualistic consciousness (39). It is anxiety ridden, and is underpinned by an alienated form of relationship. It is recorded in a memory system somewhere down the hierarchy of memory (see Table V). This is explained in the following way.

Hughlings Jackson, who influenced both Pierre Janet and Sigmund Freud, considered an assault on the brain-mind system to cause a retreat down a hierarchy of function decreed by evolutionary history. Those functions that evolved last and develop latest in an individual's life, are the first to be lost. Seen in this way, those forms of memory that involve reflective awareness are the most fragile and the most easily lost (39, 40).

Most typically, traumatic memories are stored in the semantic system (41). They are beyond reflective awareness and, in this sense, are unconscious. When triggered, they are not known to be memories. Since the memory system that retrieves the original episodes of their occurrence cannot be accessed, what is remembered concerns the facts (the "cognitions," some might say) of the original trauma e.g. that one is hopeless,

Table V. HIERARCHY OF MEMORY*

Memory Type	Age of Appearance	Degrees of Reflectiveness	Declarative vs Non-declarative
Remote episodic or autobiographical	4 years	Reflective (autonoetic)	Declarative
Recent episodic	2–3 years	?	Declarative
Generic episodic (episodes)	2–3 years		Declarative
Semantic (facts)	Last part of first year	Non-reflective (noetic)	Declarative (in 2nd year)
Procedural (movements)	Early	Non-reflective (anoetic)	Non-declarative
Perceptual representation (sensations)	Birth		

*This table adapted from Meares (40).

weak, ugly and so forth in the presence of someone critical, controlling, and so forth. This experience is located in the present, so that the attributes of the original traumatizer and traumatised are given to those in the present. This is the experiential zone of "transference." It leads to a repetitive and limited kind of conversation that has the form of a "script" (29).

The intrusion of the unconscious traumatic memory system into the therapeutic conversation is often shown by very slight changes. They include diminishment of self-features and a relative loss of inner speech. There is frequently (i) devitalization, (ii) negative emotional tone, (iii) outer orientation, (iv) loss of reflective function and (v) linear thought form. The change in the underlying form of relatedness is reflected in grammatical structure, e.g., questions might be asked, so that a subject-object dichotomy becomes salient.

At times, the change in the form of relatedness is the most prominent element of the shift. This involves more than a sense of disconnection and subtle alienation. The "facts" of the original traumatic situation dominate and determine the form of relatedness that now appears. Since the traumatic memory system is sequestered, unassimilated into ordinary consciousness, it is as if "loose" or unstable, so that the polarity of the original traumatic relatedness may oscillate, sometimes causing the subject, rather than playing out the experience of the victim, to be inhabited by the role of the original traumatizer in a system of "reversals" (7, 42), a phenomenon first noted by Freud in 1915 (43, p. 399-400).

It is important to remember that the patient, who is now in the grip of those feelings relating to the trauma, may now begin to tell a story, which, although he or she is not aware of it, has the features of the original trauma and *also*, of what happened at the moment when the memory was triggered. The trigger may be external (e.g. something the therapist did or did not say), or internal, paradoxically an emergent feeling of liveliness or creativity (44).

The unconscious traumatic memory system creates powerful subliminal signals, building up an "expectational field" (6, 45) that draws the therapist into its net. The sensitive therapist now feels a slight coercion to behave in a particular way that, on processing the matter, leads to the realization that he or she is cast in the role of the original traumatizer and is in danger of acting out the part. This realization affords a second means of getting to know the circumstances of the original trauma. (This phenomenon has been understood in terms of projective identification (46).)

The therapist cannot tackle the "facts" of the "script" (or the distorted cognitions) while the trauma system continues to operate. His or her remarks are understood in terms of the reality of the system. What is uttered with benign intent, may be experienced as criticism or devaluation (3). To repeat, the aim is integration. The first step is towards establishing a form of relatedness that is not part of the trauma system, so that the experience can be reflected upon and, played around with. This is dependent on the therapist being able to set up, once again, a relationship in which the patient feels understood and valued.

Reflection upon the traumatic experience, and the movement from a linear form of psychic material into an associative kind, transfers the traumatic experience into something nearer the form of ordinary dualistic consciousness, so that it may "mingle" with it, rather than remaining sequestered. Pierre Janet called this process "liquidation" (47) of the trauma.

So baldly stated, "liquidation" seems a straightforward task. It is, however, complex, difficult and often slow. There are powerful impediments to change.

The first impediment is the kind of relatedness that underpins the adualistic traumatic consciousness. Rather than intimacy it is an attachment, a phylogenetically earlier form of relationship. The individual characteristically lives in states of "non-intimate attachment" (48). If the traumatic consciousness is to alter, so also must the pathological attachment to which it is linked. Fear of the loss of this attachment is a fundamental obstacle to integration.

Other impediments come from the satellite systems surrounding the unconscious traumatic memories. The satellite systems are designed to prevent the reexperiencing of the trauma. They most commonly involve "avoidance" or "accommodation" (44, 6). In the former circumstance, they determine repetitive strategies to ward off the kind of damage that was done to the feeling of self in the past. In the latter case, the individual habitually behaves, particularly under the influence of anxiety, in a way that he or she believes will maintain the attachment to the other. Such systems might determine the shaping of an entire life.

DISCUSSION

My aim has been to give an overview of the Conversational Model, highlighting the more salient features of the approach. However, the brevity of this account has deficiencies. In this summary, it will be apparent that privilege is given to feeling-tones and how they arise in particular forms of relatedness. A primary focus is upon the shifts in moods and emotion out of which "meanings" frequently come and upon which depend the valuation of personal existence. Conversations are not merely made up of words and their literal meaning. The subtleties and complexities of the conversational experience cannot be encompassed in so short a space as this article. However, clinical illustrations appear in the publications mentioned.

In this kind of account there is also a danger of creating a sense of fixity. The Conversational Model is not a closed but an open theory, evolving on the basis of new data generated in such fields as neurophysiology, child development, linguistics, memory research, trauma studies, and, most importantly, accounts of personal experience, coming not only from the clinical setting but also from expressions found in art, literature and philosophy.

Although the model is emergent, the core therapeutic foci remain constant. They concern (i) the potentiation of that experience James called self and (ii) the integration into this experience of disruptive traumatic memory. These two foci allow the theory to accommodate, and reconcile, some of the main ideas put forward by other schools that sometimes seem disparate or opposed.

The therapeutic aim is to transform those conversations into that we enter during our early encounters with our patient. They characteristically have the form of "chronicles" or "scripts" and are conducted in an atmosphere, however subtle, of alienation. The transformational objective is towards another kind of conversation in which the elements of selfhood

begin to appear and which reflects a new form of relatedness that Hobson called "aloneness-togetherness."

The success or failure of each therapeutic contribution to the conversation necessary to this form of relatedness is judged not by its theoretical "correctness" but by "what happens next" (49). The fluctuations in the evolution of "aloneness-togetherness," in that "connectedness" is central, are reflected in changes in the totality of experience of self, including its bodily feeling (50) and sense of spatiality (51).

Responses of the other that "match," or "resonate" with, the subject's immediate reality promote an experience of personal being that feels solid and substantial (52, 6, 7). It is accompanied by an amplified and more vital form of consciousness (53).

This primary aim implies that it is the relationship that is transformational. What is most important is that the conversation, which both manifests and constitutes the relationship also manifests and constitutes a particular kind of consciousness. Seen in this way, the fine details of conversational structure are crucial. The new direction implied by the Conversational Model is that focus upon the *form* of the therapeutic conversation is as important as its *content.*

Finally, the idea that the syntactical structuring, together with the other major elements of language, lexicon and phonology, allows us to chart the waxings and wanings of the experience of personal being during the therapeutic conversation introduces a new dimension into the developing science of psychotherapy. Since words, or rather, the way words are used, can be made the markers of self, we are able to study the process of therapeutic change in a way that approaches the quantitative methods of orthodox science and that is beyond the subjectivity of rating scales and similar devices. The idea allows us to test the hypotheses of therapeutic action, to some extent fulfilling Hobson's ambition to find "a testable model of psychotherapy."

REFERENCES

1. Hobson, R. F. (1985). *Forms of Feeling: The Heart of Psychotherapy.* London: Tavistock.
2. Hobson, R. F. (1971). Imagination & Amplification in Psychotherapy. *Journal of Analytical Psychology, 16,* 79–105.
3. Meares, R., & Hobson, R. F. (1977). The persecutory therapist. *British Journal of Medical Psychology, 50,* 349–359.
4. Meares, R. (1977). *The Pursuit of Intimacy: An Approach to Psychotherapy.* Melbourne: Nelson.
5. Meares, R. (1976). The Secret. *Psychiatry, 39,* 258–265.
6. Meares, R. (2000). *Intimacy and Alienation: Memory, Trauma and Personal Being.* London: Routledge. Paperback, 2001.

7. Meares, R. (1993). *The Metaphor of Play: Disruption and Restoration in the Borderline Experience.* Northvale, NJ: Jason Aronson. Revised edition, London: Routledge, 2004.
8. Meares, R. (1973). Two kinds of groups. *British Journal of Medical Psychology, 46,* 373–379.
9. Meares, R. (1986). On the ownership of thought. *Psychiatry, 49,* 80–91.
10. Shapiro, D. A., & Firth, J. A. (1985). *Exploratory therapy manual for the Sheffield psychotherapy project.* (Memo 733) Psychological Therapies Research Centre, University of Leeds, England.
11. Shapiro, D. A., & Startup, M. J. (1990). *Raters manual for the Sheffield psychotherapy rating scale. (Memo 1154) University of Sheffield, Sheffield: MRC/ESRC Social and Applied Psychology Unit.*
12. Shapiro, D. A., & Firth, J. A. (1987). Prescriptive V. exploratory psychotherapy: Outcomes of the Sheffield psychotherapy project. *British Journal of Psychiatry, 151,* 790–799.
13. Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral therapy and psychodynamic-interpersonal psychotherapy. *Journal of Consulting Clinical Psychology, 62,* 522–528.
14. Shapiro, D. A., Rees, A., & Barkham, M. (1995). Effects of treatment duration and severity of depression on the maintenance of gains following cognitive-behavioral therapy and psychodynamic-interpersonal psychotherapy. *Journal of Consulting Clinical Psychology, 63,* 378–387.
15. Guthrie, E., Creed, F., Dawson, D., & Tomenson, B. (1991). A controlled trial of psychological treatment for the irritable bowel syndrome. *Gastroenterology, 100,* 450–457.
16. Guthrie, E., Moorey, J., Margison, F., Barker, H., Palmer, S., McGrath, G., Tomenson, B., & Creed, F. (1999). Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. *Archives of General Psychiatry, 56,* 519–526.
17. Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Marino-Francis, F., et al. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. *British Medical Journal, 323,* 1–5.
18. Stevenson, J., & Meares, R. A. (1992). An outcome study of psychotherapy for patients with Borderline Personality Disorder. *American Journal of Psychiatry, 149,* 358–362.
19. Meares, R., Stevenson, J., & Comerford, A. (1999). Psychotherapy with borderline patients: 1. A comparison between treated and untreated cohorts. *Australian and New Zealand Journal of Psychiatry, 33,* 467–472.
20. Stevenson, J., & Meares, R. A. (1999). Psychotherapy with borderline patients, Part II: A preliminary cost-benefit analysis. *Australian and New Zealand Journal of Psychiatry, 33*(3), 473–477.
21. Hall, J., Caleo, S., Stevenson, J., & Meares, R. (2001). An economic analysis of psychotherapy for Borderline Personality Disorder patients. *The Journal of Mental Health Policy Economics, 4,* 3–8.
22. James, W. (1890). *Principles of Psychology.* New York: Holt.
23. Meares, R. (1994). A pathology of privacy: Towards a new theoretical approach to obsessive-compulsive disorder. *Contemporary Psychoanalysis, 30*(1), 83–100.
24. Meares, R. (2001). A specific developmental deficit in Obsessive-Compulsive Disorder: The example of the wolf man. *Psychoanalytic Inquiry, 21*(2), 289–319.
25. Hobson, R. F. (1974). Loneliness. *Journal of Analytical Psychology, 19,* 71–89.
26. Kohut H. (1984). *How Does Analysis Cure?* A. Goldberg, (Ed.). Chicago: University of Chicago Press.
27. Flavell, J., Green, F., & Flavell, E. (1993). Children's understanding of the stream of consciousness. *Child Development, 64,* 387–396.
28. Meares, R., & Orlay, W. (1988). On self boundary: A study of the development of the concept of secrecy. *British Journal of Medical Psychology, 1,* 305–316.
29. Meares, R. (1998). The self in conversation: on narratives, chronicles and scripts. *Psychoanalytic Dialogues, 8*(6), 875–891.
30. Piaget, J. (1926). *Language & Thought of the Child.* London: Routledge & Kegan Paul.
31. Piaget, J. (1929). *The Child's Conception of the World.* London: Routledge & Kegan Paul.
32. Winnicott, D. W. (1971). *Playing and Reality.* London: Tavistock.
33. Vygotsky, L. S. (1962). *Thought and Language.* E. Hanfmann & G. Vakar, Ed. and Trans. Cambridge, MA: MIT Press.
34. Meares, R. (1990). The Fragile Spielraum: An Approach to Transmuting Internalization. In A

Goldberg (Ed.). *The Realities of Transference: Progress in Self Psychology 6.* Hillsdale, NJ: Analytic Press.
35. Meares, R. (1997). Stimulus entrapment: on a common basis of somatization. *Psychoanalytic Inquiry, 17*(2), 223–234.
36. Horvath, T., Friedman, J., & Meares, R. (1980). Attention in Hysteria: A Study of Janet's hypothesis by means of habituation and arousal measures. *American Journal of Psychiatry, 137,* 217–220.
37. Meares, R. (1983). Keats and the "impersonal" therapist: A note on empathy and the therapeutic screen. *Psychiatry, 46,* 73–82.
38. Meares, R. (1999). Value, Trauma, and Personal Reality. *Bulletin of the Menninger Clinic, 63*(4), 443–458.
39. Meares, R. (1999). Hughlings Jackson's contribution to an understanding of dissociation. *American Journal of Psychiatry, 156*(12), 1850–1855.
40. Meares, R. (1999). The Adualistic Representation of Trauma: On Malignant Internalization. *American Journal of Psychotherapy, 53*(3), 392–402.
41. Meares, R. (1995). Episodic memory, trauma, and the narrative of self. *Contemporary Psychoanalysis, 31*(4), 541–555.
42. Meares, R. (1993). Reversals: On Certain Pathologies of Identification. In A. Goldberg (Ed.). *Progress in Self Psychology,* pp. 231–246. Vol. 9, Hillsdale, NJ: Analytic Press.
43. Laplanche, J., & Pontalis, J. B. (1973). *The language of Psychoanalysis.* (D. Nicholson-Smith Trans.). New York: Norton.
44. Brandchaft, B. (1993). "To free the spirit from its cell." In A. Goldberg (Ed.), *Progress in Self Psychology,* pp. 209–230. Vol. 9, Hillsdale, NJ: Analytic Press.
45. Meares, R. (2000). Priming and Projective Identification. *Bulletin of the Menninger Clinic, 64*(1), 76–90.
46. Ogden, T. (1982). *Projective identification & psychotherapeutic technique.* Northvale, NJ: Jason Aronson.
47. Janet, P. (1925). Treatment by mental liquidation. *Psychological Healing: Vol. 1* E. & C. Paul. Trans. London: Allen & Unwin, pp. 589–698.
48. Meares, R., & Anderson, J. (1993). Intimate space: On the developmental significance of exchange. *Contemporary Psychoanalysis, 29,* 595–612.
49. Meares, R. (2001). What happens next? A developmental model of therapeutic spontaneity: commentary on paper by Philip A Ringstrom. *Psychoanalytic Dialogues, 11,* 755–769.
50. Meares, R. (1980). Body Feeling in human relations: The possible examples of Brancusi & Giacometti. *Psychiatry, 43,* 160–167.
51. Meares, R. (1984). Inner Space: Its constriction in Anxiety States & Narcissistic Personality. *Psychiatry, 47,* 162–171.
52. Meares, R., & Grose, D. (1978). On depersonalisation in adolescence: a consideration from the viewpoints of habituation and "identity." *British Journal of Medical Psychology, 51,* 335–342.
53. Meares, R. (2002). Amplification & Forms of Relatedness. In R. Meares (Ed.). *The Self in Conversation.* pp. 222–237. Sydney: ANZAP Books.