A Conversational Model of art therapy

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This paper illustrates a ‘Conversational Model’ of art therapy. The Conversational Model was jointly created by Robert Hobson and Russell Meares. It is a developmental theory unique in its clinical application. The focus of the paper is two sessions that altered the course of therapy. In these sessions, variations on Donald Winnicott’s “squiggle-game” and Hobson’s “party game” were used to engage an isolative, reluctant incarcerated patient. The interventions illustrate the basic tenets of the Conversational Model. The theoretical process – from disruption to repair – is visually recorded in the artwork. The central argument of the paper is that interactive art therapy interventions can be effective, when used appropriately. By engaging the patient in a ‘visual’ conversation, he/she may develop an emotional vocabulary, a prerequisite for a psychotherapeutic conversation. The paper begins with a brief historical overview of the interface between art and psychoanalysis, the context out of which ‘art therapy’ – a distinct body of theory – evolved. Theory interweaves with clinical material in a narrative style.

What I say and do in therapy is aimed at promoting understanding; a ‘conversation’, a meeting between two experiencing subjects (an I and a Thou), here and now, in such a way that learning can be effective in other relationships. 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 in its ‘minute particulars’.


This paper illustrates the ‘minute particulars’ of a ‘Conversational Model’ of art therapy that was used to engage an isolative, reluctant, incarcerated patient charged with a capital offence. The playful nature of the ‘visual’ conversations triggered poignant ‘verbal’ conversations. This enabled the patient to reflect on his disturbed early

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The focus of this paper is two sessions that altered the course of therapy. The interventions illustrate the basic tenets of the Conversational Model. As therapist and patient began to engage in interactive visual games, symbols of alienation and persecution – at first predominant – faded. Rapport quickly developed, facilitating the beginnings of a self-reflective capacity. This resonated through the imagery.

To understand the journey it is important also to understand the historical context. Art therapy emerged from a synthesis of art and psychoanalysis. This drew on the vastly different creative energy of both, but its unique genius derived from working on their complementary nature. It was out of this intellectual construct that the concept of using art as a therapeutic tool – that is, art therapy – emerged.

Art and psychoanalysis: A brief overview

From the earliest days of psychoanalysis, the making of art was viewed according to the analyst’s theoretical stance. This is illustrated in the attitudes of the two giants of psychoanalysis – Sigmund Freud and Carl Jung. While the former was ambivalent, the latter was unequivocal. There is abundant literature on the connection between art and psychoanalysis, but I will limit my focus to those psychoanalytic theories of art and the artist\(^1\) directly related to the theory and practice of art therapy\(^2\) outlined in this paper.

Freud’s ambivalence is reflected in his view of the artist as ‘not far removed from neurosis’. In Freud’s view he/she is ‘oppressed by excessively powerful instinctual needs’ and ‘turns away from reality and transfers all his interest, and his libido too, to the wishful constructions of his life of phantasy, whence the path might lead to neurosis’. Freud described conflicting constitutional factors: ‘a strong capacity for sublimation and a certain degree of laxity in the repressions’. But, in the same paragraph, Freud also wrote: ‘there is, in fact, a path that leads back from phantasy to reality – the path,

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\(^1\) Due to space constraints, important historical works exploring psychoanalytic theories of art and creativity have been omitted, e.g. Ernst Kris’s (1952) Psychoanalytic explorations in art; Marion Milner’s (1957) On not being able to paint; Otto Rank’s (1932) Art and artist: Creative urge and personality development; Hanna Segal’s (1991) Dream, phantasy and art.

that is, of art’ (Freud, 1973 p. 423). The psychology of the ‘true artist’, he believed, was a convoluted journey from neurosis to ultimate fulfilment. The latter equated to ‘honour, power and the love of women’ (p. 424).

Recognizing the centrality of images in dream interpretation, Freud still did not incorporate art-making into his classical technique. This was despite the following observation, much quoted by art therapists (Dalley, 1984; Rubin, 1987):

We experience it (a dream) predominantly in visual images; feelings may be present too, and thoughts interwoven in it as well; the other senses may also experience something, but nonetheless it is predominantly a question of images. Part of the difficulty of giving an account of dreams is due to our having to translate these images into words. ‘I could draw it’, a dreamer often says to us, ‘but I don’t know how to say it’ (Freud, 1973, p. 118).

Freud’s colleague and contemporary, Carl Jung (1964, 1966, 1967), was the forerunner of art therapy. He viewed art-making as a means of expressing the sacred and mysterious – an important element in the ‘individuation’ process. Jung used art in his own self-analysis and encouraged his patients to express themselves ‘by means of brush, pencil or pen’, between sessions (1966, p. 48). Here Jung preempts the art therapy movement:

It is not a question of art at all – or rather, it should not be a question of art – but of something more and other than mere art, namely the living effect upon the patient himself (1966, p. 48).

Extending the application of Freudian theory, Anna Freud and Melanie Klein (1959) incorporated art-making into their respective psychoanalytic techniques, to overcome a lack of free association, in their work with children.

Taking this journey further, one of the pioneers of art therapy, Margaret Naumburg, regarded art as ‘symbolic speech’. A Freudian analyst, Naumburg published her findings on the therapeutic and diagnostic value of art-making in the treatment of neuroses (Naumburg, 1947) and psychoses (Naumburg, 1950). She paved the way to the central thesis of this paper – that symbolic ‘visual’ communication is for some patients less problematic than, and can facilitate the later development of, ‘verbal’ speech:

Objectified picturization acts then as an immediate symbolic communication which overcomes the difficulties inherent in verbal speech (Naumburg, 1958 p. 512).

Developing a strategy on the use of art as symbolic speech, British analyst Donald Winnicott (1971) converted a pre-existing drawing game into a ‘technique’ to engage his young patients at the start of therapy. He named it ‘the squiggle-game’, describing it as ‘a game with no rules’ (1974, p. 141). The focus is on engaging his patient, rather than the creation of a product for interpretation:

In this squiggle game I make some kind of an impulsive line-drawing and invite the child whom I am interviewing to turn it into something, and then he makes a squiggle for me to turn into something in my turn (1974, p. 19).
Winnicott expands upon the theoretical aspects of the game:

The squiggle game is simply one way of getting into contact with a child . . . An artificial link is made between the squiggle game and the psychotherapeutic consultation, and this arises out of the fact that from the drawings of the child and of the child and myself one can find one way of making the case come alive (1971, p. 5).

Robert Hobson (1985) also adapted a pre-existing game, a ‘party game’, to psychotherapy. In work that has particular relevance to this paper, Hobson used this ‘technique’ to engage a withdrawn adolescent called ‘Stephen’. Using a shared lead pencil and an old envelope, he invited the boy to play, the instructions being simply that ‘someone draws a line and then someone else goes on with the picture . . . Let’s play together and see what comes out of it’ (p. 10). He viewed the technique as ‘an invitation to explore the unknown, an adventure which calls for courage’ (p. 11).

Hobson refers to it as ‘imaginative activity’ as distinct from Jung’s ‘active imagination’. The latter, Hobson (1985) defined as ‘a kind of colloquy, or dialogue, with the personalized fantasy images . . . an inner conversation with personal ‘selves’ (p. 102), a solitary activity. In contrast, ‘imaginative activity proceeded within a relationship – a verbal and non-verbal dialogue’ (Hobson, 1985 p. 102). As exemplified by both Hobson’s ‘party game’ and Winnicott’s ‘squiggle game’, both analysts specifically utilized these techniques in their initial interviews with difficult-to-engage adolescent patients.

The Conversational Model

The Conversational 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 (Shapiro & Firth, 1985; Shapiro & Startup, 1990). PI has proved to be effective in depression (Shapiro et al., 1994; Shapiro & Firth, 1987; Shapiro, Rees, & Barkham, 1995), in certain psychosomatic disorders (Guthrie, Creed, Dawson, & Tomenson, 1991), and to be cost-effective in treating repeated users of clinic services (Guthrie et al., 1999). A brief form of PI is useful in reducing repeated episodes of self-harm (Guthrie et al., 2001). The conversational model also produces beneficial effects and is cost-effective in the treatment of personality disorders (Hall, Caleo, Stevenson, & Meara, 2001; Meara, Stevenson, & Comerford, 1999; Stevenson & Meara, 1992, 1999).

3 Marie-Louise von Franz (1964) described active imagination as ‘a certain way of meditating imaginatively, by which one may deliberately enter into contact with the unconscious and make a conscious connection with psychic phenomena’. But, unlike with ‘guided imagery’, ‘the meditator remains completely devoid of any conscious goal or program. Thus the meditation becomes the solitary experiment of a free individual, which is the reverse of a guided attempt to master the unconscious’ (pp. 206–207).
At the heart of the Conversational Model is the idea that ‘I can only find myself in and between me and my fellows in a human conversation’ (Hobson, 1985, p. 135). To an outsider this may seem like an ‘ordinary’ conversation, but it is a ‘special kind of conversation’ (p. 199) in which the therapeutic focus is on the mutual creation or discovery of a ‘language of the heart’. Hobson explains that ‘in an intimate personal conversation we are sharing a feeling language’ (p. 49, italics added).

Elaborating upon the idea of a ‘feeling’ language, Russell Meares (1998) identifies two kinds of conversation. One is connected to a particular use of words which becomes a ‘linguistic marker of self’ (p. 875). This conversation has a non-linear form – an aimless, meandering quality in which shifts and jumps occur according to associations and analogy. Importantly, it is characterized by a feeling of well-being or pleasure, a sense of ‘aliveness’ and an attitude of intimacy. Attention is focused on an inner world of personal meaning, which is connected to the world of symbolic play, the world of metaphor. Meares (1995) calls this the ‘narrative of self’ (p. 541).

In contrast, the ‘linear’ language – connected to the traumatic memory system – is characterized by anxiety, a lack of vitality, a sense of disconnectedness from self and other, and a diminished capacity to play or use metaphor. Attention is directed outward, towards the external world. Events are reported chronologically, sequentially, devoid of personal meaning (Meares, 1998).

**Developmental theory**

Meares (2000) has further developed the model, providing a theory that supports the development of a non-linear ‘feeling language’. Extrapolating from empirical studies, he proposes that soon after birth, mother and infant become involved in ‘a proto-conversation’, a ‘form of conversational play, out of which will emerge the ‘selfhood’ of her child’ (p. 15). Meares suggests that it is ‘the resonance between the ‘conversing’ partners’ which has ‘a transformational effect’ (p. 17). Developmentally, it is this initial proto-conversation within the dyadic intersubjectivity of mother and baby, that makes ‘symbolic play’ possible (Meares, 2000, p. 138).

Meares (1993) focused extensively on the establishment of a therapeutic ‘play space’ in which the sense of self can be generated, on the fragility of that play space, and on how and what may disrupt it. During symbolic play, the child transforms the objects in his environment into symbols of his own imagination – i.e. the leaf becomes a boat – whilst all the time chattering to himself in an inner-directed conversation, totally absorbed, seemingly oblivious to the presence of the care giver.

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5 There are strong parallels between Meares’ ‘play space’ and Winnicott’s ‘playground’ – a ‘potential space’ – a space where play between mother and baby starts. And later, the space between therapist and patient, in which the artwork – synonymous with Winnicott’s notion of the ‘transitional object’ – is created. However, a comparison of Winnicott’s theories with those of Hobson and Meares would be well beyond the scope of this paper.
It is through this process that the child begins to sense an ‘inner world’, a sense of selfhood. For the adult patient the process is similar. It is this symbolic play which is the precursor of the adult state of self-reflection or contemplation. But when a developmental disruption has occurred, as illustrated in the following clinical illustration, the therapist’s task is to foster the emergence of the non-linear ‘narrative of self’. Meares (2000) elaborates:

In essence, the therapist’s goal is to participate in the creation of a feeling of ‘aliveness’ in an individual whose sense of ordinary living is one of ‘deadness’ (p. 125).

This is a fitting introduction to the patient, who was in such a state of ‘deadness’ when he first entered therapy.

**Clinical illustration**

Alex was an isolative, 25-year-old incarcerated psychotic patient convicted of murder. He approached me requesting individual, rather than group, sessions. Alex made it clear he would not talk about his feelings, his past, his family or his offence, but he would draw.

Initial sessions were characterized by stilted disjunctive dialogue and long periods of silence. Note the linear quality of the image (Fig. 1), the faceless disembodied stick-figure pinned to the cross. Alex’s suffering was palpable. My attempts to explore the artwork were met with monosyllabic responses and heavy sighs.

**Disjunction and repair**

Central to the Conversational Model is the concept of disruption and repair. Meares (1993) recognized that therapy generally begins in a state of disjunction. Thus the therapist’s task is to make a connection in a manner that resonates with the patient’s inner world (Meares, 2000, p. 124).

I clearly needed to connect with Alex. Aware that I am part of what may appear to Alex as an abusive autocratic system – a prison hospital – I mused aloud about how painful our therapy sessions must feel for him. And with regret stated ‘I must seem like a torturer!’ For the first time Alex smiled and began to explain that if he didn’t attend he was afraid he might never be discharged. What a terrible bind! Aligning myself with him I said, ‘well, if you have to be here, you may as well enjoy it! How about we play some

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6 Other analysts spoke of ‘aliveness’ and ‘deadness’: Winnicott (1971) interpreted a ‘squiggle’ as a picture of ‘a coming alive ‘inside’, following a phase of deadness ‘inside’ (p. 109); regarding a lack of mirroring, Kohut (1976) wrote ‘his craving to fill an inner void, to obtain a sense of aliveness, therefore became intense’ (p. 809); and Thomas Ogden (1997) monitored his own sense of aliveness/deadness during ‘reverie’ to understand the analysand’s unconscious communications.

7 Meares and Hobson (1977) elaborate on ways a therapist can damage a patient. Certain interventions can leave the patient feeling attacked and persecuted. The therapist may evade his/her part in a two-person psychology by inferring that all the patient’s responses to the therapist are ‘transference’, denying the therapist’s responsibility for empathic failures/the countertransference.
'drawing games together?' Alex beamed. The idea that one could 'enjoy' therapy and 'play games', was new and appealing. It seemed we had finally connected and the process of repair had begun.

It was Donald Winnicott (1974) who first acknowledged the importance of 'play' in an 'adult' psychotherapeutic context, in relation to a sense of self:

> It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self (p. 63).

Squiggle with a twist

Next session I suggested we play Winnicott's (1971) 'squiggle-game'. However, when played with a range of art materials rather than a lead pencil - as in Winnicott's original version - the game took on a whole new dimension.

Choosing a pale blue crayon I made a scribble and invited Alex to 'make something out of it'. Alex drew a distressed face (Fig. 2a), and without prompting related it to recent frightening 'paranoid' thoughts - abusive 'foul-mouthed voices' in place of the usual comforting voice of his 'forgiving loving' God.

**Figure 1.** Early in therapy this faceless disembodied stick figure pinned to the cross emerged, perhaps reflecting Alex's own distress.

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Thomas Ogden (1997) and his colleague Bryce Boyer (1997) used the phrase a ‘verbal ‘squiggle game’” to describe how their own internal dialogue informs their analytic work. Ogden interprets his periods of ‘reverie’ within the session as intersubjectively co-constructed, and subsequently interprets the analysand’s material in accord with this ‘reverie’. Boyer believes that, through ‘projective identification . . . the analyst learns from the patient what the latter cannot think consciously’ (pp. 64–65). The Ogden/Boyer ‘squiggle game’ differs from Winnicott’s (1971) version, which primarily aimed to facilitate the patient’s free-associations, interpretations rarely being given.
Reflecting on the formal qualities of Alex’s artwork, I note a sense of distortion and fragmentation, with disparate parts precariously linked together. The image could well symbolize Alex’s battle to hold together a fragmented self.

On the same sheet of paper, choosing green crayon Alex made a scribble. My intention was clear, I would respond to his image. After completing my drawing (Fig. 2b), instantly recognizing that the images related to one another, Alex said, ‘she’s sad about him feeling so bad’. Undeniably, a visual conversation had begun. Judging by the image that followed, Alex experienced my pictorial response as empathic.\(^9\)

My turn to draw the scribble. Choosing blue crayon, on a new sheet of paper I drew a shape. Alex responded. Using yellow crayon he drew an oval shape, eyes and a mouth showing teeth (Fig. 3a) – at this point he’d left out the ears, nose, eyebrows and hair. ‘It’s a smiling face’, he said, before drawing a mauve coloured scribble for me to complete. With the same crayon, I completed my drawing in response to his (Fig. 3b). Delighted by his shift in mood I had ‘amplified’ his expression.

Amplification, a basic tenet within the conversational model, was originally a Jungian concept. It is beyond the scope of this paper to elaborate on this concept, but Hobson (1971) provided a detailed analysis of the genesis of Jung’s complex theory of amplification, before later reinterpreting the concept in terms of the Conversational Model:

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\(^9\) Unintentionally I drew the mouth as a pink heart – on its side – perhaps relating to my intention to respond with soothing comments.
A single work... has many facets... It cannot be translated into unequivocal discursive language; but it can be extended, expanded, or amplified (Hobson, 1985, p. 54).

Implicit within the Conversational Model is the ‘amplification’ of positive affect, based on the premise that positive affects – knocked out during repeated childhood traumas – are reactivated during the therapeutic process. Being the benchmark of a sense of self, positive affects are highly prized. Similar is the Self Psychological concept of ‘mirroring’, which relates to the patient’s need to have their archaic grandiosity reflected back through the ‘gleam in the mother’s eye’ (Kohut, 1966, p. 252). However, Hobson (1985) differentiates between the two, explaining that ‘in responding, I am amplifying, not merely reflecting’ (p. 23). For Hobson the difference resided in the added ‘inflection’ provided by the therapist.

Explaining that he wanted to make his drawing ‘more real... like yours’ Alex went back to ‘finish’ his own, using an expanded colour range – ears and nose in deep red, hair in green and eyebrows in brown. Finally, I reached over and drew half a blue rectangular border enclosing his half of the page. Using the same blue crayon, he completed the blue border, mirroring my marks. The border acted as a frame to ‘contain’ the images, whilst drawing attention to the feelings – further ‘amplifying’ them.

For the art therapist, translation from the ‘visual’ to the ‘verbal’ may or may not occur. Either way the joint focus is on the artwork in which is embedded a metaphor,
created within the dyadic intersubjectivity of therapist and patient. The artwork symbolizes the ‘triadic’ intersubjective dimension of the therapeutic relationship (Meares, 1998). Analogous is Meares’ concept of the ‘metaphoric screen’ upon which the patient projects associative thoughts - like a movie in the making - to be gazed upon by both patient and therapist. The therapist’s task is to stay within the metaphor, remarking upon the artwork/movie, rather than the patient/co-observer (Meares, 1983, p. 76).

**Hobson’s ‘party game’ reinvented**

In the following session I invited Alex to draw a picture ‘together’ – taking it in turns to draw something, or anything, using whatever colours we liked. Hobson (1985) described a variation of this technique.

Alex began, drawing a large mauve circle (Fig. 4) in the middle of the page. No words were spoken. I saw the circle as an egg. Choosing green crayon – the patients wear green tracksuits – I drew a person curled up in it, a kind of embryo. Again using mauve crayon, Alex drew both the water and a huge wave. Now, it seemed, the embryo was threatened by the wave. I drew two flesh-coloured hands coming from outside the picture, symbolic of my rescue fantasy. In response – using black crayon – Alex drew a thick crack on the egg near the hands. Next a thought flashed through me – ‘I need some grounding’ – so I drew the grass, a solid base. Alex then drew the shark – another threat, I thought, this time from below. In response, I drew a fishing rod with the hook in the shark’s mouth. Alex took the bait, drawing a man, albeit a stick-figure, smiling, holding the rod. I drew a woman beside him, sharing his delight. Finally, he drew two clouds which I associated with lowered mood. In response I drew the sun, for me a hopeful symbol. He put his crayon down, saying ‘it’s finished’.

So what did the picture mean to him? Without hesitation he said it was a picture of himself ‘being saved by God’. I note his positive interpretation, indicative of his sense of feeling valued by an idealized other. As Meares says:

The child who feels good, attaches meaning to this feeling and to this valuation, so that people who are part of him or her, share this goodness and are idealised. On the other hand, experiences which are essentially traumatic involve a negative valuation. The traumatised child senses himself or herself as bad, even though the trauma was not his or her fault. The other people who are part of the experience are also bad, persecutory, and so on (Meares, 2000 p. 68).


11 In relation to such countertransference, Stuart Perlman (1999) concluded that ‘a common dynamic for therapists involves a search to repair the deprivations and traumas of their own lives by curing patients, who are seen as representing the therapists’ needy child parts’ (p. 60). In reality, Perlman recognized, it is the patient who has to make the changes. The best we can do is to remain open, point the way, and give encouragement.
Clearly, I was being idealized here, but I chose not to interpret the transference. A ‘traditional’ transference interpretation links together a current incident in the patient’s life, the therapeutic relationship, and the patient’s developmental history (Casement, 1985). Although several analysts have warned against ‘premature’ transference interpretations (Casement, 1985; Winnicott, 1974), few have questioned their ultimate therapeutic value. Meares (2000) however, actively discourages transference interpretation:

More recent studies, which involve taped recordings, produce, in the main, opposite results. The studies, comprehensively reviewed by Henry et al. (1994), tend to show that transference interpretation correlates negatively with outcomes. One of the better known of the studies cited came from Piper et al. (1991). These and other findings cannot be ignored. Yet the management of transference phenomena . . . is central to the therapeutic process (p. 164).

Meares recommends that the therapist use the transference to monitor the patient’s subjective experience of the therapeutic dyad,12 and their own countertransference,

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12 Similar is Patrick Casement’s ‘interactional viewpoint to listening’. Casement attempts to gauge the impact of his therapeutic interventions from the patient’s responses - as distinct from the more autonomous intrapsychic material which arises-as well as the patient’s effects upon him in terms of countertransference (1985, p. 59).
rather than as a tool to promote ‘insight’ in the patient. For, by passively accepting the therapist’s ‘expert’ knowledge, the compliant patient forfeits any possible sense of agency, diminishing, rather than strengthening a sense of self (Hobson, 1985; Meares, 2000).

This serious but playful visual conversation allowed a joint yet separate exploration into the inner worlds of therapist and patient - as Hobson noted - bringing pleasure to both. Rather than a ‘collusive avoidance of anxiety’ (Hobson, 1971, p. 100), Hobson argues that such interactive therapeutic interventions exemplify the sharing of a ‘symbolical attitude’ (Hobson, 1985, p. 10). Hobson defined this important term as ‘an openness to receive what is novel, a counteraction to the more usual tendency to confirm our assumptions and presuppositions’ (p. 142). Moreover, although a purposeless\(^\text{13}\) activity in that one didn’t know where one would end up, the Hobson’s ‘party game’ seemed to serve the purpose of engaging a patient who, for one reason or other, had not been able to speak.

American art therapist Mildred Lachman-Chapin (1979, 1983, 1987) proposed a Self Psychological approach to art therapy. She devised a controversial ‘interactive technique’ which differs significantly from the Winnicottian and Hobsonian drawing games outlined in this paper. Essentially, art therapist and patient engage concurrently in separate artworks, neither looking at the other’s artwork in progress:

> When we have both finished, the patient shows me what he has done and we talk about what it means to him, what ideas it stimulates, how he feels about it. Then I tell him what responses his artwork evokes in me. Next I show the patient what I have done and ask him to respond to it. Finally, I talk about my work. (1983, p. 14).

Critics question the therapist’s motives, suggesting that it may be the therapist’s anxiety or exhibitionism which led him/her to create artwork along with the patient. It is considered unlikely that the therapist can be attentive to the patient if immersed in his/her own inner world. According to Meares, however, the effectiveness of any intervention - controversial or otherwise - can only be judged by what follows (Meares, 2001).

**The family**

Alex took another sheet and quietly began to draw (Fig. 5). A child-like picture of his family emerged. There’s Dad, his sister and himself. Mum is absent. He began to speak of his childhood dream to live with his father. Finally he began to tell his story.

\(^{13}\) Winnicott (1974) recognized the importance of ‘relaxation’ as a precursor to a sense of ‘non-purposive being’ in contrast to ‘purposive activity’. In the former state, free-association becomes possible (p. 64).
When Alex was 10 months old his parents separated. His father took Alex’s sister, who was 18 months older, back to Eastern Europe to live with her grandparents. Alex was left with his mother. He did not see his father again until he was 5 years old, and his sister until he was 10, when she returned to live with her father. At 12, Alex began using alcohol. At 15, Alex’s mother moved back to Eastern Europe, leaving no forwarding address. Alex tried, but failed, to look after himself, ending up in squats and on the streets. He began to drink heavily and abuse drugs. A short stint of living with his father ended disastrously. After an intense argument about leaving empty beer cans lying around, Alex was ‘kicked out’; his father’s last words being ‘and don’t come back’. Once more rejected and abandoned, Alex headed back to the streets, enraged.

With interest I noted that the large black ‘Dad’ stick-figure had no ears, and wondered aloud if it was something about Alex ‘not being heard’. He didn’t comment but drew on the ears in blue, the colour used to represent himself. Then, oscillating between the past and the future, memories began to flow. He recalls being quietly tearful while Dad was driving him home to Mum, wanting to stay with Dad but too afraid to ask. A huge sun fills the right hand side of the image. ‘When I’m released we’ll be together’ he says, future hopes reactivated. On the left, a house

**Figure 5.** Alex’s own drawing of a house with father, sister and himself. Mother is absent.
is drawn. Commenting ‘there’s smoke coming out the chimney’, I speculate that there’s a sense of ‘warmth’ there. He tells me how he would ‘muck around’ with Dad. I note that the house has an attic, ‘a place to put things’ says Alex. In this way the stories began to flow. The form of conversational language associated with the ‘sense of self’ had began to emerge and an attitude of intimacy was developing (Meares, 2000).

The family revisited

Some months later Alex again drew the family (Fig. 6). This time Mum is included. His (future) dog – previously identified with qualities of faithfulness, protection and playfulness – is beside him. Note the detail in this pencil drawing, particularly the ears, the smiling mouths and the hands. This is the ‘happy family’ that eluded him.

His was a deprived childhood. Mum worked long hours. No room of his own, he slept on a camp bed in the living room. A witness to violence perpetrated by various male callers left Alex feeling powerless and ashamed that he couldn’t protect his mother. Mum ‘beat’ him for such misdemeanours as finding his sandwiches in ‘the toy box’. Alex blames himself; he was ‘bad’ and deserved to be punished.

From a stylistic perspective, Alex explained that he liked the drawing in pencil because he ‘can change things . . . and make it right’. I note that it looks faint, easily ‘rubbed out’. He’s drawn himself as extremely muscular, yet he tells me how ‘skinny’ he

Figure 6. Seven months later, Alex drew the happy family that eluded him, complete with (future) dog.
was at 15. He felt depressed, couldn’t eat. He recalls saying goodbye to his mother at the airport. Overcome with grief and panic, Alex wept, but was told to stop. He felt ashamed.

In this drawing he’s sixteen, which is interesting because this is a year after his mother left. His fantasy is clear. He wished his parents had stayed together, been a ‘real’ family. He’s convinced he wouldn’t be in this predicament today, wouldn’t have been living on the streets, wouldn’t have turned to drink, drugs and crime.

At 18, a drunk, drugged, angry and violent Alex, with a friend, without provocation, beat-up and ultimately murdered a vagrant, before setting him alight. Mystified, Alex recollects his ‘co-accused’ having told him that, as he hit the man, with every blow, he shouted ‘Mum . . . Mum . . .’. Alex recalls it like a nightmare, hazy, menacing, unreal, but with intense shame. Meares’ (1993) explains such acts of violence, where the victim becomes the victimizer, in terms of his theory of ‘reversals’. During a trauma the precarious self and traumatizer are fused. At times of intense anxiety, an unassimilated traumatic state is triggered, knocking out any sense of self. With no ‘sense of self’ left, it is as though ‘the other comes to inhabit the victim’, resulting in a ‘switch’ or reversal (Meares, 2000, p. 87).

More recently, Alex didn’t draw at all. He began to speak of the ‘near disasters’ suffered in childhood, corresponding to the various scars on his head and body. The conversation crescendos when, during various sporting activities, he has been able to make a ‘come-back’, ‘winning against all odds’. Through this metaphor he was able to acknowledge how far he’s come since the start of therapy 7 months earlier, when he ‘couldn’t talk’. While pointing to the circular space above and between us I commented ‘it’s almost as if you’ve done the drawing up here today, rather than down there’ pointing to the blank paper. He smiled, realising that he’d ‘talked the whole session!’ No longer dependent upon the artwork to facilitate expression of ‘the third zone’ (Meares, 2000), the process was becoming internalized.

**Conclusion**

The Conversational Model provides a sound theoretical basis from which to understand and explore the patient’s inner world. Alex entered therapy with a disrupted sense of self, characterized by an impoverished ability to play. Trapped in a linear world, exemplified by his image of the disembodied faceless figure nailed to the cross, Alex struggled to overcome a sense of disconnectedness from himself and others. His rigid religious beliefs, although an attempt to find inner peace, further isolated him, creating an unbreachable schism between the saintly and despised aspects of himself. Through our joint participation in the modified Winnicottian and Hobsonian games, an atmosphere of connectedness developed between us, allowing symbolic play to begin.

Through the process of therapy, Alex was beginning to develop a self-reflective capacity and an emotional vocabulary; first visual, then verbally articulated.
His repertoire of responses expanded, he could now both draw and talk. The images, reviewed over the course of therapy, provided ample opportunities for further expansion, elaboration and clarification. There was a chance to note repeated themes, recognize differences and similarities, whilst appreciating over time the subtle but noticeable shifts in style, content, colour and tone.

Clearly, this approach was successful with this patient, and may be successful with others. However, such interactive interventions have been discouraged from the general practice of psychoanalytic art therapy - particularly in Britain - despite precedents set by Winnicott and Hobson. It is important that any 'technique' be used with caution, with sound clinical judgment in accord with the therapist’s training and expertise, and with each patient’s specific developmental needs in mind. Some patients are clearly able to engage both visually and verbally without such a directive approach. Some may in fact find such interventions extraneous, or worse, intrusive or childish and thus insulting. However, in this particular case, Alex may have been deprived of the opportunity for a positive therapeutic experience without the art therapy ‘conversations’. The journey undertaken suggests that, with some patients, working interactively with visual imagery may facilitate the development of a therapeutic relationship in which words can at last be spoken. This process could mean the difference between a patient becoming a member of the community, or remaining a threat to it.

References


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