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Abstract

Open Dialogue is a collaborative systemic approach to working with families in crisis. A core feature is the creation of dialogue through the elicitation of a multiplicity of voices. Using conversation analysis we studied fourteen hours of Open Dialogue sessions. We found that therapists recurrently produced utterances containing “I’m wondering”. These utterances topicalised particular issues and invited stance positions from other participants while also allowing the therapist to mitigate their deontic authority and present potentially disaligning stances. Therapists thus exercised authority in eliciting stances, but provided recipients with multiple avenues for responding. These findings illustrate that therapist authority is not necessarily antithetical to dialogue and, in well-crafted forms, may even be necessary for the creation of polyphony through the elicitation of multiple stances.

Keywords: Open Dialogue, polyphony, conversation analysis, stance, authority, power, wonder

Eliciting Stance and Mitigating Therapist Authority in Open Dialogue Meetings

Open Dialogue is a collaborative and systemic approach to working with people and their families, who are experiencing psychological crises (Gromer, 2012; Haarakangas, Seikkula, Alakare, & Aaltonen, 2007; Seikkula, 2003; Seikkula & Arnkil, 2006). Originating in Finland, it has growing interest in Scandinavia and internationally (Buus et al., 2017;

Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016; Ong et al., 2019; Razzaque & Wood, 2015; Rosen & Stoklosa, 2016). Open Dialogue is characterised by a number of principles including: immediate help; the inclusion of a person's social network and; the flexibility, continuity, and responsiveness of the therapy team. The central principle of the approach, however, is the promotion of dialogue through the elicitation of multiple perspectives (Olson, Seikkula, & Ziedonis, 2014). These multiple perspectives, also known as polyphony, include the different voices of all the people present in the therapy session (including the therapist), as well as the various thoughts, emotions and responses within each person (Seikkula, 2008). The role of the therapist in Open Dialogue - and dialogical approaches generally - is to create the conditions and opportunities for these multiple voices or perspectives to be expressed in the therapeutic conversation (Anderson & Goolishian, 1992; Olson, Seikkula, & Ziedonis, 2014; Seikkula, 2002, 2008). Therapists must balance being responsive and respectful of each person's contributions, while also managing the participation and speaking time of each family member (Haarakangas, Seikkula, Alakare, & Aaltonen, 2007; Olson, Seikkula, & Ziedonis, 2014).

Dialogical approaches also promote equality and collaboration between the therapist and the family. Therapists are advised to understand the problem from the perspective of the family, follow the lead of the family, and to base their responses on what the client and family have said (Anderson, 2002; Anderson & Goolishian, 1988; Seikkula, 2011; Seikkula & Arnkil, 2006). This creates a potential dilemma for therapists as they are advised to be collaborative and to follow the lead of the family, while also having to be directive in order to manage the session. For example, therapists may need to manage speaking times so that multiple perspectives can be heard, or to make decisions on when to transition to a reflection, or to decide what topics are important to explore in greater detail. There has been scant empirical investigation of how therapists actually manage these potential conflicts in real-life therapy sessions. One research technique that can reveal how such family conversations are actually conducted is conversation analysis (Ong, Barnes, & Buus, 2019, 2020; Schriver, Buus, & Rossen, 2019; Tseliou, 2013).

Conversation analysis (CA) is an approach to analysing verbal and non-verbal interaction as it occurs in real life situations (Goodwin & Heritage, 1990; Sidnell & Stivers, 2013; ten Have, 2007). CA focusses on the observable details of interaction to describe the conversational practices and normative expectations that people utilise and orient to when coordinating their social activities. Put another way, CA seeks to describe how people achieve various social actions through conversation and the methods they employ to achieve

them. CA has been applied to different aspects of family therapy (Ong, Barnes, & Buus, 2019, 2020; Tseliou, 2013). For the current study two features of conversation are particularly relevant: stance (Du Bois, 2007) and deontics (Stevanovic, 2018; Stevanovic & Peräkylä, 2012, 2014).

The expression of stance is a conversational, linguistic act that invokes some form of evaluation (Du Bois, 2007). Stance can take a number of possible forms, and may invoke attitudes, emotions, epistemics (knowledge) and/or deontics (power) (Stevanovic & Peräkylä, 2012; Stivers, 2008). Rather than focussing singularly on types of stance, Du Bois (2007) instead recommends describing how the stance act occurs in interaction. According to Du Bois (2007), a stance act is an interactional achievement constructed through a sequence of turns at talk. In a stance act, a speaker evaluates a particular stance object. Consequently, this same person is reciprocally positioned in relation to the stance object. Other people may also describe their stance position towards that same stance object. The relative level of agreement between these two stance positions varies along a continuum from alignment to disalignment (Du Bois, 2007). The analysis of stance therefore requires attention to interlocking sequences of talk rather than to the internal states of individuals (Kärkkäinen, 2006). An understanding of stance, on these terms, has the potential to add depth to family therapy practice and research by describing family interactions and the positions people adopt as they actually occur in conversation. For example, Everri, Fruggeri, and Molinari (2014) demonstrated how an analysis of stance can be used to understand the micro-transitions involved in the development of identities in families. Stance can therefore aid clinicians in developing empirically informed hypotheses about family therapy and describing how family members construct identities (Everri & Fruggeri, 2014). Logren, Ruusuvoori, and Laitinen (2019) have used analyses of stance to examine responses to self-disclosures in group diabetes health counselling sessions. They found that, after a self-disclosure by a group participant, other participants responded in a variety of ways. These included an aligning stance through sharing the same experience, or by disaligning through offering a contrasting perspective. Their focus on group processes meant that they excluded responses by the clinician. The clinician, however, has a unique position in relation to stance acts because of the deontic authority associated with their institutional position.

Deontic authority refers to the rights of a person to determine future actions in a particular domain (Stevanovic, 2018; Stevanovic & Peräkylä, 2012). While power can be considered as the ability to unilaterally impose consequences, authority is seen as legitimate and obeyed by the subject of authority with free will (Stevanovic & Peräkylä, 2012).

Deontics specifically refers to how power is expressed and negotiated by participants in interaction. Due to our focus on conversational interaction, we focus on deontic authority rather a broader representation of power as something external to interaction. A person with a high deontic status in a particular domain, has greater authority relative to others. Depending on the context, this authority can come from their personal history, level of expertise, or their institutional position. Deontic rights are not fixed or static but instead are regularly displayed and re-negotiated in conversation (Asmuß & Oshima, 2012). Deontic stance describes how a person presents their authority in interaction. A person may have a high deontic status but, for various interactional reasons, present a downgraded deontic stance (Stevanovic, 2013). In family therapy, therapists have the authority or deontic status, inherited through their institutional role, to direct and guide a session (Guilfoyle, 2003; Hare-Mustin, 1994). For example, Ong, Barnes, and Buus (in press) have examined how Open Dialogue therapists propose a transition to a reflecting conversation. This study found that although the therapists had a position of high deontic authority, when they proposed transitioning to a reflection they made efforts to present a downgraded deontic stance. They did this through prefacing their proposals with “I’m wondering”, asking permission to have the reflection, and by providing reasons for their proposals. The therapist’s deontic status may therefore create potential difficulties for a dialogical therapist who wishes to promote dialogue and particular forms of participation from clients and family members. Ong, Barnes, and Buus (in press) focussed on deontic authority specifically in relation to therapists’ proposals for reflections and did not examine how deontic authority interacts other therapist activities such as the elicitation of stance. Using CA, the aim of this study is to explore how therapists following an Open Dialogue approach elicit multiple stances and manage their own deontic status and stance in family sessions.

Method

Data

The data for this study come from a corpus of ten Open Dialogue sessions. A total of fourteen hours of video recordings were collected in 2018 in a child and youth mental health service in Western Sydney, New South Wales, Australia. Each session was video and audio recorded with three cameras placed in different points around the room in order to capture the verbal and non-verbal communication from each participant. Participants included 12 clinicians training in the Open Dialogue approach, and 36 community members including

clients and their personal and professional networks, such as family and support workers. Ten of the therapists had completed a 5-day training program in Open Dialogue and had at least 2-years of experience in both Open Dialogue practice and supervision. At the time of data collection, seven of these therapists were participating in advanced training in systemic practice through either a 3-year Open Dialogue therapist course, or a 2-year Open Dialogue trainer program. This training was conducted by visiting clinicians from Finland. The remaining 2 therapists had an informal orientation to Open Dialogue practice by their more experienced colleagues.

The recruitment process involved information sessions about the study run by the first author, who works in the same service as the therapist participants and has not been involved in any service provision to the participating clients and families. If therapists wished to participate then they approached the first author to provide consent. The participating therapists then approached clients and families that they worked with to provide basic information about the study. If clients and their families were interested then the first author provided them with more information about the study. If clients and families still wished to participate then they provided written consent. There was no prior selection of sessions to be recorded. Instead recorded sessions were collected based on mutual availability of the therapists, families, and the first author to set up the recording equipment. The study was approved by the Nepean Blue Mountains Local Health District Ethics Committee (reference number: HREC/17/NEPEAN/135) before data collection began. All identifying features have been changed in the presented extracts in order to maintain anonymity and confidentiality.

Analytic Process

The analytic process followed recommended procedures for CA (e.g., Pomerantz & Fehr, 2011; ten Have, 2007). This included a basic transcription of the recordings and then reviewing the recordings and transcripts together, adopting an “unmotivated looking” approach. This involved inspecting the data without prior expectations, hypotheses or assumptions for phenomena of interest (Psathas, 1995; Schegloff, 1996). During this process, we noted the recurrence of a conversational practice used overwhelmingly by therapists: the phrase “I’m wondering” and its morphological variants. Taking this conversational practice as our starting point, we sought to describe how it was utilised, and what actions and interactional functions it served (Kent & Kendrick, 2016). We identified all instances of this practice (n=119) which were then transcribed in greater detail according to CA conventions

(Hepburn & Bolden, 2017, see Appendix 1). This included all instances produced by all participants, although most were produced by therapists (n=112, 94%). We found that “I’m wondering” can occur in different positions in speaking turns, but were mainly employed at the beginning of utterances and in the course of an utterance. “I’m wondering” was utilised for different actions in these different positions. Ong, Barnes, and Buus (in press) examined how “I’m wondering” was utilised at the beginnings of turns and specifically in therapists proposals to have a reflecting conversation. In this analysis, we report on uses of “I’m wondering” that are employed not at the beginning of turns, but in the middle of turns as part of an ongoing utterance. We identified 25 examples of “I’m wondering” as part of an ongoing utterance, of these, only four examples were spoken by family members. We then analysed each of these examples with particular attention to turn-taking, sequence and sequential organisation, and recipient responses. We then compared each example for similarities between turn design and what actions each example was doing to identify common patterns (Heritage, 1988). We also looked for examples of complex and deviant cases that did not seem to fit the common patterns (Potter, 1996). Ultimately, this iterative analytic process was directed towards ensuring that analytic findings were robustly grounded in the moment-by-moment sense-making of the parties to the interaction.

Findings

Overview of Findings

The use of “I’m wondering” by therapists as part of an ongoing utterance arises in a particular location and serves a number of functions. It is preceded by a set-up that is backwards looking and acknowledges or topicalises some prior talk by the family. “I’m wondering” then introduces some new configuration for the interaction. This is through selecting a new speaker and eliciting a new stance position, and/or through introducing a new matter for development. The talk following “I’m wondering” is recipient-focused as it seeks comment on matters within the recipient’s epistemic domain. “I’m wondering” implicates the therapist’s own stance positioning, which makes them responsible and accountable for what they say next. However, it also mitigates the epistemic authority of the therapist, making the stance position they adopt defeasible. This allows the therapist to introduce a controversial idea or question, which can later be disavowed if required. Consequently, “I’m wondering” is a concession, by the therapist, to the epistemic authority of the recipient regarding the matter being raised. In addition, therapists work to design their stance-eliciting questions as open

and thus allowing for greater flexibility in the responses of the recipients. This means that, even though the therapist is exercising their deontic authority by selecting the next speaker and nominating a topic for discussion, the design of these turns affords the recipient with some responsive flexibility. As we will demonstrate, in some cases, this flexibility causes problems for turn uptake. Below, we present specific examples to illustrate these findings.

Eliciting Stance and Mitigating Deontic Authority

In Extract 1 we present an example of how the therapist topicalises a part of the family's prior talk. Using "I wonder", the therapist transitions to the stance-eliciting component while also mitigating the therapist's deontic authority to direct the recipient's response. At the beginning of this extract the family have been talking about difficulties caused by the client (C3), (Isabella) and her distress. This includes a stance position that describes the negative effect that the distress has been having on the mother (data not shown) and on everyone else having to look for things that the client has lost (lines 1-4).

Extract 1

(S4.E2, 16:12)

T1: therapist 1; Mo: mother; Fa: father; C1: child 1; C2: child 2; C3: child 3

```
1  C1      like (0.2) [go:d forbid      ] one of=
2  C2              [wasn't it one of her]
3  C1      =her:: like toys goes missing (0.2) .h (.)
4          coz we=all be looking for it
5          (0.8)
6  C2      mm'na:
7          (0.5)
8  C1      HH um: h what else [((laughs))]
9  C2              [((laughs))]
10         .hh
11 C1      [u:m      ]
12 T1     [i feel] like i'm (.) i (0.2) >haven't (.)
13         quite heard (0.3) as much from: (0.5) natalie
14         and isabella (0.3) i know you started the
15         conversation natalie by saying:=
```

16 Mo =a'ɛwa (0.2) [ha]
 17 T1 [.h] (0.7)
 18 the effec[t:]=
 19 Mo [(cl. throat)]
 20 T1 =(0.3) [an then] there's been a lotta=
 21 Mo [hh]
 22 T1 =conversation about the effect (.)
 23 -> an i wonder what (0.5) what's going on:
 24 (0.5) listening to that or
 25 (1.3)
 26 C3 >what do you think [about]<
 27 T1 [what] (0.5)
 28 wha[t's come u]p;
 29 Mo [tch .hh]
 30 (0.3)
 31 T1 an i'll [give you a] cha:n[ce °in a seco]nd=
 32 Mo [yeah:]
 33 [wa: it's:]
 34 T1 =[issa°]
 35 Mo [it's:] true but (0.3) what (0.6) you know:=
 36 C3 [mm hm]
 37 Mo =(.) that's:: h (1.2) >how=i:s (.)
 38 it's not (0.3)
 39 Fa no=
 40 Mo =ex[actly] how i can just >say oh guys i'm=
 41 T1 [mm.]
 42 Mo =going to hawaii for a week (.)
 43 um: manage like=

At line 12, therapist 1 (T1) commences a new turn about not having heard as much from Natalie and Isabella, indicating them as recipients and potential next speakers. Through the set-up, T1 then acknowledges and summarises the talk so far as being about “the effect” (of Isabella’s distress). This topicalises talk about “the effect” as the background for the following question. The beginning of the therapist’s turn thus indicates the addressee and

potential next speaker, as well as delimiting the topical space for the subsequent parts of their turn. At line 23, T1 uses “and I wonder” to transition to the stance-eliciting, recipient-focused component; the question “what’s going on listening to that or... what what’s come up”. By prefacing the question with “and I wonder” the therapist implicates their own epistemic stance, while the following question is epistemically tilted towards the recipient. This means that the therapist is both reporting on their own thoughts (or wonderings), and also eliciting the stance of the recipient.

At line 25, there is a long silence of 1.3 seconds signalling a lack of uptake by the recipients. At line 26, C3 progresses the conversation (Stivers & Robinson, 2006) with a question that possibly completes T1’s prior utterance: “what do you think about”. However, T1 doesn’t adopt C3’s proposed question design and instead selects a more open and less restrictive question to the mother of “what’s come up?”. T1 then addresses C3 directly stating that C3, referred to as “Issa”, will get the chance to speak in a second (lines 31 and 34). The therapist thus explicitly demonstrates their deontic authority to select the next speaker. So, although the therapist is directing the session through speaker, topic and question selection, “I wonder” combined with the non-specificity of the stance-eliciting question removes a certain degree of the directness associated with a more specific question. The mother responds first with an aligning stance about “the effect” with “it’s true” at line 35. She then responds to earlier comments about how she is managing as a criticism, as evidenced by a justification “that’s how it is” (line 37) and that that she can’t just to go to Hawaii and leave everyone to manage on their own (lines 40-43). The mother thus initially responds to the therapist’s topicalising of “the effect”, but then returns to an earlier part of the conversation for further comment. The therapist’s question including “i wonder” and the non-specificity of asking about “what’s come up” provides the mother with the freedom to respond to an earlier part of the conversation that was not specifically selected by the therapist. The therapist thus exerts the deontic authority to select the next speaker while mitigating their authority to dictate the content of that speaker’s turn.

Before Potential Disalignment

In Extract 2, we present an example of “I’m wondering” when the therapist is about to introduce a potentially disaligning stance position. At the beginning of the extract, the mother (Mo) is describing a previous interaction where her child’s school asked if the child (Tayla), feels she needs to stay home to care for her mother.

Extract 2

(S7.E11, 1:18:04)

T1: therapist 1; T2: therapist 2; Mo: mother; Cl: client

1 Mo =the schoo:l arksed (.) tayla:: (0.6)
2 er (0.5) couple a weeks ago (.) .h in a
3 meeting (.) .hh (0.3) if (.) tayla feels (.)
4 like (0.8) she can't go to school because
5 she needs to care for me? (0.5) .hh (0.2) an
6 um (0.2)
7 T2 hm=
8 Cl =that's not (0.4)
9 Mo no:(h):
10 Cl [it's [not]
11 T2 [that's [()]
12 Mo [w-] acs- actually [was .h]=
13 T2 [°right°]
14 Mo =(0.2) rea:lly offensive (.) to say that=
15 T2 =hm
16 Mo .h because if they know me a bit why would
17 they say that, (.) .hh (0.2) [you know]=
18 T2 [hm:]
19 Mo =(0.2) [know] us
20 T2 [hm]
21 (0.3)
22 T1 hmm.
23 T2 .h (.) ↑but look i i↑ don't kno:w i'm a
24 clearly that was offensive .h (.)
25 -> >but i'm wondering if mum's not
26 well would you wanna< sta:y by mum?
27 (0.8)
28 T2 is part of you: wants to ↑be with mum
29 because she's sad?

30 (1.5)

31 C1 ye:s: (.) b[ut]

32 T2 [a] bit

33 (1.0)

34 C1 [↑ye]a:h (0.7) >but when a< (.) [but i have=

35 Mo [e-]

36 T2 [yeah

37 C1 =to go to school

38 T2 of course

39 Mo °ha ha ha°

40 C1 huhm

41 Mo >°ha ha ha [ha ha°<]

42 T2 [heh] huh huh

43 (0.2)

44 Mo .hH (.) sorry about that [darlin]

45 T2 [°yea:]:h°=

46 Mo =huh [huh huh

47 C1 [mm

48 T2 yea::h

At line 14, Mo puts forward her stance position that the school's comments were "offensive". The therapist's response begins at line 23 by connecting with the Mo's previous talk. The therapist begins with an account: "i don't know i'm a" signalling potential disalignment with the Mo's stance. But the therapist then self-repairs their turn to add a more aligned: "clearly that was offensive". T2 appears to orient to the delicacy of the topic at this point and before presenting their next question, makes an attempt to first establish an aligned stance with the Mo. T2 continues at line 25 with, "but I'm wondering", foreshadowing an upcoming contrast or transition of some kind. This contrast manifests in two ways. First, there is a change in addressee, with the therapist inviting a stance position from the client. Second, the therapist presents the question "if mum's not well would you wanna stay by mum?", which contrasts with their previously established, although modulated, alignment. That is, the therapist introduces a question that is disaligning and potentially "offensive" to the mother, and risky for the therapeutic relationship. It also places the C1 in a difficult position because if she agrees then she is contradicting her mother's prior stance. "I'm

wondering” implicates the therapist’s ownership of the stance position conveyed via the question. However, “I’m wondering” also makes the stance defeasible and something that the therapist can disavow or distance themselves from as necessary. The disaligning nature of the question is evidenced at line 27, where there is silence and no uptake from C1. T2 redesigns the question to ask if a “part” of C1 wants to be with Mum. This question is more acceptable in that C1 can agree to a part of her wanting to be with Mum and not necessarily contradicting her mother’s prior stance. This redesigned question is again met with little uptake with a long silence at line 30, then a drawn out “ye:s:”. T2 responds by further underscoring that C1’s agreement is only partial with “a bit”. C1 then qualifies her agreement with an explanation that she still needs to attend school. C1 thus works to align with both T2 (by agreeing that she would like to stay home with her Mum), while also aligning with her mother, that she still needs to go to school. Mo responds with laughing (line 41) and an apology to the client for her feeling like she needs to stay home with the mother (line 44). The mother then goes on to talk about how she feels that she needs a carer at the moment (data not shown). The therapist’s introduction and elicitation of a disaligning stance results in the mother having a new appreciation of how her own mental health problems are affecting her daughter.

In this example the therapist works to first build some form of alignment with the mother before introducing a disaligning and potentially problematic stance position. Using “I’m wondering”, and some reframing of the stance-eliciting question, the therapist introduces and elicits a contrasting and disaligning stance position from a different speaker. Despite the sensitivity of the topic these disaligning stances are produced with no apparent offense displayed by the original speaker, who actually develops a new appreciation for how her daughter is feeling.

Problems With Turn Uptake

Extract 3 presents an example of “I’m wondering” occurring with the introduction of a disaligning stance position that results in problems of alignment with the recipient. Just prior to the beginning of Extract 3, the family have been asked if the conversation so far has made anything clearer for them.

Extract 3

(S11.E9, 1:24:34)

T1: therapist 1; Mo: mother; C1: child 1

1 C1 .h (.) it's hard because
 2 lamanda hasn't sa(h)id [anythi(h)ng]£
 3 Mo [°huhuhuh°]
 4 C1 °huh°
 5 (0.3)
 6 C1 .hh (0.2) huh huh
 7 Mo but-
 8 (0.2)
 9 C1 [.h]
 10 T1 [i] guess i'm: (0.4) #°kinda° curious about
 11 (0.7) °.h° (0.7) °hhh° (0.7) mtk .hh (0.7)
 12 coz two people can co:me to a session:
 13 (0.6) waiting for the other °person:° (0.7)
 14 ta- (0.6) do something °different°
 15 -> (0.9) >but i guess i'm wondering: (.)
 16 .h (0.4) if y- (.) you've under (.) if (.)
 17 where:: your thinking is (.) in terms of
 18 (1.2) you:r (0.4) part in your relationship
 19 with your °sister°
 20 (0.5)
 21 C1 mtk whaddayu mea:n
 22 (0.7)
 23 T1 so: (.) ah- (1.1) °°uh°° (.) i i se- i really
 24 hea:r you want (0.5) you would love for
 25 amanda to be different? (0.6) i don't know
 26 if she ca:n (.) wi:ll is ready: (0.4) .h
 27 -> (0.7) so: (.) i guess i'm curious about
 28 (2.0) have you f:- (0.2) thought of (.)
 29 >er'er ha'have you got any thoughts about
 30 (2.3) you: (0.3) as (.) part of this sister:
 31 (0.3) °relationship.°
 32 (1.5)
 33 C1 well i feel like (0.8) .hh (0.3) >i dunno

34 it's-< (0.2) <it's so: ha:rd> when i don't
35 know her- (.) what amanda's feeling

At lines 1-2, child 1 (C1) adopts the stance that it has been hard because her sister Amanda has not said anything. The therapist's turn starting at line 10 does not vocally receipt C1's assessment, suggesting some disalignment with C1's stance. T1 begins the turn with "i guess i'm: (0.4) #°kinda° curious about", and then allows a series of silences to develop, interspersed with audible breaths. T1 then changes tack, altering the grammatical shape of the turn, and re-beginning with "coz" (i.e., because). This commences the set-up component, with the "two people" who "come to a session ... waiting for the other person ... to do something different". The therapist disaligns with C1's stance, that her sister not saying anything has been problematic, and instead focuses on them both expecting the other to change. T1 seems to orient to this disalignment and designs their turn as a parable that refers to C1 and her sister in the third person and thus, to some extent, lessens the focus on them personally. At line 15, the therapist pauses with 0.9 seconds of silence and transitions to a contrasting question beginning "but i guess i'm wondering:". This signals a change of sorts, through "but", and a mitigation of the therapist's stance with "i guess i'm wondering". This recipient-focused section, however, does not go smoothly, with T1 repeatedly repairing their emerging talk. T1's repairs centre around the word "if" which projects a question with a yes or no answer (line 16), and settles on a question containing "where your thinking is" that projects a more open range of responses. T1 seems to again orient to the delicacy of their question and the implied disaligning stance and works to present their question in a carefully worded way. C1's reply involves a pause and the repair initiator "whaddayu mean" that marks some trouble with the therapist's turn (line 21). This may be due to the therapist's disaligning stance and possible rebuke, or due to the ambiguity of the therapist's question. T1's response effectively repeats their prior turn but in a more direct fashion. T1 first orients to problems in alignment by acknowledging C1's stance (lines 23-25). T1 then makes a more explicit stance statement that they don't know if Amanda can, is willing, or ready to change (lines 25-26). The second part of T1's turn again contains a number of silences and repairs as they work to design their turn in a particular way. T1 first marks the transition to the question part of their turn with "i guess i'm curious about". This is followed by a long silence of 2 seconds at line 28. T1 then establishes their desired area of C1's response, particularly her thoughts. This is again followed by another long silence of 2.3 seconds at line 30, before T1 establishes what they want C1 to comment upon, i.e., C1 as part of her sister relationship

(line 30). The complexity and ambiguity of T1's question from lines 28-31 allows for a range of possible responses from C1. There is again some difficulty in C1's response beginning with a long silence at line 32 and a slow uptake at line 33 with "well i feel like... i dunno". C1 then returns to her original stance position about the difficulties that arise when she doesn't know what her sister is thinking. T1 and C1 both seem to maintain their disaligning stance positions.

Similar to Extract 1 the therapist exercises their deontic authority to select the next speaker. However, the therapist also mitigates their authority to determine the content of the recipient's answer. This occurs through multiple efforts to design their turn in particular way, orienting to the delicacy of the topic, and to place fewer restrictions on the possible responses by the recipient. This example also demonstrates that this form of stance elicitation does not always progress smoothly. The therapist introduces a disaligning stance position that combined with an open form of question results in difficulties with uptake from the recipient. The therapist consequently has to adjust their turn in response to the evolving talk with the family.

To further support our analysis we present a deviant case. This involves identifying an example where the practice under investigation, "I'm wondering" as part of an ongoing utterance, is present in an interactional moment that does not appear to fit the proposed normative expectations for its use. By examining how participants deal with these departures from the expected use, we can provide a complementary source of evidence for its typical functions. In Extract 4, the therapist's use of "I wonder" occurs in a similar sequential position but with a different type of action, and thus receives a different response to the prior examples.

Extract 4
(S11.E14, 1:39:00)

T1: therapist 1; T2: therapist 2; C1: child 1; C2: child 2

1	T2	it's kinda like a <u>wa:ve</u> isn't ↓it
2	C1	mm hm
3		(0.5)
4	C1	literally
5		(0.2)
6	C1	[mm hm]

7 T2 [.hhh] (0.3) an:d um (0.6) you know (0.4)
8 >g- ge-it gets up there it gets a bit<
9 hea:te:d and then you come dow::n and then
10 (0.2) there's=a (0.7) you know you ya
11 connected and a bit of laughi::ng an:d .hh
12 (.) an then it kinda goes up again:
13 (0.2) particularly around .hh (.) those
14 triggers arou:nd (.) my house your [house]
15 C1 [mm hm]
16 C2 huh::
17 T2 you know:: (.) um (1.0)
18 mtk (.) an:d (0.3) uh (.)
19 -> but yeah i just wonder about
20 that (.) r- riding the wa:ve (0.2) when
21 you're together
22 (0.2)
23 T1 mm
24 C1 mtk the (0.2) literally that's what our
25 relationship is like (.) .h like a wave

In Extract 4, the therapist takes a stance position in the form of an image for the clients' relationship at line 1, i.e., that it is like a wave. This turn ends with a tag-question seeking the agreement of C1, which is quickly forthcoming with "mm hm" at line 2. This is followed by a pause before further confirmation by C1 with "literally" at line 4, and, after a silence, another "mm hm" at line 6. Despite this agreement, the therapist expands on the wave metaphor, by providing an explanation for how it fits the clients' relationship (lines 7-14). This may be because the interpretation of the image hadn't been explicitly voiced and/or that there was no uptake from the other family members. The therapist's description is followed by agreement from C1 in overlap (line 15), and a laugh by C2 (line 16). T2 continues their turn at line 17 with a number of silences and restarts before ending their turn with "but yeah... i just wonder about that... riding that wave when you're together". C1 responds soon afterwards, restating her previous agreement that "literally" that is what the relationship with her sister is like.

This example differs from those above as the therapist and C1 have already established an alignment of stance over the wave image before the therapist's utterance containing "I'm wondering". The first part of the therapist's turn also includes a description and explanation of the therapist's own wave image rather than parts of the family's prior talk as in the previous examples. Furthermore, the second part of the therapist's turn does not implicate an alternative stance position, it does not select a different speaker for an alternative stance position, nor does it end with an interrogatively formatted component. Consequently, C1 does not put forward a novel stance. This deviant case thus illustrates that the therapist can utilise a similar turn structure incorporating a backwards looking set-up, an "I'm wondering" transition, and a recipient focused ending. But, in this example, the therapist does not use "I'm wondering" to introduce or elicit a new stance position, as it has already been previously accepted. This results in a confirmation of the therapist's presented stance rather than other alternative stance positions.

Discussion

The therapist's use of "I'm wondering" within an ongoing utterance functions to implicate the therapist's own stance position while also making it defeasible and deferential to the epistemic authority of the recipient. It is also used to transition to some new matter within the recipient's domain of knowledge or responsibility. This new material includes topic variation or selecting a new speaker and effectively elicits further stance positions from the recipient. "I'm wondering" and the design of the question component of the therapist's turn allows for a range of possible responses from the recipient. The therapist thus exerts some control over the speaker and topic selection while mitigating their deontic authority on how a recipient may respond.

In general conversational terms, dialogue can be described as how prior talk is incorporated and selectively reproduced by a following speaker (Du Bois, 2014). Dialogical conversations are characterised by a parallelism between utterances. This can include repeating certain words or phrases or using a similar sentence structure. Stance acts can therefore be considered dialogic in the sense that they derive from and engage with previous turns at talk (Du Bois, 2007, 2014). As mentioned previously, a stance act involves multiple stance takers voicing their stance position towards a common stance object (Du Bois, 2007). In the Open Dialogue interactions explored in the present study, the therapist acted as an intermediary or an elicitor of stance. The therapist does this by thematising a particular prior

stance utterance for development, and selecting a recipient, who then becomes accountable for responding to that stance. However, this requires the therapist to exercise their deontic authority in order to manage the participation of speakers, and to determine the topical focus of their responses. If these findings are interpreted through the theoretical lens of Open Dialogue principles, then these findings could be seen as one way that the dialogical concept of polyphony may be actualised i.e., through the therapist eliciting and rendering stances, and asking other members of the meeting to comment on those stances. If so, then some form of structure or direction is necessary in order for polyphony and dialogue to emerge.

Dialogue requires the participation of multiple speakers across sequences of turns-at-talk, and can thus be considered as an act of distributed agency (Enfield, 2013, 2017). Agency, the ability to create action, is made up of a number of elements including controlling (or determining that a behaviour will occur), composing (the selection and execution of a behaviour), and the anticipation of how that behaviour will be responded to. When applied to the interactional moments explored in this study, it is clear that the therapist exerts some control over others' behaviour by selecting the speaker and the stance position for comment, while the client or family member, within these constraints, composes a responsive action. The activity of proposing, eliciting, and responding to stances occurs sequentially across a number of turns, with different speakers and in this way is an activity jointly distributed and co-constructed by therapists and families. Another aspect of agency is accountability (Enfield, 2013, 2017). This is because stance-taking involves a public expression and, consequently, ownership and accountability for adopting a particular value position (Du Bois, 2007). Stance acts, like actions generally, make the stance-taker subject to evaluation, and potential sanction from others if their actions do not align with various expectations (Enfield, 2013). As discussed, there is a distribution of agency in the enactment of a stance act shared by the therapist and the stance-taker. However, accountability is not equally distributed. For example, if the therapist elicits a disaligning stance from a client, it is the client who is held responsible and accountable for articulating that stance, even though it was the therapist who was responsible for instigating it. Therapists thus have the deontic authority to elicit stances from clients, however they have limited accountability for any sanction that may result from that same stance act. Therapists seem to be implicitly aware of the possible accountability associated with their stance eliciting questions. This is reflected in their use of "I'm wondering", which makes their stance position defeasible. Open Dialogue and dialogical practices have generally under-theorised the role of power in the therapeutic relationship despite some findings that power is regularly oriented to by therapists (Guilfoyle, 2003). It

seems that the accountability associated with the elicitation of stance is something that needs to be considered in Open Dialogue.

A limitation of this study relates to the fidelity to the Open Dialogue approach. While the therapists in this study have a number of years of experience working in mental health and Open Dialogue, at the time of the study they were still undertaking advanced training in Open Dialogue. This means that they may still have been developing their skills in the approach, and may conduct their sessions differently with further training and experience. While there are some indicators about what elements signify fidelity to Open Dialogue (Olson, Seikkula, & Ziedonis, 2014), there is not currently an accepted way of defining when therapeutic forms of dialogue occur in conversations. Despite this limitation, this study does highlight a particular conversational practice that has relevance for the Open Dialogue approach and, as such, makes a potentially useful contribution to understanding how Open Dialogue may be conducted.

We wish to stress that these practices do not provide a “how-to” of Open Dialogue. In our examples of problems in turn uptake, in extracts 3 and 4, we demonstrate that these interactional forms, are not a “strategy” or “technique” that can be separated from the local interactional context. Rather, we demonstrate how these forms have been utilised but also adapted and modified through the therapists’ responsiveness to the sequential unfolding of the interaction.

This study also examined “I’m wondering” in a narrowly defined turn position (i.e., in the middle of turns). As mentioned earlier, a similar study by Ong, Barnes, and Buus (in press) examined “I’m wondering” at the beginnings of turns and specifically when therapists made proposals to transition to a reflection. While in both of these studies “I’m wondering” serves a similar function of downgrading the therapist’s deontic authority, they also demonstrate the different actions that this practice can serve. Future research could therefore explore “I’m wondering” further in similar and other turn positions in order to provide a more complete account of this practice.

Another direction of future research is how common this practice is to other approaches to psychotherapy. The use of “I’m wondering” and the downgrading of therapists’ deontic authority may not be unique to Open Dialogue but rather common to other approaches that emphasise a collaborative orientation. Future research could examine whether downgraded deontic authority is a point of difference between collaborative and more directive approaches, or whether these downgraded positions serve other functions such

as maintaining therapeutic engagement or achieving a mandate for furthering the therapist's agenda.

Writings on Open Dialogue have tended to describe the principles and elements of the approach in general conceptual terms, such as dialogue and collaboration. But how these conversations actually occur in real-life settings has received limited empirical investigation. This study demonstrates that an analysis of the micro-details in therapy conversations can provide insights into dialogical practices that cannot be recovered from the theoretical principles of Open Dialogue alone. CA thus provides a means to study dialogical and family therapy conversations in a way that is systematic and empirical. Further analysis of conversations in Open Dialogue holds potential for revealing further actions and practices utilised by therapists that are not yet described, which can offer a greater range of techniques to therapists employing Open Dialogue.

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((Insert Appendix 1 here))

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Appendix 1

Transcription Symbols

Symbol	Meaning
(2 . 1)	Silence measured in seconds
(.)	Micropause, less than 0.2 seconds
()	Unclear talk
((n o d s))	Transcriber comments, description of behaviour
[Overlap beginning
]	Overlap ending
=	Latching, no discernible pause between words or turns
>where<	Speeded up talk
sho:rt	Stretched sound, more colons mean longer stretch
sure-	Cut-off sounds
reflection.	Falling or final intonation
me,	Slightly rising intonation
us¿	Moderately rising intonation
team?	Strongly rising intonation
yeah	Emphasis
NOT	Elevated volume
°okay°	Reduced volume, double degree signs are further reduced volume
↑would	Sharp rise in pitch
↓cool	Sharp fall in pitch
.h	In-breath
h	Out-breath
huh heh	Laugh sounds
n (h) o	Laugh within a word
£	Smiley voice
#	Creaky voice
->	Signals a significant line