

**Downgrading Deontic Authority in Open Dialogue Reflection Proposals
A Conversation Analysis**

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Abstract

The Open Dialogue approach promotes collaboration with clients and families in decisions about the direction of therapy. This creates potential problems for Open Dialogue therapists who seek collaboration but also have responsibility for managing the session. Using conversation analysis, we examined 14 hours of video recordings of Open Dialogue sessions, and specifically how therapists proposed the transition to a reflecting conversation. We found that, when making proposals to reflect, therapists routinely downgrade their deontic authority (i.e., adopt a less powerful, more collaborative position). They did this through framing proposals as interrogatives, providing accounts, and by prefacing their proposals with “I’m wondering”. More heavily downgraded proposals made acceptance less salient, potentially risking transition to the reflection. These findings provide more detail on how theoretical concepts such as “collaboration” and “power” are actually displayed and negotiated in practice, and can contribute to a more nuanced understanding of what constitutes Open Dialogue.

Keywords: Open Dialogue, power, authority, reflection, conversation analysis, deontics, proposals

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Downgrading deontic authority in Open Dialogue reflection proposals: A conversation analysis

The Open Dialogue approach to working with families emerged during a period of transition in family therapy. This transition, influenced by postmodernist and feminist critiques, resulted in an increased awareness of the power attached to a therapist's institutional position, and a greater emphasis on promoting collaboration and joint decision-making (Flaskas, 2010, 2011; Hare-Mustin, 1994). Open Dialogue originated in Finland with people experiencing psychosis and has since been adapted to numerous other countries and settings (e.g., Brown & Mikes-Liu, 2015; Buus et al., 2019; Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016; Tribe, Freeman, Livingstone, Stott, & Pilling, 2019). The approach is characterised by a number of principles (Seikkula & Arnkil, 2006), which include providing immediate help by seeing the client within 24 hours of referral, including the client's social network in treatment meetings (such as family, friends, work or school colleagues, and other involved professionals), and continuity of the treating team by maintaining the same therapists for the duration of the client's contact with the service. Other principles emphasise collaboration between therapists and the family, the creation of dialogue, and the use of reflections (Olson, Seikkula, & Ziedonis, 2014). In Open Dialogue, the reflection is a conversation between the therapists about the thoughts and feelings that arise in them during the session, and is observed by the family who are present in the same room (Schriver, Buus, & Rossen, 2019). Furthermore, the usual turn-taking structure of the session is altered because the reflection occurs only between the therapists. The family members are encouraged to listen until after the reflection, when they are invited to comment on the therapists' reflections. In order to maintain the structure of the reflection, with the therapists speaking and the family listening, the therapists need to communicate to the family that they are transitioning to a reflection so that the reflection can progress as planned. The initiation of a reflection is potentially problematic because the therapist is directing the session and this conflicts with a philosophical preference for a collaborative orientation and following the lead of the client (Seikkula, 2011; Seikkula & Arnkil, 2006).

There is currently little empirical research on how collaboration in Open Dialogue conversations actually occurs. The research methodology of conversation analysis (CA) provides a way of exploring conversations empirically. CA studies talk as it actually occurs in real-life interactions and describes the conversational practices that people utilise to achieve social actions (Sidnell & Stivers, 2013; ten Have, 2007). This involves detailed

analysis of verbal and non-verbal communication with particular attention to how turns are designed (including word choice, intonation, prosody) and how conversations incrementally develop. Conversation necessarily proceeds as a series of turns at talk, meaning that someone's turn at talk occurs in response to previous talk. To understand the meaning and function of a turn, it is necessary to analyse that turn in relation to the sequence of turns surrounding it. CA has been extensively used to study everyday talk, as well as "institutional" forms of conversation including psychotherapy (e.g., Georgaca & Avdi, 2009; Peräkylä, 2012, 2019; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008). This research has described therapeutic actions as they occur in real-world sessions with a particular focus on sequences and formulations (Antaki, 2008; Peräkylä, 2019). CA's granular focus on therapist and client conduct holds substantial potential for promoting therapist self-reflection (Tseliou, 2013) and expanding our understanding of practice beyond that described in psychotherapy models and theories (Peräkylä & Vehviläinen, 2003).

The use of CA to describe family therapy interactions is a less developed, but growing area of investigation. Recent reviews demonstrate how CA has been utilised to describe how families and therapists discuss blame, accountability, impasse, advice giving, and how talk occurs in reflecting teams (Ong, Barnes, & Buus, 2019, 2020; Tseliou, 2013). For example, parents can emphasise their own good parenting and make dispositional descriptions of their children's behaviour to avoid blame themselves (Hella et al., 2015; O'Reilly, 2005a; O'Reilly & Lester, 2016; Parker & O'Reilly, 2012). Other research has focussed on how therapists work to address disengagement through acknowledgment and validation (Muntigl & Horvath, 2016; O'Reilly & Parker, 2013). Therapists also respond by selecting and focussing on parts of the clients' talk that aligned with the therapist's intended therapeutic direction (Couture & Sutherland, 2006). This allowed the therapist to progress the therapeutic conversation without directly addressing the disagreement. Other research has examined the relative rights of adults and children to speak and participate in the session (Hutchby & O'Reilly, 2010; O'Reilly, 2005b, 2008). For example, children could be interrupted by adults without sanction, while children's interruptions were more often ignored. However, when therapists interrupted parents they apologised or explicitly oriented to their interruption. CA research on family therapy has thus described how therapists and families negotiate different rights and responsibilities in the therapeutic relationship.

In CA, the authority and responsibility to decide and determine courses of action within a particular domain is referred to as *deontic authority* (Stevanovic & Peräkylä, 2012; Stevanovic & Svennevig, 2015). A distinction is made between a person's deontic status and

stance (Stevanovic & Peräkylä, 2014). Deontic *status* refers to a person's level of authority relative to other participants in a certain domain of action. This can be accounted for via their personal history, expertise or position in institutional structures. For example, the institutional position of being a "doctor" inherits a higher level of deontic status regarding diagnosis than being a "patient". Deontic *stance* refers to the level of authority that a person displays in interaction, which is accomplished via their moment-by-moment interactional conduct. Deontic stance varies along a gradient (Stevanovic, 2013b). A person may present themselves as having a heightened deontic stance, indicating entitlement to direct others' actions, or a downgraded deontic stance, indicating limited entitlement to direct others' actions. This may or may not accord with the deontic authority imbued by their deontic status. In relation to family therapy, therapists are institutionally accorded the deontic authority to direct the course of the session by their status, but they have the option to present a downgraded deontic stance in order to enact a more symmetrical distribution of deontic rights.

In workplace conversations between church staff, Stevanovic and Peräkylä (2012) described differences in turn design and how these reflected the speaker's deontic stance. For example, an *assertion* about a future plan displays and claims a higher deontic stance because it states the next course of action without requiring acceptance from the recipient. Conversely, a *proposal* seeks the acceptance of the recipient before the conversation can progress (Sacks, Schegloff, & Jefferson, 1974; Schegloff & Sacks, 1973), and consequently downgrades the speaker's deontic stance. Speakers can further mitigate the imposition to respond to a proposal by prefacing it with "I was thinking", and thereby constructing the proposal as a "thought" (Stevanovic, 2013a). Similarly, Curl and Drew (2008) identified that when making requests, speakers often orient to deontic rights. If people made requests with the form "can/could you..." this framed their request as being unproblematic and easily fulfilled by the recipient. But if the request incorporated the words "I wonder if..." the speaker displayed an orientation to their low entitlement to make that request or anticipated difficulties in their request being granted by the recipient. Grammatically, the addition of "I wonder..." transforms a statement from a request or a directive to a reporting of the speaker's own thoughts, which mitigates the imposition on the recipient to respond and downgrades the speaker's deontic authority (Craven & Potter, 2010; Pomerantz, 1980; Stevanovic, 2013a).

In a CA study of cognitive behaviour therapy, Ekberg and LeCouteur (2014, 2015) demonstrate how therapists and clients negotiate deontic rights in proposals for behavioural change. They show how therapists can first elicit a client's ideas for behavioural changes, and then modify and add their own ideas to these suggestions. This shows how therapists are

active in guiding the conversation while also collaborating and co-implicating the client's responses into suggestions for future actions. If therapists made more direct suggestions without first eliciting and co-implicating the clients' suggestions then clients could invoke reasons, and the resulting deontic authority, to reject the therapist's proposals. This highlights the dilemma faced by therapists when balancing the achievement of therapeutic goals with a collaborative perspective.

CA and the concept of deontics can therefore provide a method for accessing power as a set of practices and normative orientations employed and negotiated in conversation, rather than an abstract concept. In this study, we utilise CA to explore how therapists in Open Dialogue orient to deontic authority when proposing a transition to reflections.

Method

Data and ethics

Data were drawn from a corpus of ten video recordings, totalling fourteen hours of Open Dialogue sessions conducted in a child and adolescent mental health service in suburban New South Wales, Australia in 2018. Participants included therapists utilising the Open Dialogue approach (n=12), as well as identified clients of the service, their family, and other professionals involved in their care (n=36). Ten therapists had completed a 5-day foundation training and had a minimum of 2-years experience and supervision in Open Dialogue. Seven of these therapists were also undertaking advanced training in Open Dialogue run by clinicians from Finland, in either a 3-year therapist course, or a 2-year course to become trainers. Two therapists had informal orientation to Open Dialogue through their more experienced colleagues. Therapist participants were informed about the study by the first author (who is a colleague in the same service). Therapists then approached the first author if they wished to participate. Participating therapists then approached clients and their families if they wished to participate. With all participants it was stressed that participation was voluntary. All participants provided written, informed consent before participation in the study. The therapy sessions were video and audio recorded with three cameras positioned around the room in order to capture details of each participant's embodied (e.g., direction of gaze, hand gestures) and verbal communication. The study and recruitment procedures received ethics approval from the Nepean Blue Mountains Local Health District ethics committee (reference number: HREC/17/NEPEAN/135) before data collection commenced. Names and identifying information have been changed in the extracts below to ensure participant anonymity.

Analytic process

Video recordings for all sessions were reviewed and transcribed verbatim. Following the procedural recommendations for CA (ten Have, 2007) we began with a period of “unmotivated looking”. This involved reviewing the video recordings and transcriptions without prior expectations or hypotheses for interactional phenomena of interest (Psathas, 1995; Schegloff, 1996). During this process, we noticed the reoccurrence of a conversational practice regularly utilised by therapists: the words “I’m wondering” (and its morphological variants). We then focussed our analysis on this conversational practice (Kent & Kendrick, 2016). On closer examination, it became evident that the use of “I’m wondering” occurred in different turn positions with apparently different actions. One prominent location for “I’m wondering” was when therapists were proposing a transition to a reflection. This led us to examine proposals to commence reflections in particular.

We identified fifteen examples of reflection proposals and these were then transcribed in greater detail according to CA conventions (Hepburn & Bolden, 2017, see Table S1 in supporting information). Utilising the transcript and the original video recordings, each example was analysed with attention to conversational features including: the sequential position of the proposal through reviewing the previous turns; the addressed recipient(s) through gaze and verbal resources; the design of the proposal, particularly word choice, intonation and prosody; and the responses of the recipients of the proposals (ten Have, 2007). The analyses of the different examples were then compared to identify if there were systematic normative patterns realised via the different forms of proposals (Heritage, 1988). We also identified examples of deviant cases to support our analysis (Potter, 1996; Sidnell & Stivers, 2013). Deviant case analysis is a validation tool that identifies examples that do not initially fit with the proposed normative patterns. On closer examination, if the responses of the participants show an orientation to the contrastive behaviour that is consistent with the proposed normative reasoning, this lends further support for the analysis.

Findings

Overview of Findings

Reflection proposals were only made by the therapists conducting the session. Furthermore, eleven of the fifteen proposals were addressed to other clinicians, with four examples addressed to the family. The transition to reflections were therefore entirely therapist-initiated and predominantly therapist-negotiated activities. In addition, therapists commonly presented a downgraded deontic stance when proposing transition to a reflection

through either asking permission or by downgrading practices such as turns prefaced with “I’m wondering”. In only one example did the therapist not seek some form of assent or confirmation. We now present examples to illustrate these findings.

Downgrading Authority Through Asking and Accounts

Therapists downgraded their deontic authority through a polar (yes/no) question and providing accounts for their proposals. By asking if they can transition to a reflection the therapist downgrades their deontic stance as the transition becomes contingent upon the acceptance of the recipient. Similarly, an account is offered when a person’s behaviour departs from expectations and the speaker orients to a need to justify their actions, thus downgrading their deontic authority (Heritage, 1988; Houtkoop-Steenstra, 1990).

Extract 1

(S5, 1:13:13)

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

```
1          (2.1) ((T2 gaze to family))
2  T2 ->  mtk (1.8) + can we have another reflection,
           + ((gaze to T1))
3          (0.6) + (0.4)          + (0.7)
           + ((T1 nods)) +
4  T2 ->  + is that okay?
           + ((gaze to family))
5  Mo      sure-
6          (0.9) ((T1 and T2 turn towards each other))
7  T2      we'll try an keep it sho:rt?
8          ((T2 starts reflection))
```

In Extract 1, a client and their mother are disagreeing about seeing a sister who is not present (data not shown). After closure of this sequence and a lapse in the conversation (line 1), T2 addresses T1 with an interrogatively formatted “can we have another reflection,” (line 2). The use of “can” suggests that the speaker has high entitlement and/or anticipates minimal difficulties with acceptance of their proposal (Curl & Drew, 2008). After a nodding acceptance from T1, T2 then addresses the proposal to the family (line 4). Mo’s “sure-” (line 5) reflects her positive deontic stance and orients to T2’s proposal as seeking her deontic authority to accept (Seuren, 2018). Although the design of the therapist’s proposal suggests

minimal difficulties with acceptance, it also makes transition to the reflection contingent upon the acceptance of the recipients. Consistent with the form of the therapist's question (Stivers & Enfield, 2010), the recipients provide acceptances via nodding and a clipped "sure-" respectively. In addition, at line 7 the therapist provides an account though "we'll try an keep it short;" This further contributes to the therapist's downgraded deontic stance by presenting the reflection as being short and consequently of little imposition on the family.

Extract 2 provides a more direct demonstration of the therapist's deontic authority despite their deontic downgrades.

Extract 2

(S3, 38:35)

T1: therapist 1; Mo: mother; S: sister; R1: reflector 1

- 1 (2.3)
- 2 T1 → .hh (0.2) ↑would (1.6) [may]be this is a good=
- 3 Mo [huh]
- 4 T1 =(0.3) time: + ta tu::rn ta (.) the team?
+ ((gaze to R1))
- 5 Mo huh: huh
- 6 (0.4)
- 7 S mtk [okay]
- 8 T1 → [an:]d (0.5) see what they have to sa:y?
- 9 ((reflecting team turns chairs towards each other and begin reflection))

T1 initially starts with "↑would" (line 2), suggestive of an upcoming interrogative turn format. This is abandoned in favour of a declarative turn format with rising intonation (lines 2 and 4) "maybe this is a good (0.3) time ta tu::rn ta (.) the team?" (referring to the reflecting team). The therapist downgrades their deontic authority through beginning their turn with "maybe", and the justification that "this is a good (0.3) time:" for a reflection. The therapist also seeks acceptance for the proposal though rising intonation and eye gaze (Stivers & Rossano, 2010) towards one of the reflecting clinicians (R1, line 4). Despite these indications of a downgraded deontic stance, there is evidence the therapist maintains a high level of authority to direct the session. The design of T1's talk and other conduct from lines 2 and 4 indicates that the proposal has multiple addressees. Firstly, the wording of the turn

suggests that T1 is addressing the client and the family because the reflecting team is referred to in the third person. But during this turn, T1 also gazes towards one of the reflecting therapists (line 4). T1's proposal is addressed both to the family and the reflecting team via verbal and embodied modalities respectively. The sister orients to the expectation that the proposal requires acceptance through her "okay" (line 7). However, there is no response from R1. T1 continues to pursue a response with an extension of their turn "and (0.5) see what they have to say?" This extension is still worded as addressing the family, and while there is no verbal response from the reflecting clinicians, they show their acceptance of T1's proposal through embodied action, by turning their chairs to face each other to start the reflection (line 9). The reflecting team thus performed the proposed action by starting the reflection, but without first vocalising a commitment to performing it (Stevanovic & Peräkylä, 2012). The response of the reflecting team suggests that the therapist's turn is received not as a proposal requiring acceptance, but as a directive requiring compliance. So, despite the therapist's efforts to downgrade their authority, recipients still orient to the high deontic status that is associated with the therapist's role as the leader of the session.

Despite the high deontic status of the therapist, they refrain from a directive to transition to a reflection (Craven & Potter, 2010). Instead, therapists proposed reflections through polar interrogatives and offering accounts. These practices downgrade a therapist's deontic authority as they make acceptance of the proposal necessary before the reflection can proceed. However, the polar interrogative form of proposals suggest that the therapists view their proposals as being relatively unproblematic (Curl & Drew, 2008). So while polar interrogatives and accounts downgrade the therapist's proposal they do so in relatively minor ways and maintain a focus on the (likely unproblematic) acceptance or rejection of their proposal. Recipients provide minimal forms of acceptance either verbally or through embodied responses, thus displaying an orientation to and acceptance of the therapist's deontic authority to make the proposal. In the next section we describe examples where therapists' reflection proposals fall further along a downgraded deontic gradient.

Downgrading Authority Using "I'm wondering"

The phrase "I'm wondering" and its morphological variants were commonly utilised, having occurred in ten of the fifteen examples of reflection proposals. In the following examples we demonstrate how "I'm wondering" is used to further downgrade the speaker's deontic stance. Just prior to Extract 3 the client has been talking about his mother cleaning when she is stressed.

Extract 3

(S10.E9, 58:47)

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

1 Cl i told you to get that yea::h it'll get done
2 in a sec (0.3)
3 two minutes later mum's pickin it up
4 (0.2)
5 Mo huhuhuh ((smiles from T1 and T2))
6 (1.3)
7 Fa hehehe
8 (0.3)
9 T2 → s_o (0.5) i'm wondering if it's a good time
10 (0.3) to (.) call that pause what we
11 mentioned? (.)
12 an let (0.3) me an charlie an have a (.)
13 chat amongst us while you're listening to us;
14 Mo + yep?
+ ((nods))
15 (0.6)
((Mo, Fa and Cl nodding))
16 Mo that's ↓cool=
17 Cl =[yeah]
18 T2 =[yeah?] (0.4) okay;
19 ((Mo and Fa nod))
((intervening talk, T2 begins reflection))

At lines 1-3 the client recalls his mother picking something up after he has said he would do it. This sequence closes with laughs and silences. T2 then proposes transitioning to a reflection (lines 9-11). Beginning with “s_o (0.5) I’m wondering” the therapist marks the following talk as a report on their current thoughts (line 9). As mentioned, “I wonder” and presenting a proposal as a thought mitigates the imposition on the recipient and downgrades one’s entitlement to make that proposal (Curl & Drew, 2008; Stevanovic, 2013a). T2 also provides an account for having a reflection: “it’s a good time” (lines 9). At line 11, T2 ends

their turn with rising intonation thus seeking a response. When no response is forthcoming from the family, T2 continues their turn with an expansion specifying what the reflection will involve. T2's turn again ends with rising intonation that seeks a response from the family (line 13). An accepting response comes from all family members through nodding and a "yep" from Mo, and a later "yeah" from Cl. Mo's "that's cool" at line 16, is also a positive deontic stance orienting to the therapist's talk as a proposal and her deontic rights to accept (Seuren, 2018). After this acceptance T2 seeks further confirmation with "yeah? (0.4) okay?" at line 18, in overlap with client's acceptance followed by confirming nods from Mo and Fa. T2 presents their proposal as something that they are "wondering" about, as being in need of justification, and requiring the acceptance of the family. However, the family's minimal responses of acceptance do not provide an indication of the potential barriers foreshadowed via the therapist's turn design. It seems that the recipient orients to the deontic status of the therapist rather than their downgraded deontic stance.

In Extract 4, the therapist's downgraded authority and invitation for joint decision making is even more clearly marked.

Extract 4

(S8.E3, 31:58)

T1: therapist 1; T2: therapist 2

1		(1.8)
2	T2	((gaze and open hand to T1))
3		(1.7)
4	T2	>i thought i< (.) sa:w a (1.1) a something?
5	T1	a' <u>huh</u> =
6	T2	=huh
7	T1	there was a [something]
8	T2	[hh huh] huh huh huh
9	T1	→ i wondered if=
10	T2	=huh=
11	T1	=there was a space for (0.8) reflection.
12		(0.2) but i don't kn <u>o</u> :w (.)
13		[>where you're] at< °°°()°°°
14	T2	[↑ <u>yeah</u> :]

15 (3.7)
 ((T1, T2 nodding, wide eyes, "go ahead" hand
 gesture))

16 T2 yeah

17 (0.3)

18 T1 is that okay

19 T2 yeah

20 (.)

21 T1 °okay°

22 (3.0) ((mutual gaze T1 and T2))

At lines 2 and 4, T2 invites T1 to speak having noticed some previous preparation to speak by T1. T1 presents a deontically downgraded reflection proposal beginning with "I wondered if" (line 9). At lines 12-13, T1 provides a specific reason for the downgrade: "but I don't know (.) >where you're at<". T1 explicitly expresses the potential problem of proposing a reflection at this point as uncertainty about whether T2 is agreeable to a reflection, thus orienting to high contingency as well as low entitlement in making the proposal. This is further highlighted by T1 seeking confirmation at line 18, even after three instances of agreement by T2, including "yeah" and nodding at lines 14, 15, and 16. Through these responses, T2 provides weak and minimal acceptance of the proposal. T1 may therefore be orienting to these minimal and weak acceptances as not adequately embracing their heavily downgraded proposal. Furthermore, unlike proposals that utilise a polar interrogative, and more clearly set up the relevance of acceptance or rejection, proposals with "I'm wondering" are more ambiguous and equivocal, providing a broader range of possible responses by recipients.

Contrastive cases

In this section we provide further support for our analysis though presenting a contrastive example (Extract 5) and a deviant case analysis (Extract 6). In Extract 5, a therapist proposes a reflection to another therapist, but, instead of the usual minimal acceptance from the recipient and transition to the reflection, there is a period in which deontic rights and the proposal are explicitly negotiated.

Extract 5

(S5.E11, 55:58)

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

1 (0.4)
2 Mo but li:fe would'a been a bit easier
3 if you'd [got]
4 Cl [O:H] SHH::[::]
5 Mo [a'huh::] (.) huh (0.4)
6 censored again
7 (0.3) huh huh huh huh [.hh]
8 T1 [my god] (you're:/yeah:)
9 Mo hah heh heh=
10 T1 =interesting + (sense/censor) ()
+ ((T2 gaze to T1))----->
11 (0.2)
12 Mo ye(h)ah: (0.2) huh huh huh [huh huh]
----- + ((T2 gaze to family))
+ ((T1 gaze to T2))----- +
13 Cl [stop la]ugh+ing
14 (0.3)
15 Mo ah
16 Cl shh
17 (0.8) ((T2 gaze to T1, then returned))
18 T2 → >↑i'm=wondering if we should have< another. (0.3)
(to T1))
19 'flect↑ion: >or if we should ask< (0.3) greta
20 (1.3)
21 Cl hhuh
22 (0.2)
23 T2 °what she's thinking°
24 (0.3)
25 T1 ↑hm:. maybe gre:ta,
26 (0.9)
27 T2 → i'm not sure how we should do this should one of us
28 (0.4) talk (.) to [greta or do]=

29 T1 [>or should we all three?<]

30 T2 =both of us talk °°to greta°°

31 (0.5)

32 T2 do you have a preference? ((gaze to Mo))

33 Mo (i'm/um) (0.5) °no° (don't worry)

34 (0.5)

35 Cl huh

36 (0.5)

37 T2 → maybe we'll (0.2) [maybe] =

38 T1 → [all three?]

39 T2 =all three of [us will] (.) [just] =

40 T1 [↑o↓kay]

41 [↑yeah]

42 T2 =(0.5) ask greta what she's hea:rd;

43 T1 yea::h.

44 ((T2 starts reflection with question to Greta))

Extract 5 starts with Cl stopping Mo from speaking about Cl's difficulties getting ready in the mornings, followed by some joking and laughing. T2's proposal begins at line 18 and includes the downgrading features of "I'm wondering" and an account that they "should" have a reflection. T2 also proposes an alternative action, that is, if they should ask the third therapist, Greta, "what she's thinking" (line 23). T2's proposal thus makes relevant not acceptance but a greater degree of collaboration from the recipient who has to make a selection between two alternatives. By only providing two choices T2 constricts the number of possible responses that T1 can expectedly provide and presupposes that there will be some form of change in the session, ostensibly an upgraded deontic position (Antaki & Kent, 2015).

After T1 selects the option of speaking with Greta (line 25), T2 does not explicitly acknowledge this response and instead invites further collaboration. This turn begins with an account "I'm not sure how we should do this" before again presenting two possible options i.e., should one or both of them talk to Greta. At line 29, T1 proposes "all three" of them speak together in overlap with T2. T2 again does not respond to T1's proposal but instead finishes this turn, and then after a gap, asks the family if they have a preference (line 32). T2 thus seeks collaboration from T1 on multiple occasions but when it is forthcoming it is not

acknowledged. T2 seeks collaboration in decision making from both T1 and Mo, but this results in overlooking T1's decision.

From line 37 there is a back and forth wrestling of deontic authority between T1 and T2. T2 begins formulating a decision on how to progress the session "maybe we'll (0.2) maybe". Although downgraded with "maybe", T2 is in the process of deciding the direction for the session, thus claiming deontic rights to decide. In overlap, T1 proposes "all three?" repeating their earlier unacknowledged suggestion, consequently reclaiming some deontic authority in deciding the next part of the session. T2 then repeats "all three of us will (.) just (0.5) ask greta what she's heard;" At line 40, T1 confirms this with "↑o↓kay". With falling intonation, this works to confirm T2's acceptance of T1's earlier suggestion. This sequence thus displays a back and forth claim and counter-claim of deontic authority between T1 and T2.

This example deviates from the usual trajectory of reflection proposals where the therapist proposes a reflection with various downgrades of their deontic stance and seeking the acceptance from the recipients. The proposal is then usually followed by minimal acceptance by the recipient with transition to the reflection. But, in this example, the therapist making the proposal seeks the input of the other therapist, but then does not explicitly acknowledge the other therapist's response. The therapist thus makes a downgraded deontic proposal but their following actions are not consistent with this downgraded position. This results in competition for deontic authority between the therapists and risks destabilising the session and its methodical development.

Extract 6 is an example of a deviant case where the therapist does not follow the usual form of reflection proposal, i.e., downgrading their authority and seeking acceptance. This is met with a disaligning (i.e., unsupportive) response from a recipient, followed by the therapist amending their turn and seeking acceptance (although cursorily). Extract 6 begins with C3 protesting against her sister (Julia) previously saying that C3 does not like birds (data not shown).

Extract 6

(S4, 1:05:27)

T1: therapist 1; T2: therapist 2; C1: child 1; C2: child 2; C3: child 3

1 C3 [NO I d[on't i love birds
2 T1 [oh okay

3 C1 yeah like running [around the garden with them
 4 C3 [they're so precious to me::
 5 Mo [oh that's good [julia] okay
 6 C2 [((laughs))
 7 T1 [uh]
 8 T1 + uh (.) i'm thinking we've probably: (0.4)
 + ((gaze to C3)
 9 we're approaching the end of our time? (0.7)
 10 C3 i don't hate birds [julia]
 11 T1 → [i ju]st wanted to check with
 12 charlie if he's got (.)
 13 → other things he's (.) + [got] on his mind?
 + [((gaze to T2))
 14 T2 [mm]
 15 (0.2)
 16 C3 → NOT again
 17 T1 [or any]thing=
 18 T2 [mm]
 19 T1 → =[else that you've heard? + (.) if that's okay]
 + ((gaze to C3 then T2))
 20 C1 [shhh shh no talking]
 21 (0.2)
 22 C3 that's fine
 23 (0.6)
 24 T1 you may [not]
 25 T2 [actual]ly no no: (0.5) right now

At line 11, T1 initiates reflection by stating that they want to check with their colleague, Charlie, if he has other things on his mind. T1 then physically turns towards T2 marking the beginning of the reflection. T1's initiation of reflection departs from the previous examples as the account for the reflection is provided first, and the reflection is stated as a unilateral decision without further downgrading elements nor seeking acceptance. This reflection initiation also occurs towards the end of the session and this movement towards ending the session may explain T1's transition to a reflection without first seeking

acceptance. At line 16, C3 disaligns with the transition with a loudly spoken “NOT again”. At line 17 and 19, T1 adds an increment to their earlier turn (now addressed to T2) if there is “anything else that you’ve heard?” that he may want to add. T1 then momentarily turns back to C3 seeking agreement “if that’s okay” before returning to T2, this appears to be a delayed response to C3’s “NOT again” at line 16. C3 provides acceptance at line 22 with “that’s fine”.

This example differs markedly from the forms described above. When T2 departs from the usual form of reflection proposal it is met with a disaligning exclamation from one of the recipients. In response, T2 suspends the transition to the reflection and orients to the need to gain acceptance before the reflection can proceed. The participants thus orient to the implicit preference that the therapist first gain acceptance from clients before a reflection can proceed.

Discussion

When proposing a transition to a reflecting conversation, therapists using Open Dialogue routinely work to downgrade their deontic authority. These downgrades fall along a deontic gradient from relatively minor downgrades, utilising polar interrogatives that present the proposal as relatively unproblematic, to more heavily downgraded proposals incorporating multiple downgrading features such as the use of “I’m wondering”, providing accounts, and specifically seeking acceptance and confirmation from recipients. The polar interrogative forms make directly relevant the acceptance or rejection of the proposal by the recipient. Consequently, they maintain a focus on the progressivity (i.e., unproblematic development) of the conversation toward the reflection, while also requiring the collaborative acceptance of the recipient/s. Proposals utilising “I’m wondering” are more equivocal and do not make acceptance or rejection as strongly relevant. These proposals downgrade the therapist’s authority and invite collaboration, but also potentially obscure the action of transitioning to a reflection. As illustrated in Extract 5, this invitation to collaborate can result in the therapist repeatedly exerting their deontic authority as they seek and respond to the suggestions of other participants.

In general, recipients accepted reflection proposals quickly and without negotiation, apparently orienting to the deontic status, rather than the stance of the therapists. The persistence of therapists’ deontic downgrades may therefore serve functions other than the seeking of collaborative decision-making. Various approaches to family therapy have

emphasised therapist expertise with mechanistic perspectives on family problems and the therapist as an external agent intervening in the family system (Flaskas, 2010). However, clinicians working in Open Dialogue construct their identities through distancing themselves from the traditional roles as “experts” or “fixers” of mental health problems and promote a willingness to be vulnerable in front of clients (Schubert, Rhodes, & Buus, 2020). Writings on Open Dialogue and dialogical approaches similarly recommend that therapists take a position of “not-knowing” (Anderson & Goolishian, 1992), following the lead of the client (Seikkula, 2011), and tolerating doubt and uncertainty (Seikkula & Arnkil, 2006). Doubt, uncertainty and the pursuit of collaboration are thus central theoretical aspects of Open Dialogue. However, these concepts are ambiguous and ill-defined providing therapists with little specific guidance on how these concepts may be brought into practice. Peräkylä and Vehviläinen (2003) have described how CA’s detailed analysis of actual conversations can expand our understanding of therapeutic practice by providing more details on how ambiguous therapeutic concepts, such as collaboration, are actually achieved in practice. This study thus demonstrates one way that the general concept of “collaboration” may be manifested by therapists through conversational downgrading of their deontic authority. Further research in this area could greatly improve our understanding of what constitutes dialogical therapy and thus improve teaching and clinical practice.

A limitation of this study is that although the participating clinicians have a number of years of experience in Open Dialogue they were also undertaking advanced training at the time of data collection. Therefore, their work may reflect their attempts to incorporate new ideas and techniques into their practice and may not represent “good” Open Dialogue practice. However, there does not currently exist any accepted measures of fidelity in Open Dialogue research. Furthermore, the principles of Open Dialogue are sufficiently ambiguous to allow for a range of possible manifestations in different contexts. In fact, it has been proposed that Open Dialogue will necessarily need adapt and develop to the needs of the local contexts where it is applied (Buus et al., 2017). So rather than providing definitive directives for practice, we instead hope that this study continues a “dialogue” about what constitutes dialogical practice.

This study also empirically highlights the pervasiveness of deontics in clinical practice with therapists regularly downgrading, and thus orienting to, differences in authority. Differences in power and authority are unavoidable elements of a therapeutic relationship (Hare-Mustin, 1994; White & Epston, 1990). But the role of power in Open Dialogue has

been under-developed, with power seen as simply impeding the creation of dialogue (Guilfoyle, 2003). Our findings suggest that deontic authority and directing the course of a session are not necessarily contrary to the values of Open Dialogue, but rather something that is relevant, downgraded, and negotiated by participants to varying degrees. Enfield (2013) asserts that relationships are defined by the nature of the interactions between people and their relative enactment of rights and duties. In this view, an awareness and negotiation of authority is potentially meaningful in developing a certain forms of relationships between therapists and clients. However, further research is necessary in order to understand the complex negotiations of authority in different parts of an Open Dialogue session.

We can conclude that experienced therapists undergoing advanced training in Open Dialogue orient to deontic authority in their interactions with clients, and work to present a downgraded deontic stance that is weaker than their institutional status would implicate. However, further research systematically exploring the deontic relations across everyday conversation, Open Dialogue, and other therapeutic approaches is necessary in order to confirm if these forms of deontic downgrading are unique to Open Dialogue. Previous findings on requests and proposals in institutional and everyday contexts (Curl & Drew, 2008; Stevanovic, 2018) suggest that deontic issues are, to some extent, generically relevant for human communication, even if there is some particularisation of them in the Open Dialogue context.

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