Title: Developing multiple perspectives by eliding agreement:
A conversation analysis of Open Dialogue reflections

Version 2, 20.4.2021
Accepted and scheduled for publication in Discourse Studies 24(1), expected February 2022.

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Running head: Eliding agreement in Open Dialogue reflections

Word count: 7843

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Ben Ong is a psychologist and family therapist working in a child and youth mental health service in Australia. He became increasingly interested in the Open Dialogue approach to working with families and particularly how the concept of dialogue is produced in these meetings. This has led to work on a PhD using conversation analysis to investigate Open Dialogue interactions.

Dr Scott Barnes
Scott Barnes is a speech pathologist and conversation analyst. His research focuses on communication in the course of everyday life, with a view to exploring the interface between the organisation of interaction, language, cognition, and related impairments. Scott is especially interested in how interactional systems like turn-taking and repair organisation can provide fundamental insights into the nature of communication disability, and inform speech pathology assessment and intervention strategies. Scott is currently the Course Director for the Master of Speech and Language Pathology at Macquarie University, Sydney, Australia.

Dr Niels Buus
Niels Buus is an Open Dialogue practitioner and researcher working at Relationships Australia NSW, the University of Sydney, and the University of Southern Denmark. He is very interested in how Open Dialogue approaches fit into different contexts: including the mental health services, the social health services, and the primary and secondary education system.

Abstract

Open Dialogue is an approach to working with mental health problems that emphasises promoting dialogue between multiple perspectives within an individual person and between all the people present, including the therapists. Therapists' own perspectives are often introduced during conversations called *reflections*, which present a potential source of different perspectives. Using conversation analysis we analysed 14 hours of video-recorded Open Dialogue sessions with a focus on therapists' reflections. We noticed that therapists did not display explicit agreement with each other's reflections. This absence of explicit agreement was displayed through a variety of verbal and non-verbal forms. Eliding agreement facilitated deference to the epistemic authority of the client, assertion of epistemic rights from second position, emphasis of a positive perspective, or to voice multiple perspectives. Therapists avoided consensus and thus presented multiple perspectives to the family while also attending to issues of contingency. The implications of epistemic primacy and asymmetry connected to sequential structures in talk pose a challenge to the generation of collaborative reflective dialogues.

Keywords: psychotherapy, Open Dialogue, conversation analysis, disagreement

Developing multiple perspectives by eliding agreement:

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Collaborative approaches to psychotherapy are client-centred. This means that therapists focus on eliciting the perspectives of the client or family and position the client as an "expert" in their own lives (Anderson and Goolishian, 1992; Rogers, 1951). The therapist also has expertise, in the form of professional training and experience that is potentially helpful to the family. There can be a tension around how a therapist's expertise is introduced into the conversation without minimising or invalidating the perspectives of the family. A collaborative approach such as Open Dialogue (Haarakangas et al., 2007; Seikkula and Arnkil, 2006) introduces the expertise of the therapist in two main ways. One way is to position the therapist as an "architect of dialogue" or a "conversational artist" whose skill lies in asking certain questions and promoting dialogue between the family members (Anderson and Goolishian, 1988: 371). Another way introduces the therapists' perspectives more explicitly through a technique known as reflections (Andersen, 1987).

In Open Dialogue reflections, the therapists pause the session with the family, and turn to each other to speak about their thoughts, images, feelings, or experiences that arose during the conversation with the family (Andersen, 1987; Olson et al., 2014; Ong et al., 2020c). The family is encouraged to listen to this conversation without speaking until the reflection is finished, at which point the family is invited to respond to the therapists' reflections (Seikkula, 2008). In reflections, therapists are encouraged to be tentative, use the words of the family, and to present their thoughts in a way that avoids offence (Andersen, 1987; Haarakangas et al., 2007). Therapists are also encouraged to avoid agreement with each other so as to present a range of different ideas (Andersen, 1987). Reflections are thus an explicit way that the therapists' perspectives are introduced into the session, and are thought to introduce further possibilities for dialogue (Seikkula and Trimble, 2005; Anderson and Goolishian, 1988). Considering the importance of reflections in Open Dialogue, it is necessary to have a more explicit and thorough understanding of how these conversations actually occur, rather than only theoretical descriptions. Studying real-world Open Dialogue sessions provides an opportunity to describe dialogical processes, and how therapists construct dialogical reflections. One way of investigating such interactions is through conversation analysis, which examines the micro-processes of interaction and how people utilise various conversational practices in order to achieve social actions (Goodwin and Heritage, 1990; Heritage, 2013).

Conversation analysis (CA) uses video and audio recordings of naturally occurring interactions to describe and analyse spoken and embodied interaction. CA has two main lines of interest, describing both the normative structural elements of conversations, and how people use these structural aspects to achieve and negotiate situated social actions. In CA, the analysis of social actions is not through reference to the internal processes of the participants but rather through the orientations displayed by the participants via their interactional conduct. CA has been used to study a wide range of interactions in different approaches to family therapy (for more detailed reviews see Ong et al., 2020b; Ong et al., 2020a; Tseliou, 2013).

One area of interest in these studies is the use reflections in family therapy which are briefly described below. Although not specifically described as such, Muntigl and Horvath (2016) analyse a brief reflection in a Structural Family Therapy session. In this example, one of the therapists voices a perspective that disagrees with the participating mother while preserving face and not addressing the mother directly. The reflection also provides the mother with the opportunity to observe and consider the therapists' talk without the

opportunity or obligation to respond. In another CA study, Williams and Auburn (2015) described how therapists in reflecting teams adopt stance positions that are orientated towards relational descriptions, and promoting hope and positive connotations. For example, a participating stepfather that was labelled by the family as strict and over-protective, was described by the reflecting team as having "love" towards his step-daughter. In Open Dialogue reflections, Schriver et al. (2019) used CA to describe two types of reflections. These included *reporting* my-side tellings, where therapists described their observations of what the family said and did, and *inferring* my-side tellings, where therapists provided their interpretations of what the family said. These studies show how therapists voiced different assertions and adopted stance positions towards the family that were generally positive and relationally-focussed. These assertions vary along a continuum from observations of what a family said or did, to more inferential or interpretive statements about the family. While these studies have focused on how the family is discussed by the reflecting therapists, they did not explore how therapists collaboratively constructed their reflections. Because reflections require therapists to make various assertions about a family, they would seem to implicate responses of agreement or disagreement from the receiving therapist. Therapists are thus tasked with presenting their ideas about the family while also negotiating and managing the normative demands of conversation and their own potentially contrastive positions in their reflections. It is not clear how therapists present different ideas in reflections nor how they manage issues of agreement and disagreement.

Past CA research suggests that there is a preference for maximising agreements and avoiding disagreements in conversation (Pomerantz and Heritage, 2013). For instance, agreements with assessments are usually provided quickly with little delay and can contain upgraded responsive stances, e.g., if a person says that it is a "beautiful" day then an upgraded second assessment from the recipient can be that the day is "gorgeous" (Pomerantz, 1984: 59). Upgraded second assessments also display a speaker's independent assessment and thus regain a degree of epistemic authority when speaking from second position (Heritage and Raymond, 2005; Enfield, 2011; Thompson et al., 2015). In contrast, disagreements are delayed until later in a turn though silences or adding a preface to the beginning of the turn (Pomerantz, 1984). Disagreements are a dispreferred response and they are produced less often in favour of responses that promote interactional progressivity and, consequently, social solidarity (Heritage, 2013; Sifianou, 2012). Because disagreements in reflections potentially risk social solidarity, their introduction requires some interactional effort.

In psychotherapy, disagreement can occur when therapists introduce alternative ways of thinking and acting that contrast with a client's perspective. As a catalyst of change, disagreements can be considered a helpful and necessary part of psychotherapy. However, disagreement needs to be responded to and resolved in some way so that the interaction can resume a therapeutic trajectory (Muntigl and Horvath, 2014). CA studies have identified that therapists can respond to client disagreements by retreating from their prior formulation to affiliate and strengthen the client's alternative position (Muntigl et al., 2013), or the therapist can maintain their position in either a convergent and supportive way or a divergent and unsupportive way implying that either the therapist's or the client's understanding was in need of correction (Weiste, 2015; Viklund et al., 2010; Muntigl et al., 2013). More recent studies have shown how therapists work to downgrade both their deontic and epistemic authority in Structural Family Therapy and Open Dialogue sessions (Ong et al., 2021; Ong et al., 2020c; Muntigl and Horvath, 2020). By downgrading their epistemic authority through phrases such as "what I hear..." (Muntigl and Horvath, 2020) or "I'm wondering..." (Ong et al., 2021), therapists defer to the epistemic authority of their clients and promote reflection and elaboration. As a whole, these studies show how therapists balance introducing new ideas

that may be beneficial to the client with having to maintain therapeutic engagement, social solidarity, and respect for the epistemic authority of the client and family. At the same time, such practices also have the effect of maintaining normative structures of sequences, promoting aligning responses from their recipients.

Reflecting conversations between therapists constitute a different interactional environment. This is because therapists do not have the same obligations to maintain the therapeutic relationship between one another as they do with clients. However, therapists likely still have to display some form of solidarity because overt disagreement may potentially confuse the family and derail the therapeutic process. In Open Dialogue reflections, therapists have to manage the institutional task of introducing multiple ideas to the family while also mitigating the potential negative effects of overt disagreement. At the same time, they must also manage generic conversational contingencies such as preference and normative expectations of aligning responses. In this study, we aim to identify how Open Dialogue therapists respond to each other's reflections, manage institutional tasks and generic conversational contingencies, and explore the implications of the elided agreement and potential disagreements for reflecting conversations.

Method

Participants and Data

Study participants consisted of Open Dialogue therapists (n=12), their clients and the clients' social networks including family and other professionals (n=36). Ten therapists had completed a 5-day foundation training in Open Dialogue with a minimum of 2-years of experience working in the approach. Seven therapists were undertaking advanced training as Open Dialogue therapists or to be Open Dialogue trainers. The remaining two therapists had informal orientation training in Open Dialogue through their more experienced colleagues. Open Dialogue is centred around a number of principles focussing on providing immediate help, including families and social networks, maintaining therapist continuity through the therapeutic process, and promoting dialogue (Seikkula and Arnkil, 2006; Haarakangas et al., 2007). Decisions about treatment are made collaboratively between therapists, clients, and their families and can include other forms of psychotherapy if it is jointly decided on. Open Dialogue can thus be considered a form of family therapy centred around promoting dialogue as well as a collaborative decision-making process (Ong et al., 2019). In this study we focus only on one aspect of Open Dialogue, the reflecting conversation.

The first author provided information on the study protocol and aims to potential therapist participants. If therapists were interested in participating, they then approached the first author and provided written consent. The participating therapists then identified families who may be interested in participating. If families were interested in participating, the first author provided them with detailed information on the study. If they still wished to participate, they provided written consent. Data collection consisted of video and audio recordings of 10 Open Dialogue sessions, totalling 14 hours of video. Three cameras were placed around the room to document verbal and non-verbal conduct from all participants.

The study was approved by the Nepean Blue Mountains Local Health District ethics committee (reference number: HREC/17/NEPEAN/135). All data presented in this article has been anonymised to ensure participant confidentiality, with personal names replaced with pseudonyms.

Analytic Process

The analytic process followed the procedures recommended by ten Have (2007). This included first viewing and transcribing the recordings verbatim and an "unmotivated looking"

for interactions of interest (Psathas, 1995; Schegloff, 1996). These initial viewings yielded a number of conversational practices of interest that have been published previously (name withheld, 2020a, 2020b). For this study, we examined therapist assertions during reflecting conversations. We identified 17 reflecting conversations across the 10 sessions, each averaging 5 minutes in length. We noticed that, at times, therapists did not explicitly agree or disagree with each other. We focussed our analysis on identifying examples of absences of explicit agreements, specifically focussing on environments where an absence of agreement occurred after an inferential form of reflection and were thus noticeably absent (Schriver et al., 2019). Examples were transcribed in detail according to CA conventions capturing details such as intonation, prosody, overlap and silences (Hepburn and Bolden, 2017; Hepburn and Bolden, 2013).

Findings

We found that therapists' initiating reflections consisted of assertions about the family that were not responded to with overt agreement/disagreement, thus departing from normative expectations. Instead, responding therapists tended to elide agreement or failed to endorse the other therapist's reflection through silences, prefaces, and re-starts. These responding turns then proceeded to defer to the epistemic authority of the client, assert epistemic rights from second position, emphasise a positive perspective, or voice multiple perspectives. Through eliding explicit agreement, therapists introduced multiple perspectives rather than one agreed upon singular perspective from the therapists while also attending to contingency.

Deferring Epistemic Authority to Client

In Extract 1, the absence of explicit agreement is displayed through silences and prefaces, and a proposal to direct the conversation towards the client and their primary epistemic rights and authority. In this extract, the therapists are discussing a prior conversation with the family where the client was feeling uncomfortable with direct eye contact and the therapists tried looking in a different direction while speaking to the client. At the beginning of Extract 1, T2 is reflecting on whether looking away was easier for the client.

Extract 1

S8.E11R – 48:35

T1: therapist 1 (Julie); T2: therapist 2; Tracey: client

```
1           (1.6)
2   T2      >i- so i guess julie< that's one of the-
3           (0.2) also the things i (.) wonder about huh
4           .hh (0.3) is (0.2) was it easier to
5           have the conversation about the i q testin:g
6           (0.2)
7   T1      mm
8           (0.3)
9   T2      without the look↑°ing?°
10          (0.2)
11  T1  →   yea:h (0.3) i wonder (0.3) °if=sorta° (.)
12          tracey might (0.3) be able to tell us?
13  T2      hm
14          (0.4)
```

At line 2, T2 addresses the co-therapist, T1 (Julie). There is a long beginning to the turn with multiple components as T2 focuses on achieving a particular wording. The turn includes "I guess" suggestive of an upcoming evaluation and response seeking (Kärkkäinen, 2007) and "I wonder" which is associated with low entitlement and high contingency (Curl and Drew, 2008) and a downgrading of epistemic and deontic authority (Ong et al., 2021; Ong et al., 2020c). T2 thus foreshadows an upcoming evaluative position as well as displaying their low rights to make that evaluation or potential difficulties in the recipient's ability to answer. T2's turn ends with a yes/no interrogative about whether the prior conversation (about IQ testing) was easier for the client (Tracey) when they weren't looking at her directly. This refers to an earlier part of the session where the client was feeling anxious and the therapists tried not looking at the client directly when speaking to her (data not shown). This interrogative is preceded by "also the things I wonder about" transforming the interrogative into a speculative statement or inferring my-side telling (Schriver et al., 2019). T2's turn contains multiple components that project a number of possible responses i.e., an interrogative projecting a confirming or disconfirming polar response (Raymond, 2003), or a complex assertion projecting agreement/disagreement. In any case, T2 topicalises the client's response to the conversation about the IQ testing as the focus of their turn.

T1's response does not include explicit agreement (beginning at line 11) and contains a number of mitigating features. At line 11, T1 begins with "yeah". This "yeah" has the quality of an acknowledgement token, which does not precisely conform to the expectations set-up by the previous interrogative, and instead conveys weak and/or neutral receipt of the turn more broadly. This is followed by a number of within-turn silences without non-verbal agreement markers that also avoid providing straightforward agreement with relevant parts of the prior turn. T1 continues with "I wonder" and "if sorta" foreshadowing an upcoming proposal with low entitlement (Curl and Drew, 2008). "I wonder" was also present in T2's initiating turn (line 3) thus communicating a similar downgraded epistemic position and maintaining a degree of syntactic continuity (Du Bois, 2014). T1 then proposes directing the question towards the client, Tracey (line 12) who has epistemic authority and rights to comment on their own internal experience. The conversation then moves out of the reflection to speak with Tracey directly (data not shown).

In summary, T2's initiating turn presents a complex speculative action with a number of mitigating features that downgrade their authority and certainty. T1's response displays an absence of explicit agreement (through acknowledgement and lack of non-verbal agreement markers), a similar downgraded epistemic position, and proposes to direct the question to the client. T1 thus avoids participating in further speculation about a topic in that is in the client's epistemic domain. This allows the client to display and claim epistemic rights on their own experience as well as avoiding a potential breach of social solidarity by not overtly disagreeing and undermining T2's initiating turn and perspective.

Asserting Epistemic Authority from Second Position

In Extract 2, an absence of agreement, displayed through verbal and non-verbal resources, is later modified to present a re-authored independent stance claiming epistemic authority from a responsive position. This displays how therapists manage and respond to generic conversational expectations during reflections, and how these considerations may interpose in the content of the reflection. Extract 2 begins with the therapists commencing a new sequence of talk about the humour displayed by the family earlier in the session.

Extract 2

S4.D2 – 47:08
C1: child 1; C2: child 2; C3: child 3; C4: child 4; T1: therapist 1; T2: therapist 2

```
 1          (1.6)
 2   C3     ((whines))
 3   T2     >there was a lot've< [humour thrown]=
 4   C4                          [shh          ]
 5   T2     =around=i think- (0.2) [>the family uses it<=
 6   T1                            [mtk .hh
 7   T2     =for resil°ience i thi:nk°
 8   C1     +°°yeah we do°°  ((to C2))+=
     T1  →  +upturned mouth and shrug+
 9   T1  →  =°i don't° kno:w (0.2) but [they certainly]
10   C1                                [°huh huh heh°  ]
11          (0.2)
12   T2     mm
13          (1.6)
14   T1     huh
15          (0.7)
16   T1     yea::h. (.) there's a lot've laughter
17   T2     [m↓m,
18   C1     [((whisper))
19          (1.0)
```

The example begins with a silence of 1.6 seconds (line 1) marking closure of the previous sequence. At line 3, T2 launches a new sequence with an observation there was "a lot've humour thrown around". T2 continues with another component, "I think" latched on to the prior utterance. After a brief silence, T2 completes the turn with an inferential statement that the family uses it (humour) for resilience, in a lower volume and ending with "I think". T2's turn thus consists of a behavioural observation and ends with their own inferential interpretation about the family's use of that behaviour. T2's inferential component begins and ends with "I think", which presents their inferential talk as something that is from their own perspective or opinion while also introducing a downgraded certainty and lack of commitment, and seeking a response such as endorsement or rejection from the co-therapist (Kaltenböck, 2010; Stevanovic, 2013). T2 thus presents an inferential statement in the form of a declarative that makes relevant agreement or disagreement from the other therapist. This differs from Extract 1, where the therapist's initiating turn contained multiple components that could be heard as an interrogative or a complex assertion that in turn makes relevant a greater number of possible fitting responses.

At line 8, C1 whispers to her sister C2, "yeah we do" displaying her agreement that the family uses humour for resilience. It is not clear if it was heard by the therapists. C1's talk occurs in overlap with T1's shrug and upturned mouth expression suggesting upcoming disagreement with T2's prior turn. At line 9, T1 responds with "I don't know", which functions as an account for not agreeing with the prior turn and is also associated with avoiding commitment to the current course of action when following evaluations and questions (Weatherall, 2011). T1's turn has an absence of agreement with all or part of T2's prior turn through verbal and non-verbal means. T1 continues with an aborted "but they certainly" followed by a short silence. T1's turn is not yet complete, and the other therapist forgoes taking a substantial turn with a continuer, "mm", at line 12. After a long pause, T1 laughs and, following another silence, provides an agreement token with an emphasised and

drawn out “yeah”. T1 then voices their own observation “there’s a lot’ve laughter”, which is an aligning, although re-authored version (Thompson et al., 2015) of T2’s prior observation that there was “a lot’ve humour”. In addition to being re-authored, T1’s “there’s a lot’ve laughter” occurs in an initiating position and through this, T1 states their own independent assertion about the family that is different from T2’s prior position. T1 claims independent access and asserts their epistemic authority (and agency) to produce an independent interpretive assertion about the family (Heritage and Raymond, 2005; Enfield, 2011).

In this extract, the absence of explicit agreement is displayed through non-verbal signs of an upturned mouth and shrugging, and a verbal marker of “I don’t know”. T1 makes an observation about the family that is partially consistent with T2 but, because T1’s observation is an initiating turn and re-authored, it claims an independent assessment of the family. Through this conduct, T1 does not explicitly agree with T2’s claimed function of the family’s behaviour, even when there is an (albeit possibly unheard) endorsement by a family member during the reflection. This extract also demonstrates how the sequential organisation of conversation and the ensuing implicit assumptions about epistemic primacy and authority influence how therapists produce and respond to reflections.

Emphasising a Positive Perspective

In Extract 3, the absence of explicit agreement is displayed through minimal responses and a return to earlier talk in the conversation that emphasised a more positive focus. Just prior to the extract, the therapists have been discussing that there is a lot of love between the daughter and her mother, and also a lot of negative feelings between the sisters (data not shown). At line 1, T1 describes the love between the sisters as “obviously it is there but then” before moving on to describe the negative feelings between the sisters as “the hatred which is there”.

Extract 3

S5.D3R – 1:15:52

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

```
 1  T1     [>obviously it's< the:re but then,]
 2         [((Mo and Cl inaudible talk))
 3  T1     >is=the [hatred which is there.< (0.8)=
 4                 [((Mo and Cl inaudible talk))
 5  T1     =which i could s:ee becoming [bigger?]=
 6  T2                                  [mm     ]
 7  T1     =+.hh +
    T2      +nods+
 8         (0.6)
 9  T1     an (.) prevailing over (1.1)
10         thoughts [an fee:li:ngs and wo::rds=
11  T2              [°mm.°
12  T1     =[an actions (0.3) .hh
13  T2      [°mm_°
14         +(0.6)+
    T2     +nods +
15         (1.0)
16  T2     °mtk=yeah.°
17         (0.7)
18  T1     °mm:°
```

```
19          (1.7)+(0.6)                                    +
    T2  →         +head tilt with hand palm up and down+
20  T2      (    ) >i said i< thin:(.)k (0.8)
21  T1      hmm:.
22          (0.2)
23  T2  →   >it=wz important that< (.) they could also
24          (0.2) that they were still able to
25          talk °about it°
26          (0.3)
27  T2      °that (.) for=me felt important°
28          (0.3)
29  T1      hmm.
30          (1.7)
```

T1's talk at line 1 occurs in overlap with the mother and daughter who are speaking to each other. At line 3, T1 begins a question "is the hatred which is there". This is followed by an inserted clause "which I could see becoming bigger..." (line 5). The question is not completed and the turn instead ends in an inferential telling in the form of a prediction about the hatred between the sisters becoming bigger. This finishes with rising intonation seeking a response from the other therapist (Stivers and Rossano, 2010). T2 responds with nods but does not provide a verbal response, leading to silence at line 8. T1 then adds an increment to their turn with a further prediction about the hatred then "prevailing" over other thoughts, feelings, words, and actions. During this turn, there is an absence of explicit agreement as T2 provides receipts with a quiet "mm" at lines 11 and 13. T1's turn, from lines 1-12, has an ambiguous structure as it begins with an interrogative format that is not completed and ends with what could be considered an inferential prediction. There are thus multiple elements of the turn that T2 can respond to; the question and the propositions conveyed via the question or the predictive inferential telling.

T2 provides minimal uptake with silences (lines 14-15), nods (line 14), and a verbal response of a quiet "yeah" (line 16). This is followed by further silences at lines 17 and 19. The response tokens of nods, "mm" and "yeah" are superficially similar to usual agreement markers. However, in this context and combined with quieter volume, lack of emphasis and silences, these response tokens instead suggest acknowledgement rather than agreement and delay the voicing of disagreement (Pomerantz, 1984). In addition, through these silences, response tokens and delayed responses, T2 is displaying a similar downgraded epistemic stance to T1. The subsequent verbal and non-verbal actions of T2 confirms their lack of explicit agreement with T1's prior talk as well as a similar downgraded epistemic stance. At line 19, T2 makes a momentary gesture briefly turning their hand palm up and down with a sideways head tilt (intuitively, an "I don't know" gesture), followed by another silence. At line 20, T2 begins a turn with "I said I think", foreshadowing something that they said earlier in the reflection. After a silence T2 continues their turn, focusing on the relationship between mother and client and specifically that it was important that they were able to talk about the problems, something that T2 had mentioned earlier in the reflection (data not shown). At line 27, T2 stresses that this is their interpretive evaluation, stating "that for me felt important". This specifically locates the importance as occurring for them personally and not as an objective observation while also emphasising the independence of their position (Thompson et al., 2015; Heritage and Raymond, 2005). This is followed by a receipt from T1 and silence that is later followed by a topic change (data not shown).

In this extract, T1's initiating turn begins with an interrogative form but ends with a strong prediction about the conflict in the family that receives minimal response and no

explicit agreement from the other therapist. T1 then adds more detail to their turn that again receives little response from T2. T2 responds by not mentioning T1's prior talk, instead repeating his own positive interpretation of the family's behaviour that was mentioned earlier in the reflection. This closes further talk on T1's previous predictive statement and the conversation moves to a different topic. T2's turn with an absence of explicit agreement through minimal responses and embodied actions, leads to a change of topic that closes the current conversation. T2 does not explicitly disagree and thus avoids negating T1's earlier statement but does voice a contrasting positive perspective on the sisters' relationship.

Eliding Agreement to Voice Multiple Perspectives

In Extract 4, both therapists produce successive speculative statements that are met with an absence of explicit agreement. Extract 3 also demonstrates the non-verbal resources that can be utilised when eliding agreement, and how the absence of agreement can transition to sequence closure through a change of topic. Extract 4 starts with T1 speaking about how the focus of the family has shifted to Harry (previously the concerns were about Harry's sister). At line 1, T1 begins with a statement speculating on what the conversation has been like for Harry and the family during the session today.

Extract 4

S9.D1R – 52:57

T1: therapist 1; T2: therapist 2; Liz: mother; Harry: child; Abe: biological father

```
 1   T1      i'd (.) >i wonder what it's< li:ke,
 2           (0.6) for harry an for everybody really da:
 3           (0.3)
 4   T2      mm_
 5           (0.8)
 6   T1      to (.) talk about this toda:y.
 7           (0.6) ↑°i° don't know if they ca:me
 8           prepared °for+this° °°or not°°
     T2                    +circular head movement------>
 9           (0.2) +
             ----->+
10   T2      mtk (.) yea:h.
11           (0.4)
12   T1      [um:          ]
13   T2      [>i fel=like<] the focus has <shifted
14           maybe> +[ta] (0.2) .h (0.6) + now (.)=
15   T1             +[mm]                +
                    +nodding-------------+
16   T2      =from harry being in the background
17           <maybe he's now> (0.7)
18   T2      +mm                              +
     T1   →  +shrug, eyebrow raise, palms up+
19   T2      (0.4) (             ) ca[n: ]
20   T1                              [mtk] (or)
21   T2      maybe [talk    a]bout right now
22   T1            [°°yeah.°° ]
23           °↑it's something to ta-° .hh (.)
24           i'm=rEAlly aware that (0.2)
```

```
25          abe isn't in the roo:m
26          (0.2)
27  T2      mm
```

At line 8, T2 responds with an ambiguous circular head movement that is partially vertical (i.e., nodding) and partially lateral (i.e., head shaking). This is accompanied by the verbal token "yeah", which could be acknowledgement or agreement (line 10). In either case there is not a strong marker of agreement from T2 in response to the speculative part of T1's turn. Both therapists begin talking at the same time at lines 12 and 13. T2 continues that they feel like the focus has shifted (line 13). T1 agrees via nodding and a prosodically stressed "mm" (line 15). At line 16, T2 continues that the focus has shifted "from Harry being in the background maybe he's now". This suggests an upcoming speculation about Harry that is not immediately completed and is instead followed by a silence and "mm" (lines 17-18). Following T2's speculative beginning, T1 offers a collection of uncertainty gestures including a shrug, eyebrow raise and an upturn of both palms, in a gesture of "maybe" or "I don't know". These gestures convey an unwillingness to explicitly endorse T2's assertion while also presenting a similarly downgraded epistemic stance. T2 completes their turn at line 19 and 21, but it is only partially audible. T1 voices a quiet "yeah" at line 22 but, in the context of T1's other talk and non-verbal gestures, this indicates acknowledgement/receipt rather than agreement. At line 23, T1 begins an acknowledgement of T2's talk with a quietly spoken modified repeat "it's something to ta-" which may be "something to talk about". T1 aborts this turn and exerts their agency and deontic authority by launching a new topic, spoken with increased volume, that the biological father "Abe" is not in the room, thus closing off the prior topic of conversation.

In this example, both therapists produce speculative assertions and both are responded to with verbal and non-verbal gestures including a quietly spoken acknowledgement token, shrugging, eyebrow raises and upturned palms, indicating an absence of agreement with the speculation. The speculations also differ in the degree of directness with the first (lines 1-8) utilising multiple components like in Extract 1, and the second stated more directly as in Extract 2. At the end of the extract the uncertainty gestures and absence of explicit agreement is quickly followed by a change of topic that closes the current sequence and any further speculation about the effect on the client. The therapists thus produce multiple perspectives without developing sequences involving explicit agreement or disagreement. This allows multiple perspectives to be voiced without preferencing or invalidating the other perspective. Therapists thus produce multiple perspectives while also managing normative conversational expectations.

Discussion

Using CA, we analysed and presented a number of ways that Open Dialogue therapists elided explicit agreement during reflections. Therapists utilised a range of verbal and embodied resources to accomplish this, including the use of delays in responding, within-turn silences, minimal responsive tokens, and bodily movements like shrugs, head tilts, upturned mouth, and hand gestures. This absence of agreement was particularly noticeable when one therapist voiced some form of inferential telling such as an interpretation, speculation, or prediction about the family. In addition, the absence of agreement had an impact on the direction of the reflecting conversation by transitioning into other areas, such as transitioning to a question directed to the client thus deferring to their epistemic authority (Extract 1), transitioning to a therapist's independent assessment of the family (Extract 2),

and closing down the current topic of discussion with a more positive interpretation (Extract 3), or transitioning to a new topic (Extract 4). Through eliding explicit agreement, therapists regulated the conversation and each other's actions by receipting/acknowledging prior turns and closing down some areas of conversation and transitioning into others. Therapists thus did not work to resolve their lack of agreement towards either congruent or divergent outcomes before transitioning to new topics. This differs from disagreements between therapists and clients where therapists worked to produce some form of resolution (Muntigl and Horvath, 2014; Muntigl et al., 2013). Therapist reflections instead included sequences of assertions that produced multiple perspectives, while also attending to normative conversational expectations such as receipt and acknowledgement of prior talk.

The multi-clausal turn design evident in both the initiating reflection and the responses with an absence of agreement suggests that there are multiple factors influencing the construction of therapists' reflections. These include more proximal and generic conversational factors such as the relative distribution of epistemic access and rights and the epistemic implications of speaking first. There are also institutional influences such as the stocks of interactional knowledge (Peräkylä and Vehviläinen, 2003) on how Open Dialogue is to be conducted. It seems that the epistemic rights that are encoded in conversational structures conflict with the promotion of collaboration and equality recommended by Open Dialogue. In order to present a collaborative position, Open Dialogue therapists need to design their turns in ways that mitigate the authority that arises not only through their institutional position but also the authority implicated through sequential positioning.

Open Dialogue reflections involve observations as well as inferential statements and assessments about the client and family (Schriver et al., 2019). First position assessments claim epistemic primacy by virtue of their sequential position of being first while further assessments (about the same object) are heard as responding to the first assessment (Heritage and Raymond, 2005). This creates possible tensions and competition between therapists in reflections as it may appear that those who voice reflections first are seen to be introducing new information while subsequent ones may appear to be *merely* agreeing, even if they had previously thought similar ideas independently. This can result in first position assessments or assertions being downgraded in order to promote a more symmetrical distribution of authority as in Extracts 1, 2, and 4. Similarly, a therapist may upgrade their authority from second position by withholding agreement and making efforts to produce an independent assessment even though it is in alignment with the initial assessment by their co-therapist (see Extract 2). The asymmetries inherent in the structure of conversation do not easily fit with conceptual ideas such as collaboration and equality between voices as promoted in Open Dialogue. These asymmetries and the potential for competition over epistemic authority, can potentially distract the family from the content of the reflections and their purpose of introducing multiple perspectives into the conversation.

Therapists also made efforts to explicitly mark their ownership of their presented thoughts during the reflection. By making explicit the ownership of their interpretations, therapists forgo the opportunity to present their interpretations as objective facts and mitigate the implication of superior claims to knowledge about the experience of the family. Issues of epistemic asymmetry and downgrading practices are also important and relevant for everyday conversation, with speakers constructing their talk orienting to the relative epistemic access and authority of their recipient/s (Heritage and Raymond, 2005). The position of a therapist, however, is different from those in everyday conversation as the role of a *therapist* has certain institutional roles and duties, as well as connotations as an authoritative expert on matters of mental health regardless of the intentions of the individual (Guilfoyle, 2003). Conceptual writings on Open Dialogue encourage the voicing of different perspectives under the metaphor of polyphony (e.g., Mikes-Liu et al., 2016; Olson et al., 2014; Seikkula, 2008).

Therapists therefore have a principled imperative to contribute their own thoughts and inferences into the conversation while avoiding making superior claims to understanding the family or generating a single "version" of a family's experiences. However, therapists' utterances unavoidably have authority by virtue of their institutional status. In order to promote a collaborative approach with families, dialogical therapists need to constantly work at downgrading the authority connected with their position (Guilfoyle, 2003). So, while epistemic downgrading is present in everyday conversation, it has particular institutional relevance for Open Dialogue therapists who are encouraged (and obligated) to promote collaboration and equality.

CA research has detailed a generic conversational preference to provide agreement with assertions in order to maintain sequence progressivity and social solidarity (Pillet-Shore, 2017; Sacks, 1987). This conversational preference again does not easily fit with the institutional imperative to promote multiple polyphonic perspectives; if therapists agree with prior reflections it reduces the possibility for multiple perspectives, while disagreement risks social solidarity. Eliding agreement may be a way of fulfilling both of these opposing demands. Through an absence of explicit agreement, therapists can generate multiple candidate interpretations of the families' experiences, and avoid explicit disagreement or negation of the perspective of the other therapist, thus minimising disruptions to social solidarity. By avoiding explicit disagreement therapists may also avoid undermining each other's authority in front of the family. The absence of agreement may therefore be an expected and appropriate response in reflections. This aligns with previous research that has found disagreement to be not necessarily a negative act and, in some situations, is appropriate and even expected. For example, when problem-solving in business settings, disagreement is viewed as useful, necessary, and associated with creativity (Angouri, 2012), and in focus groups or debates, moderators encourage and invite disagreement and different perspectives (Angouri, 2012; Sifianou, 2012; Myers, 1998). However, disagreement involves some delicacy from the dialogical perspective in order to promote collaboration and avoid making superior claims to the experience of others. Therapists therefore did not produce a bald disagreements and instead utilised a number of means of withholding agreement before introducing other perspectives.

A limitation of this study is that most therapists were engaged in advanced training in Open Dialogue and these practices and actions may reflect their different perceptions of the approach or their attempts at trying new techniques. Further research on this topic involving more experienced therapists may provide an interesting comparison to the current study. This study is also limited in its ability to make firm recommendations for clinical practice. Instead, we present these findings as examples of ways that therapists *may* produce reflecting conversations and the complex conversational ways that this is achieved. These findings still represent actual conversations and the displayed orientations of therapists. These conversations provide a source of practice-based evidence that can inform current understandings of dialogical approaches by providing details of therapist conduct not previously considered or described in theoretical models (Peräkylä and Vehviläinen, 2003). The Open Dialogue community may then consider how therapists manage the opposing imperatives described above and if these or other conversational techniques may better achieve the goals of Open Dialogue.

In this study, using conversation analysis, we demonstrated how Open Dialogue therapists elided explicit agreement and some functions this supports in reflecting conversations. The presentation of different perspectives in a reflection is a means by which therapists present diverse ideas to a family that can result in different perspectives and potential disagreement between the therapists. Eliding agreement is a way in which therapists can guide the conversation in particular directions while delivering independent perspectives.

Eliding agreement avoids creating consensus between the therapists, allowing a number of perspectives to be presented in reflections while also avoiding explicit disagreement and potential ruptures to social solidarity. We also hope to have demonstrated how an examination of the details of conversations, as they actually occur, can provide insights that are not considered or proposed by theories about therapy and its conduct. Theoretical principles are necessarily realised in context-sensitive ways and it is important to acknowledge that therapeutic practice must proceed with reference to both theoretical principles and their empirical realisations.

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