This is a draft of one part of Chapter 7 of my book in press. I shall discuss some examples reported in this text in my first lecture on the dialogical methods in professional practices. I shall also present some video-clips related to these examples. It would be helpful if the students glanced through this text.
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1. The Ego-Alter interdependence in dialogical professional practices

In non-problematic communication, dialogical features like co-construction of meanings, heterogeneity, multivoicedness, unfinalizability of messages and others, are adopted largely implicitly and become routinely implemented. The Self and Other take these features for granted as part of their mutually shared social environment (Chapter 5). Therefore, unless specific communicative problems arise, the participants have no reason to bring up any questions about these dialogically shared features. In contrast, in a discourse involving people with communication difficulties the participants often become explicitly aware of these dialogical features because they cannot be routinely applied. Communication difficulties lead to the disruption of communicative synchrony and to misunderstandings. Since professional practices like psychotherapies, counselling, training, learning-teaching, and so on, are all based on communication (e.g. dialogue, interview, confession, etc.), the negotiation and interpretation of dialogical features present a challenge. Both professionals and clients or patients have to cope with misinterpretations leading to disagreements, with emotional and fear-producing situations which can be loaded with mutual trust and distrust, and with various kinds of communicative errors. These situations require dialogical sensitivity on the part of professionals to negotiate problems with patients and family members, to establish trustful relations and to cope with conflicts and tensions. Listening to and understanding patients and clients requires the capacity to interpret what is said and what is not said, as well as to comprehend reasons why certain things are said and not said. The participants have to cope with unfinalized processes, each of them being a unique case requiring a specific dialogical relation. Consider some cases.

1.1 The Ego-Alter interdependence in congenital deafblindness

Communication involving people with congenital deafblindness (CDB) presents an extreme case of difficulties that the dialogical mind encounters. The British national charity

for deafblind people, *Sense,* defines CDB as a condition of 'any child who is born with a sight and hearing impairment or develops sight and hearing loss before they have developed language in their early years' (http://www.sense.org.uk/content/congenital-deafblindness). It is important to emphasize that congenital deafblindness refers to the condition that is present in the child before he/she acquires language and this is why CDB differs in fundamental ways from acquired deafness, blindness and deafblindness.

The French philosopher Denis Diderot (1749/1916) in his extensive letter on the blind and the congenitally blind posed intriquing questions about life without sight and about the features of the mind and other senses by means of which the individual compensates for blindness. Diderot was a philosopher of rationalism during the period of Enlightenment and he was aware of the importance of commonly held signs and symbols underlying language and communication. Humans share signs that are recognized by eyes in alphabets; there are also commonly held signs recognized by ears in articulating sounds. However, there are no common signs recognized by touch and therefore, there can be no communication between 'us' and those who are born deaf, blind and mute: 'They grow, but they remain in a condition of mental imbecility' (Diderot, 1749/1916, p.89). Diderot admits that perhaps the deaf, blind and mute could be trained if someone communicated with them from infancy by some means. But 'to train and question one born blind would be an occupation worthy of the combined talents of Newton, Descartes and Leibniz' (Diderot, 1749/1916, p. 118).

As a philosopher of rationalism and Enlightenment, Diderot considered a deafblind person simply as an individual who was in need of training. At that time it did not occur to him that communication is not a one-sided training but that it is a dialogical process involving both parties[1]. This is why training of such an individual would be an enormous achievement. And yet, contemporary professionals involved in the care and communication

[1] Jacques Souriau drew to my attention that more than 30 years later Diderot wrote an addition to his letter in which he acknowledged his earlier errors concerning his views on the mental capacities of blind people. Instead, he then described with admiration mental capacities of a blind young woman who 'with wonderful memory, and strength of mind as wonderful, what progress she would have made in science if she had had a longer life' (Diderot, 1749/1916, p. 157).

of people with CDB have succeeded not just in training, but in dialogical communication. The foremost challenge for a child with CDB and his/her carers is to use senses like touch, smell, taste and body awareness as the dialogical resources in communication (Souriau, 2000; 2001; in press). Since people with CDB have the same needs as everybody else, in order to meet their needs, the development of communication has been the main priority for carers and services (Janssen and Rødbroe, 2007; Rødbroe and Janssen, 2006; Souriau, Rødbroe and Janssen, 2008; 2009). Having been aware of the Self-Other interdependence as a vital dialogical resource, professionals, carers and researchers working in the field of CDB have been among the first to have methodically explored the nature of the dialogical mind. The terminology which they systematically use, e.g. 'co-construction', 'co-creating communication', 'co-production' 'co-presence', 'co-development' and possibly some other 'co-' indicates their supreme dialogical concerns.

1.1.1 Life as a 'hyper-dialogue'

Dialogue, which forms the vital feature of life in CBD (Nafstad, in press), cannot be viewed as a single episode that takes place here-and-now, but must be viewed as a slice in life that has its past, presence and future. Every moment in dialogue brings about past experiences, and previous dialogues and interactions. This has led Jacques Souriau (2013) to maintain that each single conversation is part of a 'hyper-dialogue', i.e. a part of conversations that take place throughout the whole life, recalling memories of the past, co-constructing present experiences and imagining the future. The term 'hyper-dialogue' refers to the very dialogicality and historicity of the human life, that is, to the fact that the present encounter draws on the previous one and that it anticipates the future encounter. Despite their communicative difficulties, persons with congenital deafblindness construct hyper-dialogue throughout their entire lives. This historical perspective of dialogicality enables humans to be aware of continuities and changes over time and to construct their Selves (Ricoeur, 1990/1992; Souriau, 2013).

Therefore, Souriau suggests that a 'hyper-dialogue' is not a metaphor, but that it directly touches the vital social reality of persons with CDB: it is through the continuity of dialogical interactions that persons with CDB co-construct their concepts of the Self (see also Berteau, 2010). As in communication involving people with vision, hearing and speech, so in communication involving people with CDB, dialogical experiences are brought into conversations both implicitly and explicitly. Nevertheless, in the case of people with CDB, in

order to establish communication, all dialogical experiences, implicit and explicit, must be explicitly acknowledged, negotiated and agreed upon by both parties (Berteau, 2010).

In his exploration of the Ego-Alter interdependencies and socially shared knowledge in conversations between carers and persons with CDB, Berteau (2010) focuses on different kinds of dialogical tension. He discusses them as complements or oppositions involving three main dyadic relations: implicit versus explicit knowledge; educational versus dialogical learning; and attachment versus trust.

The opposition between implicit and explicit knowledge in conversations involving people with CDB can create tension due to the difficulties of both parties to recognize elements which are and are not tacitly shared, and which are intended to be shared, thematized and topicalised. The second kind of opposition concerns educational and dialogical learning. Beartau observes tension arising from the discrepancy between different scenarios in the mind of the person with CDB and that of the carer. If the carer monologically follows his/her own teaching scenario in terms of 'imperative and declarative communication' without listening to the person with CDB, the participants do not achieve the educational goal. Through his analysis Berteau arrived at the third dialogical opposition, that between the attachment trust and dialogical trust. Only reciprocity in the Self-Other interactions can establish the attachment trust (on attachment and trust, see earlier, Fonagy and Allison, 2014). In order to develop dialogical trust, Self-Other interactions must allow people with CDB to express their agency. As Nafstad (in press, p. zz) explains, to trust the Other implies the belief that the Other adopts the listening attitude with respect to the Self and that listening will be sustained despite the difficulty in predicting the intended meaning. She connects dialogical trust with the Self's feeling of being 'worthy of being listened to' and with the sense of dignity. This means that the Self must experience that he/she is acknowledged by the Other, is worthy of the attention of the Other and is uplifted by that attention (Nafstad, in press, p. zz). This also implies that trust as the search for dignity and social recognition facilitates dialogical relations and strengthens the Self's belief that he/she is treated with dignity. In contrast, if such acknowledgement is not forthcoming, dialogue turns into a monologue and is associated with distrust and uncertainty.

None of these dyadic relations discussed by Berteau and Nafstad remain stable during the course of conversation involving people with CDB, but they are constantly reorganized and adapted to new situations as the topic of conversation develops and changes. Berteau shows that ongoing reframing of dialogical thinking is an essential feature of communication

involving people with CDB. For example, he observes how the expression ‘mum’ in a conversation is reframed in another conversation into ‘family moving house’ in which ‘mum’ becomes part of the moving event. Berteau suggests that ongoing reframings contribute to the construction of a hyper-dialogue.

1.1.2 The uniqueness of tactile dialogues

The *uniqueness* (Chapter 6) of each individual manifests itself exceptionally strongly in people with CDB (Souriau, 2001; in press). They are affected by the condition to different degrees (some people may have residual vision and hearing); they may have other conditions (e.g. autism, learning difficulties), and just like everybody else, they will have specific personality features. In every situation, each individual experiences CDB differently, and is affected by it in different ways. Rødbroe and Janssen (2006) highlight that carers and services must focus above all on the fact that they are concerned with the individual who has the disability, rather than with the disability as such: ‘Recognition of his or her uniqueness is essential when deafblindness is considered’ (Rødbroe and Janssen, 2006, p.10). The authors emphasize that the visual and hearing impairment is the only thing that is common to deafblind people: in everything else they are unique. Therefore, the ways in which people with CDB create meanings together with their carers through repetitions, the ways in which they acquire knowledge and co-create narratives, are achieved uniquely.

While meanings in spoken or sign language are commonly understood because they belong to a shared symbolic system, meanings based on tactile communication of people with CDB are unique to each Self-Other dyad. Communication of people with CDB is built on their capacities to use tactile and motor experiences, and to co-construct, together with their carers, symbols and concepts in and through replaying events in which these symbols and concepts were used previously (Souriau, 2013; in press).

Tactile dialogues, in which the Self and Other mutually reciprocate gestures and signs, become shared in the process of negotiation (Nafstad, in press). The following example of tactile communication of a person who is totally deaf and totally blind is discussed by Rødbroe and Janssen (2006). Kirtsten, a 48 years old woman, expresses herself by gestures that originated from her bodily experiences. After negotiation over a long time the carer understands that Kirsten does not want to make tea but ‘hot chocolate’ which is made from chocolate broken into pieces and cooked in hot milk. Comprehension is facilitated by the fact that Kirsten moves in her familiar environment and the carer understands, from former

experience, Kirsten's idiosyncratic gestures like a 'saucepan' and 'breaking the chocolate'. In this case, the mutual understanding of the gestures of Kirsten and the carer (the Ego-Alter) mediates the Object: I BREAK CHOCOLATE/COOK MILK (Rødbroe and Janssen, 2006, pp. 75-76). As Nafstad (in press, p.zz) maintains, the triangular relationship between the Ego-Alter-Object 'co-produces and co-creates knowledge about objects, and therefore co-creates objects as social realities'.

One of the problems in the Self-Other communication is to understand that people with CDB, just like everybody else, experience tension arising from the search for intersubjectivity and the struggle for social recognition (Nafstad, in press). This issue is particularly important because communication can involve only gestures of touching, and it may also involve very long gaps between joint constructions of dialogical contributions. People with CDB communicate with a constant risk that when they speak using their unique tactile gestures they have co-created with their carers and that are specific to each individual, they may not be understood by other carers. Although people with CDB develop resilience when they encounter such problems in communication, it is equally important that in order to succeed in transmitting their messages, the Other is prepared to listen and to follow the communicative gestures of the speaker. As already noted, dialogical trust of people with CDB depends on the listening attitude of the Other which acknowledges the speaker as an agent with dignity.

1.1.3 Co-presence as a prerequisite for mutuality

When Gunnar Vege (2009) completed his study entitled 'Co-Presence is a Gift: co-presence as a pre-requisite for a sustained and shared here and now' he had already worked, for 25 years, as a professional teacher of people with CDB. One of his students was a Norwegian woman Ingerid who was 21 years old and at the time of completing his study, Vege had worked with her for 10 years. Ingerid was born totally blind due to Rubella and she had only little residual hearing which, Vege noted, had for her no functional value. The aim of his study was to examine the extent to which the carer contributes to the development of sustained communication. Specifically, Vege used the term 'co-presence' of the participants as a prerequisite for mutuality of their communicative connection and sustained attention to one another. Most importantly, participants may be physically co-present yet each could be closed in their own monological worlds. In contrast, Vege's definition of co-presence does not refer to spacial co-presence of the participants, but to dialogical co-presence of the Self-Other.Vege defines 'co-presence' as follows:

> Co-presence is an attitude, it is a state of mental, bodily and emotional awareness of co-existing in each other's presence. It is being engaged emotionally and psychologically, in a way that involves the actual other in here-and-now. It is an active state of attention that offers the individual who is CDB perceptible signs of attentiveness, which consist of expressions that have an emotional effect on the other (Vege, 2009, p. 7).

Vege's definition shows that 'co-presence' is a complex concept involving a number of competencies on the part of both participants enabling an utmost dialogical togetherness in a clinical encounter. Specifically, Gunnar Vege has brought to my attention (personal communication) that four compenencies are essential to establish a dialogical togetherness: shared attention, communicative intentions, sustained experience of perspectives and a capacity of building and sharing tension. All these competencies jointly contribute to the development of the narrative structure of the shared life story of both participants.

Awareness of co-presence can be a particular challenge for carers if the person with CDB suddenly stops responding in the middle of a conversation. This however may not indicate withdrawal of attention but a transition from external to internal dialogue on the part of the person with CDB. As Nafstad (in press) notes, the carer faces the problem of understanding that a person with CDB may take a temporary dialogical position of a thinker. This position is indicated when the person does not direct his/her gestures at the listener but at the Self. This temporary directing of attention towards the Self may indicate that he/she is engaging in making sense of his/her own position within the dialogue (Nafstad in press; Nafstad and Rødbroe, 2013). The challenge for the carer is to recognize, acknowledge and respect that the person with CDB is engaged in thinking, i.e. in making sense of, or positioning him-/herself within the space of the here-and-now. The person with CDB may subsequently wish to make known to the listener some aspects of his/her thoughts. Accordingly, he/she may then be ready to take the position of the speaker in an external dialogue, requiring the partner to shift to the position of the listener or follower of his/her utterance (Nafstad, in press).

The exploration of the transition between external and internal dialogue was one of the features of Gunnar Vege's (2009) research. Much of the discussion below is based on the DVD video made for this purpose (Vege et al. 2007). His particular interest was focused on moments of Ingerid's hesitation when she was thinking and made a gesture or a sign. Vege maintained that these moments showed that Ingerid's attention shifted away from external dialogical interaction towards an inner dialogue. He analysed this sequence in two parts,

from 00:00 till 01:04 (one minute and four seconds). It consisted of two narrative micro-structures, each leading to moments of internal dialogues. Figure 7.1 shows moments when Ingerid stopped responding and her face showed a disengaged attitude:
(00:13): 'Turning her head a bit away from Gunnar again, as hesitating, thinking…'
(00:55): 'Her head is turning away, freezing her head position a moment, as hesitating, thinking'

Figure 7.1 about here

Figure 7.1shows the video-transcription of the narrative that takes places from 00:00 till 01:04. We can summarize Vege's detailed analysis as follows: Vege invites Ingerid to go out. Ingerid eagerly responds to the invitation. Vege, in guiding Ingerid's hands to reach for the rucksack, structured the beginning of the narrative sequence. He describes what happened:

> When reaching the rucksack Ingerid explores the rucksack in a tactile manner and then (00:13) she moves her head away from the partner, and freezes the position of her head. Her facial expression looks concentrated, she seems to hesitate, think. What cause Ingerid think [sic]? A main aspect is that this scenario, just entered, is based on her tactile bodily experienced perspective of the world. The partners share expressions in a tactile dialogical manner, through touch, movements and bodily emotional expressions. And the contextual elements are based on her previous life-experiences. (Vege, 2009, p. 70).

The rucksack is a contextual artefact that Ingerid already knows because it was used previously during outings with Gunnar Vege and it always contained some food, usually an orange. At 00:17 Ingerid's

> right hand leaves the hand of her partner, expresses a gesture with an "orange shaped hand" towards her cheek, and then smiles and laughs. It is possible, by observation of her facial expressions, to suppose that the thinking process has a kind of a narrative structure. It looks like the thinking is progressing towards an emotional state, a kind of tension (Vege, 2009, p. 70).

Vege observes Ingerid's response. He comments on her expression to assure her that he is attentive to her, and adds, using touch gestures 'LIKE-YESTERDAY' (00:22). Ingerid attends to Vege who directs his body towards the rucksack and signs to Ingerid: 'FIRST-FEEL-OPEN-THE LID …. COME – COME' (00:29 and 00:33). Gunnar Vege described this situation:

> When he has signed 'OPEN-THE LID', slowly and distinctly, her under lip moves outwards. His movements towards and the touch of the rucksack, are performed more as questions than as a start of 'opening the rucksack'. When touching the sack, he does not open the top immediately. He starts to put focus on the next natural action to share; opening the first buckle of the top. The partner pulls on the buckle as a question and Ingerid smiles as both an expression showing that she understands his intention and agrees. Her partner shares every small action by the use of tactile bodily expressions in a distinct sequential manner (Vege, 2009, p. 71).

Opening of the first buckle slows down the mutual action and creates an irregular rhythm, which seems to affect Ingerid (00:51) as she moves

> her right hand to the next buckle, and the other hand is 'glued' to the partner's acting left hand. Simultaneously she moves her head downwards and then further to the right, away from her partner, like hesitating, thinking again. Her partner focuses on moving to the second buckle. He stops and asks her what to do with this one. It seems like she is able to reflect, and still be mentally aware of her partner's action. She answers 'OPEN' by pulling on the buckle, and again freezes her head position a bit. Then she both smiles and expresses the 'orange shaped hand'-gesture towards her cheek (01:02). This internal dialogue seems to consist of the same progression as the first one; from an intense state of concentration towards a kind of a state of tension, and then when smiling and expressing a gesture. The different elements in this inner dialogue again might be supposed to be experienced in a kind of a narrative structure (Vege, 2009, p. 71).

Vege maintains that the whole sequence shows joint attention of both partners, correct attribution of the intentions of dialogical contributions, and building-up the dialogical tension.

The video also captures Ingerid smiling. Sometimes she smiles momentarily, sometimes this is barely noticeable, but sometimes the video shows a big smile. For example, a big smile occurred when Gunar was talking with Ingerid about an orange. Figure 7.2 shows that occasion at time (01:10), when a big smile is accompanied by a vocal sound, as happy.

Figure 7.2 about here

1.1.4 Re-constructing shared experience

One day Ingerid and Vege were fishing for crabs and they were sharing emotions whilst feeling crabs moving in their palms and then on a bare forearm (Souriau, Rødbroe and Janssen, 2008, p.23). These included sensations and movements of a crab crawling on arms and hands, excitement of what happened on the arm, and location of movements of the crab on the body.

The following day Ingerid and Vege talked about their past shared experiences including the episode with the orange (see above). Souriau, Rødbroe and Janssen (2008, pp.32-33) describe the situation: 'Suddenly, in the middle of 'The Orange' narrative, Ingerid stood up. She took a turn in the dialogue with her left hand moving up the right arm, exactly as she had expressed the gesture in the immediate dialogue on the Pier. Gunnar confirmed her gesture, by expressing the same gesture.'

This led to re-establishing the shared experience that took place the previous day, and the two participants re-created the crab-line theme. Gunnar 'placed the crab in his palm' and Ingerid touched his palm in the same way as on the previous day. Then she 'allowed the crab to circle in her palm'. She took more initiative and 'said' that it felt like the crab going up her arm and showed it by her fingertips: 'The co-construction of the narrative continued through touching the aspects that had made impressions…the traces were then clearly fixed and stabilized manifesting themselves as distinct meaningful signs' (Souriau, Rødbroe and Janssen. 2008, p. 33).

The example of the crab-line theme and the co-construction of the narrative draw attention to imagination as a guiding force in this co-construction. In his letter on the blind Diderot (1749/1916) asked himself questions like how are 'their' mental processes different from 'ours'? How do 'they' form ideas of figures? How do 'they' imagine? 'Their' imagination comes from fingertips; 'their' only chance is to form images by calling to mind and combining palpable sensations while a sighted person calls to mind visible and coloured points. Diderot's ideas about mental processes and imagination represent the Enlightenment ideas about rationality of the individual. In contrast, imaginative thinking is one of the axioms of dialogical epistemology, which is derived from the Self-Other interdependence. The co-construction of a narrative in CDB involves imagination that is jointly produced by the person with CDB and his/her carer. Ingerid's narrative is facilitated by Gunnar's dialogical capacity to take the perspective of the person with CDB, to re-create the atmosphere of joint experience and to provide space for Ingerid's self-expression. As Souriau, Rødbroe and

Janssen (2008, p. 33) note, the traces of these experiences become stabilized and manifest themselves as meaningful signs which the participants share.

In conclusion, congenital deafblindness lays bare the essential features of dialogical epistemology by highlighting the unique capacities of the dialogical mind in the most difficult conditions of communication and life experiences (Nafstad, in press; Souriau, 2001; 2013). The uniqueness of the Self-Other interdependence in CDB is particularly discernible in Vege's and Berteau's research. They both explain that it is because of the uniqueness of individuals involved in their studies that the single case approach, to which we shall return later, was vital for success in their work.

1.2 Multivoicedness in dialogical practices

Throughout this book I have referred to dialogical multivoicedness or heteroglossia as one of the axioms characterizing the Self-Other(s) interdependence. It takes simultaneously several forms in a concrete dialogue (Wagoner, Gillespie et al. 2011). First, a concrete dialogue, we have seen, echoes other dialogues – or more generally – is part of 'a life as hyper-dialogue'. This also means that any dialogue involves not only the voices of actual participants, but that it also resonates with voices of participants who are not present, as well as with the past and contemporary cultural and institutional standpoints. Second, heteroglossia is a double-voiced discourse, by means of which a speaker simultaneously expresses two different intentions (Bakhtin, 1981, p. 324). Thus in a novel, one intention could be directly articulated by the hero or by the speaking character, while the author of the novel might express another intention. The hero's and the author's intentions may clash and lead to transformations of one another's intentions and so contribute to the dynamics of dialogue. For example, the hero may express his/her intention to carry out a particular action while the author may, through the mouth of the hero, question the morality of that intention. Manifestations of different intentions sometimes merge, and sometimes they compete with one another. Thirdly, multivoicedness or heteroglossia may refer to the speakers' external and internal dialogues. We have touched on internal and external dialogue and their possible tensions many times in this book, e.g. with respect to the speakers' confessions or with regard to internal dialogues in people with CDB. Yet another kind of multivoicedness may refer to the professional's repetitions of the partner's dialogical contribution in order to confirm that it was understood correctly. In such situations the professional or carer articulates both his/her own words and the voice of the partner with disability. We have already seen

examples of this kind of multivoicedness in communications involving people with CDB and we shall now present another instance of multivoicedness in communication involving a person with cerebral palsy.

1.2.1 Multivoicedness in cerebral palsy

Just as in the communication involving people with congenital deafblindness, where both partners visibly co-construct their dialogical contributions, the joint co-construction of dialogical contributions is made explicit in communication involving people with cerebral palsy (Collins and Marková, 1999; Marková, 2003a). Cerebral palsy is a disorder of movement and posture caused by trauma to the brain before or at birth. A person with cerebral palsy may have multiple disabilities, ranging from severely limited voluntary bodily movements, uncontrollable spasms, epilepsy and atony, to learning difficulties. People with cerebral palsy may have problems with articulating speech, and to make themselves understood, they use a range of gestures, facial expressions and bodily movements. In order to facilitate their interactions with others, they may use electronic and/or paper-based alternative and augmentative communication systems.

In this example the person with cerebral palsy is a 17 year-old woman who used a board with icons to which she pointed in order to communicate. In this particular case she was telling the carer that on Thursday night she and other girls made a joke. They put a spider into the bed of the therapist Judith. The girls had a lot of fun because Judith did not like spiders and she screamed. In this case the carer used three different voices that were clearly distinguished by intonation. The first voice articulated the non-speaker's voice as a commentator; the second voice was the carer's response to the non-speaker; and finally, the carer conveyed what she might be saying to herself, i.e. her possible inner voice. Here is an extract from the narrative the speakers co-constructed:

An extract from Spider[2]:. M = non-speaker; A = carer

M: (pointing on board)	
(vocalisation)	
A: Thursday	A articulates the word 'Thursday'
M: (pointing on board)	to which M pointed on the board. The
(vocalisation)	utterance 'Thursday night was funny after
A: night	[sic] went home' was spoken with a narrative

[2] The transcript was made by Sarah Collins.

M: ye tone – like when telling a story

M: (pointing on board)

(vocalisation)

A: was

M: (pointing on board)

(vocalisation)

A: (nods)

.huhh funny

M: after

M: (smiling)

(pointing on board)

(vocalisation)

A: (laughing)

M: (smiles)

(pointing on board)

(vocalisation)

A: (smiling)

M: (smiles)

*A: (*tuts*)* went ho*::*me

M: aye

A: (nodding)

(tuts) I missed all the fun as if speaking to herself

M: (laughing)

A: what did you do eliciting the response from M

M: (pointing on board) (pointing on board)

(vocalisation) (vocalisation)

A: (smiles)

.

.

.

A: .hhh .hhh ye::s :tell me more eliciting response from M

M: (laughs)

M: (smiling) (pointing on board)

A: put hhh .hhh

M: (smiling) (pointing on board)

A: (smiles)

M: (knowingly)

A: a spi::de::r — voicing M's word

M: (looking on board) (laughs)

A: (looking on board) (laughs)

Mm I think I know what's coming — as if talking to herself

M: (pointing on board) (laughs) (laughs)

A: in::: *(in tone of anticipation)* — voicing M's utterance

M: (nods)

A: Judith::'s be:d!

M: (nods)

A: ((tuts)) .hhhh (.) does she like spiders (serious tone) — commenting on M's message,

M: (shaking head) (pointing on board) — which expresses dislike of spiders

(laughing) (vocalisation) — in the culture they share

We can also note that the different voices that M is using to co-construct the narrative with A refer to different kinds of shared knowledge; cultural (e.g. not liking spiders), personal (e.g. appreciating emotional features of the story), dialogically established forms of interaction (e.g. anticipations and imaginations of what will happen, expressing interest in the story, inner comments). Whatever form multivoicedness takes, it testifies to the fact that dialogues are not linear strings of single voices, of transparent meanings or question-answer sequences. Multivoicedness not only testifies to the richness of communication, but it also challenges professionals and their clients to take account of the competing voices in dialogue.

1.2.2 Multivoicedness in psychotherapy

Grossen and Salazar Orvig (2011) investigate in what ways multiple and intermingling voices of actual and absent participants contribute to defining the problem in therapeutic consultation. Assuming that a concrete dialogue is no more than a slice in a life-long dialogue, the authors explore not only the voices of participants who are present but also echoes of the voices that took part in past discourses, or even in imagined discourses. This assumption recalls the Bakhtinian position that any discourse is shaped by preceding

discourses and by speakers' anticipations of responses from their listeners. Following French dialogical pragmatics (e.g. Anscombre and Ducrot 1983; Ducrot 1984; Vion, 1998), Grossen and Salazar Orvig distinguish between speakers' different 'enunciative positionings'. By enunciative positioning they mean a relation between the speaker's attitudes toward the different voices, whether his/her own voices or those of other absent enunciators (Grossen and Salazar Orvig, 2011, p. 57). They explain that speakers may consider themselves as authors of the utterance in question and therefore, they take the epistemic responsibility for the utterance. Alternatively, they may present themselves as not being epistemically responsible for the discourse; they only portray the utterance from a particular perspective. That perspective may come from a discourse that involves other voices; speakers may distance themselves from the utterance, or they may reject or reformulate it. The authors insist that among these two poles, i.e. accepting and rejecting epistemic responsibility, there are subtle forms and mitigators expressing a range of relations between speakers and the enunciative positions of the actual and absent parties.

With these dialogical presuppositions Grossen and Salazar Orvig analysed processes in therapeutic discourse, in which voices intermingled, e.g. speakers explicitly or implicitly invoked absent persons, while developing their own positions in conjunction with positions of their present interlocutors. The authors refer to these processes as a 'dialogized heteroglossia' (Bakhtin, 1981), that is, as a phenomenon in which speakers not only invoke and amalgamate diverse voices, but link together past discourses and anticipate the future ones. In and through their analysis it becomes apparent that the speaker is not homogeneous and monological, but is heterogeneous and dialogical. The authors show that in one and the same utterance a speaker not only invokes different voices, but that diverse voices may converge and conflict with one another. In the following example Grossen and Salazar Orvig show that the therapist and the mother in the interview presented an absent voice of the teacher and the reformulations of that voice in the actual discourse. In the extract, in lines 1 – 3 the mother uses the term 'brusque' that had been first used by the absent teacher. In the

actual discourse it was reintroduced by the therapist's reformulation of the mother's utterance in line 6 below, and then addressing the child in line 9[3]:

1 M 34: (. . .) the teacher also told me (. . .)

2 M 35: (. . .) he is quite brusque also in his- in his- in his

3 behaviours he's a::

4 T 39: [a direct]

5 M 36: [a little bit] excited, a bit direct yeah yeah +

6 T 40: so he is̀ brusque and then it provokes reactions'

7 M 37: from the others'

8 M 38: yeah (T looks at Alain)

9 T 42: (to Alain) how do they react when you are brusque'

This example shows that the term 'brusque', which the mother used with reference to the previous teacher's discourse, was integrated into the therapist's discourse, but it did not show any enunciative position, i.e. it did not indicate who was epistemically responsible for the meaning expressed by that term. However, the therapist's expression 'so he is brusque and then it provokes reactions' implicitly requires the mother to take a position with respect to that expression. Lastly, the therapist addresses the child using the term 'brusque' as if it was the therapist's chosen term while the reference to the teacher is now completely lost.

In sum, the speaker may simultaneously take several positions, for example, as an author of his/her utterance, as someone who responds to the interlocutor, as someone who echoes an opinion of his/her parents or of a political party, or as someone who is anxious about the opinion of his/her interlocutor. The richness of styles, genres, as well as of

[3] Norms of transcription in the extract:

( ) Parentheses are used to give contextual information, such as laughter, telephone rings, sigh, etc.

:: stretching of a sound

+ pause of a half-second

[…] a part of the turn has been cut for reasons of space restriction

- interruption

' indicates a falling intonation

stereotypes expressed in and through the diversity of voices would not be possible if speakers did not rely upon cultural, institutional, socially shared, and common sense knowledge.

1.3 Epistemic trust in dialogical practices

1.3.1 Revealing and concealing secrets

Professionals are often faced with individuals or families who are not willing to reveal sensitive information or secrets that threaten their integrity and social recognition. These encompass a wide variety of issues like incest, mental and physical illness, alcoholism, extramarital affairs, suicides, homicides, artificial procreation, adoption, and so on (Rober et al, 2012). Keeping a secret may lead to tensions and conflicts within the individual as well as the fear that, for one reason or other, one day the secret may be revealed. Keeping secrets may also result in deterioration of interpersonal relations within a family or between friends; it can be interpreted as lack of trust, or as non-recognition of the other as a worthy partner. One may disclose a secret to certain individuals while excluding others; one may avoid certain topics or change a topic or just keep silence. All this may create barriers among members of a family as well as trigger the formation of coalitions (Imber-Black, 1998) between some members while excluding others, and so leading to stress and loneliness of the excluded family members.

Rober et al. (2012) posed the question as to what dialogical tools are available to family therapists in order to cope with family secrecy in its complexity. As the authors note, one secret is often linked with other secrets, e.g. a suicide in the family may be linked to a mental illness or to poor marital relations and so on. Secrets encourage imagination and fantasies, which may be highly exaggerated and relations between members may be ruined due to presumed untrustworthy and half-true communications, silences and taboos (Imber-Black, 1998). Rober et al. (2012) carried out a case study based on the analysis of the auto-ethnographical documentary film entitled Familiegeheim (Family Secret) by the Dutch director Jaap van Hoewijk. In this film van Hoewijk investigates the secret which the family kept from the children concerning the suicide of their father. Rober et al. (2012) acknowledge that due to the polysemic nature of visual material, the use of a film as a qualitative method provides rich material for interpretation. It far surpasses methods based on verbal materials like interviews or focus groups. The authors show the interplay of trust and distrust between keeping the family secret and selectively disclosing some information to some family members but not to others. In the particular case of the film Familiegeheim, this led to tension

between the son and his mother; he could not trust her and was never sure whether she was telling him the truth.

Conventional knowledge implies that if the whole story of the family secret is revealed, then it is possible for truth to be made known. However, the authors' dialogical perspective showed that multiple voices were telling different 'truths' and none of them could count as a definite truth because they were dealing with a process never to be completed (Bakhtin, 1981). Therefore, rather than talking about a 'secret', the authors turned to the term 'selective disclosure' which captured more fully the complexities of family communication as a multifaceted process in time, allowing for the creation of an open dialogical space. Questions could be asked within that space which would permit the voicing of certain issues while accepting that other issues could not be exposed (Rober et al, 2012, p. 538). The authors conclude that selective disclosure takes place in one form or other in all families and that it would not be correct to interpret selective disclosure as a pathological response to revealing secrets. Rather than aiming at a total disclosure, the therapist should facilitate a space for dialogical communication.

Another case study on revealing and concealing secrets was carried out by Flåm and Haugstvedt, (2013), who examined caregivers' awareness of children's first signs of sexual abuse, circumstances facilitating and hindering such awareness, and trust/distrust in relation to such circumstances. The disclosure of a child's signs in their study was largely determined by dialogical sensitivity of the trusted caregivers to the child's report leading to unveiling of the event, in particular if that involved another trusted person. In such compromising cases the child needed a great deal of encouragement from the adult. Without such encouragement his/her answers did not lead to disclosure.

In contrast, when the trusted caregiver posed thoughtful questions and so provided space for intersubjective understanding, the child used this opportunity for disclosure. The difficulty of revealing such formidable secrets is due to the fact that the child, abused by a trusted person like a parent or a neighbour, might feel responsible for the abuse. The child might be frightened for possibly causing harm to others, of not being taken seriously, and so on. Moreover, the adult might not be a good listener, might disbelieve the child and be altogether lacking in dialogical sensitivity. Flåm and Haugstvedt (2013) provide numerous instances showing the caregiver's disregard for the child's information, in particular if the child is unable to speak directly about the incident and if he/she uses indirect questions like: "Do I HAVE to go to uncle?" or "Do I HAVE to wash the dishes even though I get paid?"

The adult may interpret these questions as a temporary reluctance, unwillingness or laziness. The authors find that in such cases the child does not repeat the request, and only after a long delay new information comes out through other sources. They point out that normalizing the child's request, correcting the child and not asking any further question suppresses the child's agency and stops him/her from pursuing a dialogue. In contrast, the caretaker's dialogical sensitivity provides opportunity for his/her action. Flåm and Haugstvedt (2013) provide another example: Mother was about to leave for a night shift and the daughter asks: 'Is it YOU, mommy? Do you HAVE to leave for work?' Mother found the daughter's voice strange and terrified and shortly found out that her husband was abusing their daughter. The authors conclude that the adult's open dialogical attunement provided space for the mother's recognition of the problem.

1.3.2 Epistemic trust in psychotherapy

If dialogue is a cure (Nafstad, in press), then building up and maintaining epistemic trust in and through psychotherapy is vital to the success of the therapeutic process and healing. Epistemic trust and distrust in psychotherapy can be discerned in different forms and these forms parallel those of intersubjectivity as discussed in Chapter 4, namely interpersonal, institutional and generalized (or state, system) forms. Salgado (2014) refers to several layers of trust/distrust with respect to psychotherapeutic services. These layers take place simultaneously in transindividual, interpersonal and intrapersonal forms, which grow together and transform themselves into new forms. As a transindividual form, a generalized trust of society facilitates the establishment of institutions to be trusted. Forms and degrees of trust and distrust depend on clients'/patients' own experience, on the influence of the media, on political and economic conditions, among other issues, like rules that govern activities of institutions and legal implications. As an interpersonal form, trust in the here-and-now encounter between the psychotherapist and client has a number of features, like building the therapeutic alliance as a dialogical engagement in terms of sharing emotions and of the therapeutic goal to be achieved. Interpersonal trust is interrelated with intrapersonal trust in Others as well as in the Self. In a clinical practice, these kinds of trust may be simultaneously at stake: lack of trust in oneself instigates distrust in Others and this tends to create defensive interpersonal and intrapersonal malfunctioning (see also Erikson, 1968). In this context Salgado (2014) emphasizes the role of therapeutic relationship based on shared values and

mutual understanding, cultivating 'a deep transpersonal trust' based on ethics of the profound commitment to Others and therefore, to the Self.

Referring specifically to a Bakhtinian approach based on open dialogues, Seikkula and Trimble (2005) discuss its role in therapeutic dialogue. The authors devise an Open Dialogue Approach which conceives dialogue as a precondition of the healing process in any kind of therapy. The term 'open dialogue' indicates several kinds of relations. First, it refers to the authenticity of communication of all involved parties, to openness, i.e. unfinalizability of dialogue. Authenticity implies that all conversations and all decisions must involve all participants, who are involved in the therapeutic team network. This also includes the patient, who may be very anxious at the beginning of treatment. This may present a challenge for the team in terms of tolerating intense emotional states, ambiguity of the problem, and considerable stress. The second meaning of openness, i.e. unfinalizability of dialogue, comes from the assumption that a word or an utterance derives its meaning both from the speaker and listener. During the dialogue the participants continuously shift and transform meanings and therefore open the dialogue to new possibilities of understanding. In a therapeutic team of the Open Dialogue Approach, moreover, each member expresses his/her perspective, thus giving credence to 'polyphonic' relations (Bakhtin, 1984a). Finally, openness means that sessions are not pre-planned, which allows for sharing of the emotional experience of healing between the therapeutic team and the patient. Spontaneity of communication of the involved parties facilitates the creation and usage of new words to express emotions more accurately using everyday language with which all participants are familiar. Reflection generated in and through multivoiced dialogue encourages the pursuit of detailed comments from each person in the team. Most importantly, the patient experiences that he/she is worthy of being listened to.

Being theoretically rooted in Bowlby's concept of attachment rather than in Bakhtin's dialogism, Fonagy and his colleagues (e.g. Bateson and Fonagy, 2010; Fonagy and Allison, 2014) have developed the concept of mentalizing, i.e. the capacity to understand Others' and one's own mental states and activities (see also Chapter 5). Mentalizing is a social process that facilitates the individual to achieve a sense of being understood as a unique being: 'Feeling understood in therapy restores trust in learning from social experience (epistemic trust) but at the same time also serves to regenerate a capacity for social understanding (mentalizing)' (Fonagy and Allison, 2014, p. 378). Fonagy and his colleagues study patients with borderline personality disorder. They propose that the therapeutic process proceeds

along three communication systems. The first system is based on the patient's learning of the content relating to his/her problem. In and through interaction with the therapist the patient examines issues relating to his/her disorder, which enables mutual understanding of the therapist and patient, and thereby the patient feels personally acknowledged by the therapist. This is important in order to reduce the patient's 'epistemic hypervigilance', to generate epistemic openness, and to facilitate the growth of epistemic trust. The second communication system creates a change in the quality of interpersonal communication. The patient is more open because the therapist gives him/her the feeling of social recognition and shows willingness to understand the patient's perspective. The patient is ready to listen to the therapist which leads to the development of a more trusting relationship. As Fonagy and Allison (2014, p. 377) put it, in and through social interchanges patients 'experience themselves as an agent in the mind of their therapist—they "find themselves in the mind of the therapist."' The final communication system concerns the re-emergence of social learning. Better understanding of social situations through mentalizing increases the patient's capacity for becoming aware of sensitive responses from others and of being understood. This opens up the patient's capacity for new learning in a broader context beyond the therapeutic sessions and enables the patient to form more interpersonal relations with Others. As the patient's hypervigilance decreases, his/her capacity for epistemic trust and social understanding increases beyond the therapeutic session.

Fonagy emphasizes that while he and his colleagues developed the mentalizing-based therapy in order to understand and treat borderline personality disorder, the principle of mentalizing is embedded in many other therapies. Mentalizing may be the common factor in different forms of therapy regardless of the modalities in which it takes place.