Responding to *in-the-moment* distress in Emotion-focused Therapy

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Abstract

Emotion-focused Therapy offers a setting in which clients report on their personal experiences, some of which involve intense moments of distress. This article examines video-recorded interactional sequences of client distress displays and their therapist responses. Two main findings extend understanding of embodied actions clients display as both a collection of distress features and as interactional resources therapists draw upon to facilitate therapeutic intervention. First, clients drew from a number of vocal and non-vocal resources that tend to cluster on a continuum of lower or higher intensities of upset displays. Second, we identified three therapist response types that oriented explicitly to clients' in-the-moment distress: *noticings*, *emotional immediacy questions*, and *modulating directives*. The first two action types draw attention to or topicalize the client's emotional display; the third type, by contrast, had a regulatory function, either sustaining or abating the intensity of the upset. Data are in North American English.

Introduction

The essential role that emotions play in social interaction has become a recent focus of investigation (Peräkylä & Sorjonen, 2012; Robles & Weatherall, 2021) and, more specifically, distress displays through emotion-laden conduct, such as crying, has been receiving increasing attention in both everyday and institutional contexts (Antaki, Richardson, Stokoe, & Willott, 2015; Ford & Hepburn, 2021; Hepburn, 2004, 2022; Hepburn & Potter, 2007, 2012; Weatherall, 2021; Wootton, 2012). The relationship or contribution of emotion to the organization of action sequences has generally been taken up under of the rubric of *affectual* or *emotional* stance (Stivers, 2008; Sorjonen & Peräkylä, 2012). In much of this work, resources displaying some quality of affect (e.g., lexical, grammatical, prosodic, bodily) are examined as working alongside or in tandem with various kinds of action sequences, or even as actions in themselves, making a next response from a recipient relevant (Peräkylä & Sorjonen, 2012). Studies of caller

helplines and police interviews involving episodes of upset have largely focused on how crying is oriented to by recipients as disrupting or suspending the main business of talk (Antaki et al., 2015; Hepburn & Potter 2007; Weatherall, 2021).

In this paper, we expand understanding of *emotion in interaction* by examining the sequential organization of distress displays within Emotion-focused Therapy (EFT; Greenberg, 2002, 2010), an institutional context in which upset is commonly and relevantly produced. We specifically focus on how therapist's *attentiveness* to crying and co-occurring features of distress shifts the unfolding troubles telling towards the mutual attention of the *in-the-moment* emotion as an action to be modulated and more deeply explored. In other words, through the therapist's orientation to the client's upset, these emotional displays become the *main* business of talk. Examining upset in terms of a three-part sequential structure, we consider how upset may be occasioned, how client upset is displayed with varying degrees of intensity and may be seen as responsive to a prior action, and then focus on how therapists respond to and affiliate with these emotional distress displays in order to advance therapeutic work. Our findings are discussed in light of other studies that have examined distress displays in sequences of talk.

Emotional Displays

Across disciplines, the study of emotions has a sizable history and there is growing interest in studying emotions in interaction and how they are displayed, sequentially organized, regulated, and managed in social encounters (Antaki et al., 2015; Muntigl, 2020; Muntigl & Horvath, 2014a; Buttny, 1993; Hepburn, 2004; Peräkylä, 2012; Robles & Weatherall, 2021; Sorjonen & Peräkylä, 2012; Wilkinson & Kitzinger, 2006). These

studies, rather than looking *inward* at speakers' so-called mental states, focus on the *outward* manifestations or social accomplishments of these emotions, and especially in terms of how these emotional displays are placed, shaped, and responded to, in the moment-by-moment unfolding of the interaction (Whalen & Zimmerman 1998). Emotions are considered as a temporal and spatial accomplishment in which embodied emotional stances are performed and responded to by co-participants (Beach & LeBaron, 2002; Cekaite & Kvist Holm, 2017; Goodwin, Cekaite & Goodwin, 2012; Goodwin & Goodwin, 2001).

In accordance with previous studies (Antaki et al., 2015; Wootten, 2012), we are using the term *distress* or *distress displays* interchangeably with *upset (displays)*. Distress is often exhibited through features associated with tearfulness and crying and may implicate various emotions such as sadness, anxiety, or anger (Hepburn, 2004; Hepburn & Potter, 2007, 2012; Wootton, 2012). Following the footsteps of Jefferson's (1985, 2004) seminal work on laughter and Whalen & Zimmerman's (1998) efforts to represent non-lexical items within transcriptions of heightened displays of sorrow or distress (an emotion known in vernacular terms as *hysteria*), Hepburn (2004) – and later work by Hepburn and Potter (2007, 2012) – significantly advanced our understanding of crying by making it a topic of analysis, rather than treating it as a self-evident category. Drawing from a child protection helpline audio corpus, Hepburn developed detailed descriptions and a fine-grained transcription method for what she observes are the seven generic, often co-occurring, features of crying: whispering, sniffing, wobbly voice, high pitch, aspiration sobbing, silence, and sobbing. Another form of conduct, *sighing*, has also been observed to mark distress (Hoey, 2014). Although this work does not specifically engage

with data containing distress, Hoey's examination of the import of the sequential position of sighs (pre-beginning, post-completion, stand-alone and transitional) and the common negative valence of sighs helps to inform analysis of sighs within distress-display sequences.

Attention has also been given to how displays of upset are organized as sequences that implicate responses from recipients. Much of this work, taken from institutional talk, has examined how crying often suspends or disrupts the main activity at hand (Antaki et al., 2015; Hepburn & Potter 2007; Weatherall, 2021). Responses to crying in these environments are often used to contain these disruptions and to eventually get the conversation back on track. In their child help-protection line data, Hepburn and Potter (2007) identified a certain response type or *crying receipt* that they have labelled as *take-your-times* (TYTs). These TYTs are said to be put into service by managing disruptions brought about through crying episodes. Further, by offering callers time to compose themselves, they are claimed to license, and thus affiliate with, the caller's disruptive conduct. These crying receipts, following the reporting of a past upsetting or painful event, have also been observed during police interrogations (Antaki et al, 2015). Other practices for responding to in-the-moment distress include: *haptic soothing*, which provides comfort to persons in distress and establishes intimacy and affection, and has been examined in contexts involving caregivers of crying children (Cekaite & Kvist Holm, 2017) and language and speech therapy (Merlino, 2021); a clinician's *touch t*o display intimacy and sensitivity toward a patient's reporting of past sexual abuse (Beach and LeBaron, 2002); and *gaze* as a mechanism for managing heightened distress (i.e.,

"hysteria") in interactions between two police officers and a female witness/victim (Kidwell, 2006).

Managing Emotional Distress in Psychotherapy

Emotions are seen as playing a central role in psychotherapy processes and change. It is the goal of certain modes of psychotherapy, such as Emotion-focused Therapy (EFT), to work on these emotions in ways that may benefit clients (Greenberg, 2002, 2010). Emotional-focused interventions related to sadness are designed to provide support that is necessary for clients to grieve, withdraw, surrender, and recuperate (Greenberg & Paivio, 1997). Interventions also aim to fuel client change by "accessing and fully experiencing feelings of hopelessness, and/or unpacking the cognitive-affective components of depression" (Greenberg & Paivio, 1997, p. 167).

Much emotion research in psychotherapy, however, has focussed on the psychological and neurophysiological underpinnings of emotions, whereas much less work has examined how emotions may be displayed and organized through therapists' and clients' ongoing interactions with each other. Our contribution for this paper will be to show how specific features of clients' *vocal* and *non-vocal embodied displays* of distress are isolated by therapists and incorporated as interactional tools to further talk and therapeutic progressivity within emotion focused therapy encounters.

According to Peräkylä (2019), emotions are, alongside *referents* and *relations*, one aspect of experience in psychotherapy that becomes transformed within sequences of talk. Some of these transformations, pertaining especially to clients' *emotional stances*, have been illustrated in CA studies of psychotherapy (see, e.g., Ekberg et al., 2016; Muntigl & Horvath, 2014a, 2014b; Voutilainen et al., 2010; Weiste & Peräkylä, 2014).

The term *emotional stance* is often used interchangeably with *affective stance* (see Sorjonen & Peräkylä, 2012; Stivers, 2008), and generally refers to (verbal or non-verbal) conduct that is given affective treatment through some form of lexico-grammatical, prosodic, or non-vocal means. In general, however, clients' actual emotional displays, such as in-the-moment upset or joy, and how therapists respond to these displays, have not received much attention.

Data and Methods

Our data is drawn from the York I Depression Study (see Greenberg and Watson, 1998). From this study, seven cases involving video and audio-recordings of clinically depressed clients (five females, two males) undergoing emotion-focused treatment from one of four female therapists were made available to us.[1] All participants were English-speaking, and clients' self-identification of race or ethnicity was unspecified. Twenty-one video-recorded sessions (each approximately one hour) of EFT were examined. Sessions were transcribed according to CA conventions (Hepburn & Bolden, 2017); transcriptions of bodily comportment, multimodality, and non-lexical vocalizations were further informed by Hepburn (2004), Hoey (2014), and Mondada (2018). Guided by Hepburn's (2004) work on crying, the authors specifically surveyed the recorded sessions for sequences containing displays of upset.

Adopting CA methods (Sidnell & Stivers, 2013), we identified and examined sequences of clients' in-the-moment distress and therapists' responses to these displays of

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[1] We thank Les Greenberg for allowing us access to these audio and video-recordings.

negative emotions. To inform our subsequent analysis of what may be occasioning upset (Hepburn, 2022), our survey and preliminary analysis included action sequences preceding the displayed upset, if identifiable. Particular attention was made to the following:

- identifying how clients displayed upset, with a focus on the types of multimodal resources used and how bundles of distress resources may index lower versus higher degrees of intensity; and
- identifying types of therapist responses that specifically orient to the client's upset.

For this investigation, prior consent was received from the original investigators and from the Simon Fraser University ethics board (2012s0672). All names are pseudonyms. This study forms part of a larger project on the sequential organization of disaffiliation and repair in psychotherapy interaction (Muntigl, Knight, Watkins, Horvath, & Angus, 2013; Muntigl & Horvath, 2014b; Muntigl, 2020; Muntigl, Horvath, Chubak, & Angus, 2020).

Analysis

Ninety-three distress display-response sequences were identified from our data. We found that distress display sequences most often occurred during *process-directive* task interventions involving what is termed *chair work* or *chair task interventions* (Angus & Greenberg, 2011; Greenberg, 1979). There are two forms of this role play or enactment intervention, named *two-chair* work and *empty-chair* work. For both cases, clients speak to a *non-present* party, directing their talk to a vacant chair imagined to be occupied by a version of themselves or a significant other. In two-chair work, aspects of the client's relationship with *self* become targeted and consists of a *two-party dialogue* that commonly involves a self-criticizing aspect of self on the one side and an aspect of self

that *experiences* the criticism on the other. Empty-chair work is used for *unfinished business* in which the client speaks to an imagined present significant other (e.g., parent, spouse, friend), in order to work through longstanding or unresolved feelings or unmet needs pertaining to neglect or abandonment or to abuse or trauma. Some CA-informed studies have examined chair task interventions with respect to resistance, deontic authority and how chair work is accomplished over numerous sequences of talk (Muntigl, Chubak, & Angus, 2017, Muntigl et al., 2020; Smoliak et al., 2021; Sutherland, Peräkylä & Elliott, 2014)

We report on two main findings related to how clients tended to display upset and how therapists would, in turn, respond to upset. First, it was found that clients regularly drew from a number of vocal and non-vocal resources to display distress and that certain distress features tended to cluster together on a continuum of lower or higher intensities of upset displays. Second, we identified three therapist response types that oriented explicitly to clients' in-the-moment distress: *noticings* (n=12); *emotional immediacy questions* (n=38) and *modulating directives* (n=36). Furthermore, in order to fully contextualize therapist responses to client upset within the sequence, we also discuss for each of the extracts how clients' upset may have been occasioned by a prior action and also what the display of upset may be doing within the sequence. Our findings are discussed in the sections below.

Common Display Features of Distress

Common vocal and non-vocal features of distress identified in our data, by tracing in-the-moment upset displays as they emerge, cluster and subside, are shown in Table 1. Many of these features are consistent with previous findings from studies of troubles tellings in

institutional talk (e.g. Antaki et al, 2015; Hepburn & Potter, 2007, 2012), and the generic features of crying captured from transcription of audio-only calls to a national children's helpline (Hepburn, 2004) described above. Our sequential identification of embodied, often silent, features of distress captured through video and detailed below extends understanding of how therapists respond to a wider repertoire of features of crying to further the progressivity of talk as a tool for therapeutic intervention. We draw attention to embodied distress cues absent from helplines as low and high intensity distress may present similarly when only the audio modality is available to call center workers.

Table 1: Vocal and Non-vocal distress displays: features and actions

Recurrent vocal, non-vocal and embodied distress display features and conduct		
Vocal	**Facial**	**Bodily**
- **impaired voice quality**: creaky, tremulous, wobbly - elevated pitch - aspirated talk - **reduced volume**: whispering, mouthing - extended pause, silence - sighing - sniffing, crying, sobbing	- **face**: flushed, red nose, cheeks - **mouth**: downturned, tight-lipped, pursed, quivering, smiling - **gaze**: averted, downward, upward, away from Therapist - **eyes**: closed, red, teary, exaggerating blinking - **eyebrows**: raised, furrowed	- visible in/out breath - slumps, hunches shoulders - shakes head - lowers, turns away head - fiddles with tissue, hands - brings hand to mouth, face - buries face in hands - wipes tears - blows nose - swallows mid-turn - hands, shoulders shake - shrugs (infrequent)

It was found that certain features, such as furrowing brow or covering face, undetectable with audio only, often appear in concert with other features and it is the clustering of multimodal distress displays that reveal the intensifying or diminishing of in-the-moment emotional distress. Although it was not the aim of this paper to make sharp delineations between low and high emotional intensity, we did observe that many individual features may appear at either end of what could be viewed as a low/high continuum. For example, extended silences, reduced volume, downward gaze are found

in both environments. However, within a continuum between low and high intensity there tends to be differing degrees of concentration and amplification of features of emotional display (e.g., crying displayed as being teary or sobbing), thus providing indices of distress levels. The following two extracts have been selected to illustrate typical clustering of features for both lower and higher intensity distress displays.

Distress Display – Lower Intensity

In general, lower intensity displays of distress were found to contain a smaller array of distress features. What is commonly heard percolating around and within the client's turn are pauses, marked in and outbreaths and sighs. Typical non-vocal features include facial actions of gaze away from the therapist (e.g., downturned gaze) and bodily actions of slumped shoulders, head shakes, lowering head and visible in/out breaths.

Consider Extract 1 with the client Ernie, a middle-aged, on-and-off again entrepreneur. He had previously reported that his depression partially stems from feeling helpless and frustrated due to an ongoing precarious financial situation tied to his ex-wife with whom he has an acrimonious relationship. Just prior to this extract taken from his third session, the therapist had been attempting, but without success, to engage Ernie in first time chair work to explore his stated "anxiety" resulting from this dynamic.

Extract 1 - Distress Display – Lower Intensity

EX 1: Ernie, Session 3 at ~43:00

```
01  TH:  now that you're feeling the anxiety in yer:: (0.4)
       e  -->brow furrowed, downward gaze, downturned mouth-->
       t  -->gaze to E, hands clasped around crossed knees-->
02        >anywhere in your body?< er:, (0.2) that you're
03        aware of? (.)+ >or jis:< °(ye'know/no)°,
       e                +shakes head-->
04  ER:  no.(0.2) no.
```

```
05              (0.5     +)
      e  -->shakes head+
06  ER:  No +* tch .h
      e     +gaze to T then ahead & down-->
      t      *shallow nods-->
07              (+3.6       *)
      e          +visible in-breath-->
      t  -->shallow nods-->*
08  TH:  [Somehow it's:s]  what+ a little sca:ry:? o:r (1.7)°uh:m°
09  ER:  [+°hh°          ]
      e   +visible outbreath---+   -->downturned mouth and gaze-->
010             (11.6)
      e  (slight quivering and then pursed, downturned lips)
      t  -->maintains position, gaze to E-->
011 ER:  tch +°(I) dunno°
      e      +gaze to T-->
012             (1.5)
      t  (shallow nods) -->gaze to E-->
013 TH:  So you're not aware of s: (0.6)
014      + >What are you aware of< (0.2) right no:w,
      e  +gaze downward, downturned mouth-->
015             (1.2)
016 TH:  * >an you look a little< (.) sa:d to me,
      t  *leans forward-->
017             (2.0)
018 ER:  tc.hh + ↑well=I'm w- ye:ah:, I'm feelin sad.
      e        +drops hands to sides->
019      + uh:m. (0.4) .hh (0.3)
      e  +brings hands to lap, gaze to hands-->
020      because I I've blocked a lot of that + off.
      e                                      +gaze to T-->
021 TH:  I see. * the sadness,
    t           *slow nod--> -->gaze to E-->
```

Coming into Extract 1, the therapist uses strongly rising intonation in two places to request confirmation and clarification from Ernie that he is feeling anxiety somewhere in his body and that he is aware of this anxiety (lines 01-03). During this time, Ernie's gaze is downcast, his brow is furrowed, and his mouth is downturned, which may be conveying faint or muted features of upset. Rather than confirm his awareness of the

anxiety or his experiencing it in his body, Ernie rejects her request both verbally with "no" and non-verbally by shaking his head (lines 03-06). During a 3.6 second pause that immediately follows, additional features of upset begin to emerge (gaze downwards, visible in-breath, extended silence), which may be occasioned by the therapist's topicalizing of Ernie's anxiety and her request that Ernie recognize and elaborate on this feeling. In response, the therapist proposes an alternative candidate emotion "a little sca:ry:?" (line 08), and appends a turn-final "o:r" that invites Ernie to confirm, elaborate on or reject the therapist's offer. In overlap, Ernie returns his gaze downward, produces an audible and visible outbreath, which leads into an extended silence (11.6 seconds – line10), through which Ernie continues gazing downward, his mouth slightly quivering. He then purses his lips and turns his gaze to the therapist, who has remained still, before faintly uttering "°I dunno°" (line 11). This not only works to deny knowledge of what he is experiencing emotionally, but to potentially resist any further attempts at exploring feelings of anxiety or fear (Hutchby, 2002). Ernie's increasing upset, therefore, makes public his emotional stance, creating a relevant next action for the therapist to affiliate with this stance. Therapist affiliation with Ernie's lack of awareness occurs in line 13, but then, reorients to Ernie's display of upset by first focusing the client's attention on the present emotional experience (>What are you aware of< (.) right no:w,), and then by producing a *noticing* in line 16 (>an you look a little< (.) sa:d to me,) while leaning in towards Ernie. This action of physically moving towards the client may be considered affiliative, as it brings them in closer contact with each other. These response types will be dealt with in more detail in the sections below.

Distress Display – Higher Intensity

Occurrences of higher intensity upset were found to involve a larger array of distress relevant features and, moreover, specific features that generally index higher intensities of distress (e.g., sobbing, *crying face,* shaking shoulders, lowered head/burying face in hands, wiping away tears). Higher intensity displays often occur during emotionally challenging activities such as chair work, when clients *confront* a significant other or listen to harsh criticisms directed at themselves.

Extract 2, session seven, shows the client Sofia in chair work with her father, who died when she was still a young girl. His absence, she previously revealed, remains a great sense of loss and has negatively affected other relationships with men in her life. The following provides an illustration of how multiple features work together to convey a higher intensity of upset.

Extract 2 - Distress Display – Higher Intensity

EX 2: Sofia, Session 7 at ~54:00

```
 01   SO:  ~Many times in my life°time°~ *(1.2)
        s  -->downturned mouth, flushed face, downward gaze-->
        t  -->gaze to S-->               *shallow nods-->
 02         +~I wish~ (0.2).h ~that you were (h)↑here~* (0.2)
        s  +deeply downturned mouth-->
        t                              -->shallow nods*
 03   TH:  °uhhuh°
 04              (*1.5)
        s         *tissue to face, wipes tears, flushed face-->
 05   SO:  .snif
 06              (1.6)
        t  -->leans in closer to S     -->gaze to S-->
 07   SO:  + ~I was never able to enjoy you.~ .shif
        s  +lowers tissue to lap, gaze downward, crying face-->
 08              (0.7)
 09   TH:  °uh huh°
           -->gaze to S, leaning slightly forward-->
 010             (0.8)
```

```
011   SO:  .h.h.hh
        s  -->visible inbreath, shaking shoulders, crying face-->
012             (0.7)
013   SO:  ~or to (.)↑(h)have you.~ °whenev° (0.3) ~en many
        s  -->crying face-->
014        °ti°mes~ (0.2)
015   TH:  +uh huh,(0.3) u:h. .h [(s-)]
        s  +wipes nose, lowers head, gaze to hands/tissue-->
016   SO:                          [an  ] I am so ~sorry thet
        t  -->gaze to S, leaning slightly forward-->
017        you had to go.~
018             (0.4)
           -->crying face-->
019   SO:  ~an I~           +(0.5) ~that I, (h)had~
        s                   +tilts head, furrowed brow, eyes down-->
020             (1.9)
021   SO:  ~I was (un)able +to enjoy .h.h.h. you.~ (0.3)
        s                   +brings tissue to eyes, then wipes nose
        t   -->gaze to S-->
022        +~only~ (0.3) s'only t- (0.2) hh
        s  +lowers tissue to lap, plays with tissue-->
023             (0.3)
024   TH:  uh huh,+
        s         +gaze to T. sharply downturned mouth-->
025          (0.5)
026   TH:  °uh huh.°
027   SO:  .snif +°.h.h°
        s        +bring tissue to nose, gaze to T-->
```

This extract illustrates high intensity emotional upset as Sofia attempts to tell her imagined father of the many times in her life that she has felt his absence. We note that many of the features occurring in lower intensity displays are present, such as frequent pauses, marked in and out-breaths, downward gaze, lowered head, shaking shoulders and visible in-breaths. The higher intensity upset is conveyed through an additional assemblage of co-occurring multimodal distress features: beginning with tremulous voice, aspirated speech, elevated pitch, pursed lips, downturned mouth, teary eyes, and escalating to flushed faced crying. Throughout Sofia's turn, the therapist minimally

responds with non-propositional sympathy tokens (Hepburn & Potter, 2007) and variations of *uh huh* (lines 03, 09, 15, 24, 26), maintaining her gaze on Sofia. By line 22, Sofia's emotional upset intensifies to the point when she is unable to complete her turn. We will return to this session with Extract 9 and examine the therapist's response, in which she attempts to modulate Sofia's higher intensity upset.

Therapist Noticings

One of the most explicit ways of orienting to and drawing attention to a client's just displayed emotional state is to notice it. In everyday contexts, noticings have been argued to halt the progressivity of an interaction (Sacks, 1995). They are actions that create *retro-sequences* (Schegloff, 2007): by noticing something occurring before, they work as a responsive action, but they also initiate a new sequence by projecting further action, such as confirmation. Research in psychotherapy has shown that noticings may perform a range of functions such as prompting more emotion talk, topicalizing the client's affectual stance, and moving talk in a new direction (Muntigl & Horvath, 2014a). Twelve examples of noticings were found in our corpus. Noticings tended to occur in three different formats.

1. Declarative statements that describe other's conduct (e.g., `you sighed with some feeling there`; `you hid behind your hair`; `you took a bre:ath`; `yuh got yer teeth clenched`);
2. Statements that name the other's present emotional display (e.g., `you feel °sa:d when you say that,°`)

3. Statements that are framed via verbs of perception such as *look*, *see* and *sound* (e.g., `an you look a little< (.) sa:d to me; I can see it in yer (.) chest. or in yer (2.4) sort've welling up.`).

A noticing of the third format, framed through a perception verb, was already taken up in Extract 1. The other two noticing formats will thus be examined in this section. A noticing in declarative format that describes other's conduct can be seen in Extract 3. Now in his ninth session, the client Ernie is currently in chair work, speaking with an imaginary aspect of self about how he might address his financial woes, in order to feel better about himself.

Extract 3 – Noticing

EX 3: Ernie, Session 9 at ~44:00

```
 01  TH: mm hm, mm hm.*(0.2) okay .h *so can you switch and
       t    -->nodding*              *extends hand to empty chair-->
 02      come over here now?
 03           (0.3)
 04  ER: +.hh[hh                          ]
       e +visible chest expansion--->
 05  TH:    *[Something's happening there?]  +You're sighing?+
       t    *brings hand back, leans forward, gaze to E-->
       e                                    +chest deflation+
 06  ER: =>yeh<.+Hh=ok[(heh)y]
       e        +switches chairs
 07  TH:             *[is-is-]is the si:gh,*(0.7)* anything:?    *
       t             *points toward E -----*     *extends fingers*
 08           (2.6)
       t (turns face toward E, away from camera)
 09  ER: th +sigh's (1.6) uh to do with the sort've (0.2) perhaps
       e    +brings hands together on lap, gaze downward to hands-->
010      the hopelessness an-an-[an-an  ] the daunting nature of
011  TH:                        [ri:ght.]
012  ER: the very task of doing that.
```

After the therapist requests that Ernie switch chairs, he makes an extended display of inhaling (line 04). Ernie's displayed conduct goes *on record* as marking some form of incipient distress. Further, his display may not only be conveying a degree of unease in participating in an upcoming dialogue with his *imagined self* (as occasioned by the therapist's request to switch chairs), but also makes a next response relevant that addresses this conduct. The therapist responds in overlap by producing a noticing that first states that "`Something's happening there?`" and during Ernie's exhale interprets this happening as a possible sighing (line 05). The therapist's action thus draws attention to Ernie's conduct, highlighting it as something note-worthy and potentially relevant. The rising intonation following each turn constructional unit in line 05 works to more strongly mobilize a response from the client (Stivers & Rossano, 2010). In line 06, while switching chairs, Ernie first confirms the therapist's understanding of his conduct, followed by expressed acceptance that is interpolated with laugh particles (`Hh=ok(heh)y`). In Potter and Hepburn's (2010) terms, this aspirated agreement may be indexing some kind of insufficiency with the acceptance. As Ernie switches chairs, the therapist produces a follow up question that elicits elaboration on what his sigh might imply (line 07). After a 2.6 second pause, Ernie links his sigh to the hopelessness and daunting nature of the upcoming task, thus accounting for his initial unease that stretches back to line 04.

Extract 4 illustrates a noticing produced in the second format in which the therapist names the current emotional state being displayed by the client Sofia during her seventh session. Immediately prior to this extract, the therapist proposed that Sofia's described

accounts of anxiety at work may be connected to her unfolding separation with her husband.

Extract 4 – Noticing

EX 4: Sofia, Session 7 at ~11:00

```
 01  TH: and (0.2) tch(1.3)
       t -->legs crossed, head tilted & gaze to client-->
       s -->legs crossed, head tilted, gaze to T, hands on lap-->
 02  TH: it just see:ms to me that-that you really(.)need(.)
       s (flushed face, red nose)
 03      +lo:ve. And-and you need +somebody's who's there,
       s + wipes under eye        +tilts head to side-->
 04      en someone who's:e +(.)understanding, en+.hh (0.4)
       s                    +blinks back tears   +gaze upward-->
 05  TH: yihkn- [Much like  ] you have
 06  SO:       +[(well/how?)]
       s       +gaze to T, smiles-->
 07  TH: what you had with this other man. right, .hh and
       t -->gaze to client-->
 08      I just imagine that +(0.3) not (0.4) not having that
       s                     +straightens head, slow blinking-->
 09      right now is very difficult for you
010  SO: .h +(0.2) hmm.
       s    +gaze/hand to tissue box-->
011           (1.3)
       s (takes tissue, brings in front, gaze to tissue, red nose)
012  TH: +And what I'm saying is [making you + teary. right?]
       s +folds and refolds tissue           +gaze to T-->
013  SO:                          [.h It is. It is ver-      ] yeah.
014           (+1.0)
       s       +wipes eyes-->
015  SO: yeah
```

The therapist begins this extract with an *interpretation* (Bercelli, Rossano & Viaro, 2008; Peräkylä, 2005) – "`it just see:ms to me …`" (line 02-09) – in which she displays her understanding of how difficult it might be for Sofia to be in a relationship where she is not receiving her desired love and compassion. During the therapist's turn, Sofia conveys various distress features: wipes tears from her eyes, displaying a flushed face, red nose,

and downward gaze. After the therapist's turn completion, Sofia produces minimal uptake with weak acknowledgement ("hmm." – line 10) and then reaches for another tissue from the box. Sofia's crying, therefore, may be seen as being responsive to the therapist having pointed out something potentially distressful to the client. The therapist then responds with a noticing in line 12 that draws attention to her emotional state of sadness, and also posits a relationship between the topic of talk and Sofia's emotional conduct. Sofia responds with upgraded confirmation in overlap (line 13) and then wipes her eyes.

Therapist Emotional Immediacy Questions

Focusing the client's attention on their present emotional experience may also be achieved through questions. In examining how therapists work in the present moment, Kondratyuk & Peräkylä (2011) identified two types of actions: *immediacy questi*ons and *immediacy instructions*. These actions, mostly produced in question format and with immediacy markers such as "now" or "this very minute", worked to guide the clients into their here-and-now experience by getting them to become aware of and reflect on their present experience.

The questions that we have identified in our corpus targeted the client's in-the-moment *emotional* experience and were thus more specific in scope than the actions examined by Kondratyuk & Peräkylä (2011). In general, we found that these actions were produced in *wh*-interrogative format, contained immediacy markers (e.g., *now*, *right now*, *as*, *when*), oriented to just prior emotional displays, and projected subsequent emotion talk. What we are labelling *emotional immediacy questions* or EIQs (n=38) oriented directly and virtually immediately to emotional displays of mid-intensity, but not after

contexts of outright sobbing or crying. They also tend to occur when an emotional display is becoming more intense or has changed in some way. In these contexts, the therapist's conduct often includes some sort of pointing gesture or mirroring gesture embodying the client's distress display. They most often occurred with the verb *happen*, appearing simply as "What's happening now?" or within a more elaborate grammatical construction that ties the emotional display to what the client had said, as in "what's happening when you say that." The action is often depicted in the present progressive, underscoring the action unfolding, which specifically topicalizes the client's in-the-moment distress displays. Each of these EIQ formats will be presented below.

Extract 5 illustrates an EIQ with the verb *happen* and an immediacy marker. Several sessions into her therapy, Lisa and the therapist had been discussing a certain pattern in Lisa's life in which she goes through cycles of having happy then sad days. Furthermore, this pattern of cyclical moods is very much contingent on her husband engaging with his gambling addiction.

Extract 5 - Emotional Immediacy Question

Ex 5: Lisa, Session 14 at ~24:30

```
01 LI:  so that's:(0.3) +I guess something I (0.2) I have to work
     l  -->gaze to T--> +crosses arms-->
     t  -->gaze to L, hands on lap-->
02 TH:  .hh
03           (1.3)
04 TH:  +↑well (.) I guess you're saying though
     l  +furrows brow, lowers head and gaze-->
05      +that you gist (0.3) kind of (0.7)
     l  +gaze to T-->
     t  -->gaze to L-->
06      +stay with (0.7)+ °whatever co:mes.
     l  +shallow nods---+ opens tissue held in hand,
07      +right?°
     l  +brings tissue to eye, scrunches face, gaze down-->
```

```
 08           (0.4)
 09 LI:  +°~↑yeh~°
      l  +wipes eyes, then nose, furrowed brow, gaze down-->
010           (0.6)
011 LI:  shih=
012 TH:  °What's *happening now?°=          *
      t          *extends index finger on lap*
013 LI:  +=↑uh:m (1.9) an I guess ↑accepting?
      l  +holds hand near/covering mouth-->
014           (+1.8)
      l        + turns head and gaze to T-->
015 TH:  it's hard to accept this
016           (0.4)
017 LI:  +↑yeh
      l  +nods, gaze/head lowered, scrunched face-->
```

Just prior to this extract, Lisa confirms being aware of a pattern in which she has very bad, bleak days and, in line 01, she states that this is something she needs to work on. The therapist's response, however, suggests something slightly different by drawing attention to something that is emotionally delicate; that is, Lisa tends to remain with or endure these feelings. It is during this formulation that we see Lisa displaying increased distress, such as furrowing her brow and lowering her head (line 04), opening her tissue (line 06) and bringing it to her eyes. Lisa's upset seems to be working as a response to the therapist having explicitly formulated her difficulty. Then, after a brief pause in line 08, she offers confirmation with a tremulous, quiet voice, while simultaneously scrunching her face and wiping her eyes, followed by another small pause and a sniff. The therapist, in line 12, orients to this display of distress by asking Lisa "`°What's happening now?°`", accompanied by a pointing gesture, which zooms in on the emotion by getting Lisa to focus on her present experience of distress. Lisa begins her turn with an "`↑uh:m`" and a long pause, which may be signalling the difficulty she is having in dealing with her distress. She then answers with "`an I guess ↑accepting?`" (line 13), to which the

therapist produces a summary formulation (line 15) that specifies her distress as finding it hard to accept these troubling events (i.e., her report of her husband's addictive behaviour and her constant state of sadness and depression).

EIQs sometimes appear in a slightly more elaborate form in which what is happening is specifically tied to what the client is verbalizing. These specific question types mostly occur during chair work when the client is speaking to an absent other or an aspect of self. Consider Extract 6, again with the client Lisa in a session a few weeks prior, who is currently engaged in empty chair work with her (non-present) mother. The dialogue centres around the mother's over-protectiveness and how she discouraged Lisa from leaving the home and forming relationships with others.

Extract 6 - Emotional Immediacy Question

```
EX 6: Lisa, Session 11 at ~29:00
 01   LI:  .hh at the time yeah she was:: she thought that was
        l  -->legs crossed, hands clasped, gaze forward-->
        t  -->legs crossed, hands clasped, leaning & gaze to L-->
 02         just (0.2) what was right for for +Lisa en
        l                                    +gaze to T-->
 03              (*0.8)
        t         *shallow nods-->
 04   TH:  mm hm.          *
        t  -->shallow nods*
 05              (0.4)
 06   LI:  °yeah°
 07              (0.5)
 08   TH:  *+ mm hm.    *
        t  *shallow nod*
        l   +purses lips-->
 09              (+2.2)
        l         +shifts gaze to chair-->
 010  LI:  +°uhm°
        l  +unpurses lips-->
 011             (4.2)
           (both hold positions, noticeably still)
```

```
012   LI:   tch (0.4) uh: (0.3) I know with you+ ~uh (3.4)
        l                                       + gaze to hands-->
013         ~I know y:- +you love me? an y- you ↑care+ for ↑↑me~
        l               +furrows brow, scrunches face+ crying face-->
014   TH:   mm:
015   LI:   + ~↑↑I uh (0.5)
        l   +brings hand to cheek/eye--->
016   TH:   tch +°What happens + when you say that°
        l       +lowers hand   +turns head/gaze to T-->
017   LI:   + ↑I'm sad,
        l   +turns gaze downward, furrows brow-->
```

In lines 01-02, Lisa accounts for (and somewhat justifies) the mother's actions by stating that the mother believed she was acting in Lisa's best interests. This talk is *therapist-directed*, as evidenced by Lisa's gaze directed at the therapist (line 03) and the therapist's subsequent responsive acknowledgements (lines 04 and 08). Distress seems to build in this extract when Lisa purses her lips (lines 08, 09) and then, when she resumes the empty chair dialogue by making contact with her mother in line 12, her voice becomes tremulous and her turn is suffused with pauses, elevated pitch shifts, and cut-off speech. Visible features of distress include lowered gaze, a furrowed brow, a scrunched face and touching her face and mouth. This mounting intensity of distress seems to arise from the anticipation of making contact with her mother.

In line 13, Lisa begins to direct her talk at her mother by conceding that her actions were well-intended (`~I know y:- you love me?...`). Further heightened upset is displayed during this time through hesitancy in beginning her turn, steep elevated pitch shifts and tremulous voice, and a difficulty in continuing to speak (line 15). The therapist then continues with an EIQ in line 16. Whereas the "`What happens`" orients specifically to Lisa's mounting distress displays, the following "`when you say that`" creates a link between Lisa's distress display and her directed verbalization at the mother from lines

12-13, in which she demonstrates compassion – perhaps also forgiveness – for the mother's actions. Thus, the EIQ creates the implication that Lisa's compassionate act is emotionally difficult, and it is exactly this that the distress is displaying.

Therapist Emotional Intensity Modulating Directives

One of the treatment principles of EFT is to guide clients through their emotional experience. Chair work is often used in this guiding manner to target and probe emotions, which may be very distressing for clients and may lead to increasing higher intensity displays of upset. Thus, therapists need to draw from practices in which they may be able to modulate upset, so that it remains within certain bounds, partially within the therapist's control. Within the sequential environment in which displays of upset occur, therapists may at times seek to modulate the client's in-the-moment emotion through directives that either sustain or abate the intensity of these emotions. These recurrent practices of *sustaining* or *abating* tend to occur after the client and therapist are aligned in proceeding in a particular therapeutic direction, occurring most frequently when a specific intervention (e.g., chair work) is underway.

Sustainment

Most common in our data (n=38) were therapists issuing *stay* directives following a client's embodied distress (downturned mouth, sighing, crying, sobbing). One form of sustaining action identifies a specific emotion (`Stay with the sadness; Stay with the hurt`) with the implication that the client should not *ease up*. Another form of sustainment is to reference displays of upset through deictic expressions, leaving emotion unspecified and open to possible (re)interpretation and implying *don't go further* or *we've*

now reached the right level (°Stay there°; °Stay with that.; Stay with it.). Common sequential features occur following extended pausing which contain upset displays and the therapist guides the client's focus to the embodied in-the-moment emotional state and directs the client to sustain this heightened intensity.

Extract 7 is taken from the client Jennifer's eleventh session. During prior sessions, she disclosed enduring years of loneliness; she was bullied as a child and lacked loving relationships within her family, which resulted in her feeling unlovable and all alone in the world. Here, Jennifer is engaged in a two-chair work dialogue with herself, as a little girl, on the one side, and the voice of the inner critic telling her younger self she cannot be a cheerful optimistic child, on the other. Just prior to Extract 7, Jennifer switched seats and roles, shifting perspectives to that of herself as a little girl.

Extract 7 – Emotional Intensity Modulating Directives – Sustainment

EX 7: Jennifer, Session 11 at ~28:00

```
 01  TH:  >who's+ this little girl<
        j        +shifts gaze from T to chair-->
        t  -->facing J, turned away from camera-->
 02            (+0.7)
                +gaze lowered, shoulders hunched inward-->
 03  TH:  in the pink shorts.
 04  JE:  h h
 05            (0.3)
 06  TH:  [looking in the hall mirror] +thinking (.)+
        j                               +shallow nods +
 07  JE:  [.h .shih                   ]
 08  TH:  °what is° (°°the problem°°)
 09            (+3.7)        +
        j        +shallow nods+   -->gaze downward-->
010  TH:  *and there she is over there*
        t  *points to empty chair------*
011       [saying(0.2)* be careful.]
        t              *points at J-->
012  JE:  [+.hhhh                   ]+ hhh           +
        j   +visible inbreath         + visible exhale+
```

```
013  TH:  prepare for the worst.
       j  -->gaze downward, body still-->
014           (1.1)
015  TH:  <DO:N't> (1.0)  * °think you can just run around
       t  -->pointing at J*
016       thinking you can be enthusiastic and cheerful.°
017           (1.1)
018  TH:  optimi[stic]
019  JE:        [o(h)+]ka(h)y(h)huhhhh[h          ]
       j            +crying face, face to hands, shoulders shake-->
020  TH:                              * [(°°there°°)]
       t                              *shallow nods-->
021           (4.6)
       j   -->body trembling, muted crying-->
022  TH:  °Stay there.°  *
          -->shallow nods*
023           (*0.6)
       t        *leans forward-->
024  TH:  *°Stay there.° [Jennifer]
       t  *leans whole body in toward J-->
025  JE:                 [>.HUH<  ](0.8) wHuhuh
       j  -->crying, face buried in hands-->
026  TH:  Stay there
```

At the beginning of the extract, the therapist contextualizes the two speaker roles in chair work by first casting Jennifer as "this little girl in the pink shorts", lines 01-08, and then introducing the *inner critic* as occupying the empty chair (`and there she is over there` – line 10). Afterwards, the therapist summarizes the disparaging statements that had previously been directed at the little girl by the inner critic (e.g., "`prepare for the worst.`"; "`<DO:N't> … thinking you can be enthusiastic and cheerful.`" – line 13-16). After a 1.1 second pause in line 17, with no uptake from Jennifer, she adds the increment "`optimistic`". Jennifer then responds in overlap with an aspirated, raised pitched "`o(h)ka(h)y`" (line 19), that not only marks the beginning of her flooding over into crying, but also indicates a form of submission to the critic, as she emotionally

responds to the critic's high level of censure. As she buries her face in her hands, shoulders shaking, the therapist appears to say a quiet and softly spoken "(°°there°°)" (line 20). Emotional flooding continues during an extended 4.6 second pause, as Jennifer keeps her lowered head and face buried, body trembling, her crying muted.

At line 22, and repeated at line 24, as she leans in closer to Jennifer, the therapist softly guides her to "°Stay there.°", which seems to license Jennifer's intensity of emotional expression, encouraging her to continue experiencing the hurt brought about by the critic's severe messages. The therapist's *leaning in* (lines 23-24) also displaces physical distance between them, possibly offering Jennifer with more security and comfort, as in feeling someone *close by*. When the therapist says her name (line 24), Jennifer releases a sharp sob, followed by audible crying. In line 26, the therapist again directs Jennifer to sustain this heightened intensity, thus guiding and sustaining her in-the-moment emotional experience.

Abatement

Less common in our data are abatement directives (N=5) within environments when a therapeutic intervention (chair work) is underway. Following a client's attempts at talk that is disrupted by distress displays of noticeable irregular breathing (holding breath, deep inhale, heavy sigh), the therapist responds to the client's embodied emotion with a directive that targets breathing (st'Take a breath; Make sure you breathe.; °Take a breath.). By treating breathing as an accountable action, these therapist turns suspend the progressivity of therapeutic talk and seek to alleviate the client's distress temporarily. Abatement directives were found to appear in two sequential environments:

1. Following no response from the client to the therapist's initiating action due to the

client's heightened displays of upset; 2. Client's difficulty in progressing own turn due to emotional flooding.

An example of an abatement directive following the client's inability to take up the next turn due to high intensity emotional displays, thus leading to significant or *attributable silences* (see Levinson, 1983: 299), is shown in Extract 8. This extract with Jennifer comes from the session following the one in Extract 7 and continues to explore her loneliness that she experienced as a little girl. Here she is in mid-chair work being guided by the therapist to explore what Jennifer needs to feel safe now, as she's the only one that can hear the little girl (i.e., her former self). Jennifer then responds that she doesn't know, which is followed by a chair shift.

Extract 8 – Emotional Intensity Modulating Directives – Abatement

EX 8: Jennifer, Session 12 at ~18:00

```
      j  (shifted chairs, from little girl self to adult self)
      t  (seated opposite J and empty chair, body mostly off camera)
01  TH:  *The little girl has uh said (0.8)
      j  -->hands together on lap, legs crossed, gaze to chair-->
      t  *leans forward, gaze to chair, hand extended to chair-->
02       *I need to feel safe.*(0.3)+I need to feel (0.5) confident
      t  *gaze to J-->        *brings hand in, leans off camera-->
      j                              +gaze to T-->
03       that if I'm enthusiastic I won't get slapped down.
04            (1.1)
05  TH:  * >Howdu you< + react, * to that,
      t  *points to J ----------*
      j  -->gaze to T  +lowers gaze-->
06            (0.4)
07  TH:  thee adult (0.2) here and now you.
      j  (noticeable blinking, lowered gaze, downturned mouth)
08           (11.7)
      j  (in/exhale, opens/closes mouth/swallows, holds breath)
09  TH:  Make sure + you breathe
      j            +gaze to T-->
```

```
010              (0.7)
       j  (quick nod, lowers gaze towards empty chair)
011  TH:  kay?
012              (0.4)
013  JE:  .HHhhh
       j  (deep inbreath through nose, lowers head)
014              (9.3)
       j  (slow visible outbreath, raises head, gaze downward)
015  JE:  What's the + question=Hhh
       j              +brief smile,exhales, buries face in hands-->
016              (2.0)
017  TH:  How do you react to that little girl saying that I
018       need to be kept safe.
       j  -->keeps face buried in hands-->
019              (1.5)
```

During lines 01-04, the therapist summarizes the little girl's unmet needs as feeling safe and confident, and not getting slapped down when she becomes enthusiastic. Throughout, Jennifer's closed hands are together on her lap, her legs are crossed, and her shoulders are slightly slumped, leaving an impression of a body folding in upon itself. The therapist then produces an information request (`>Howdu you< react, to that, …` – lines 05, 07), thus creating an emotionally challenging situation for Jennifer as she is being asked to respond to the vulnerability felt by her former self (i.e., not feeling safe or confident and repeatedly "slapped down"). By being directed to react to these painful past experiences, Jennifer distress becomes more pronounced. Jennifer's mouth is now downturned, and she noticeably blinks, as if holding back tears, then lowers her gaze. Instead of answering, which would be a next relevant action, an extended silence ensues (11.7 seconds: line 08), and Jennifer's displays of distress intensify. Her eyes appear almost closed; she releases a slow, visible in/outbreath, further compressing her body inward (cf. Clift, 2014 on *visible deflation*). Continuing to keep her head directed

downward and otherwise holding her body still, she opens and closes her mouth, then swallows. Tightening her mouth, her breathing is no longer visible.

At line 09, the therapist isolates this singular feature of the distress display with "Make sure you breathe", produced in imperative format. This affiliative directive potentially offers Jennifer relief from her displayed distress, while simultaneously licensing Jennifer to proceed with chair work at her own pace. The progressivity of talk is momentarily suspended, as Jennifer aligns with the therapist's directive with a quick nod (line 10), then breaths deeply through her nose (line 13). Though her distress display continues through another extended 9.3 second pause, Jennifer eventually attempts to reengage with chair work through a clarification request "What's the question=Hhh" (line 15), accompanied with a brief smile. Just as laughter may not necessarily reflect positive affect (see Potter & Hepburn, 2010), smiling can and frequently does occur in moments of upset. A heavy outbreath is tagged onto her question, followed by Jennifer burying her face in her hands. Following another extended pause (2.0 seconds, line 16), the therapist reinitiates talk and returns to the therapeutic line of enquiry (lines 17-18) through a modified repeat of lines 05, 07.

An example of a client's frustrated efforts in continuing with own turn is shown in Extract 9, which is a continuation of Extract 2, our first example of high intensity distress. This extract shows how abatement is used when clients cannot seem to go on with their turn and how abatement is used to promote progressivity in the long term.

Extract 9 – Emotional Intensity Modulating Directives – Abatement

EX 9: Sofia, Session 7 at ~54:30

```
019  SO:   ~an I~          +(0.5) ~that I, (h)had~
       s   -->crying face   +tilts head, furrowed brow, eyes down-->
```

```
020              (1.9)
021  SO:   ~I was (un)able +to enjoy .h.h.h. you.~ (0.3)
       s                   +brings tissue to eyes, then wipes nose
022        + ~only~ (0.3) s'only t- (0.2) hh
       s   +lowers tissue to lap, plays with tissue-->
023             (0.3)
024  TH:   uh huh,
025              (*0.5)
       s          *gaze to T, sharply downturned mouth-->
026  TH:   °uh huh.°.
027  SO:   .snif + [°.h.h°
       s          +brings tissue to nose, gaze to T-->
028  TH:          * [st'Take a breath.
       t          *leans forward, brings hand to upper chest-->
029             (0.6)
030  SO:   .h.h.((blows nose)) pardon? * Hh=
       s   (holding tissue over nose and mouth, audible exhale)
       t                                 *both hands to chest-->
031  TH:   =Take a breath.
       t   -->slight fluttering of hands in front of chest-->
032        (0.5)
033  TH:   + >°cuz°=there's a lot of< fe:eling * here.=
       s   +wipes nose (downturned mouth, flushed face)
       t                  -->flutters hands--->*
034  SO:   =.SNif
035  TH:   +* so take a breath*
       s   +lowers head and gaze--> (sharply downturned mouth)
       t    *flutters hands    *
036  SO:   .hhh
       s   (visible deep inbreath, raises shoulders)
037              (0.8)
038  SO:   ruaHHh
       s   (visible exhale, shoulders deflate)
```

Here we return to Sofia, in her seventh session, and further examine a client displaying higher intensity emotion. From line 19 onwards, we see Sofia's emotional intensity mounting, as she addresses her deceased father and expresses the regret she feels at never being able to enjoy his company. Her voice is tremulous, and her turn is regularly broken up through pauses, cut-offs and brief bouts of sobbing. At the end of line 22, Sofia

appears unable to continue her turn, thus conveying the hardship involved in addressing her father and simultaneously regulating her emotions, which appear to be overwhelming her. Thus, Sofia's distress seems to be occasioned by voicing her regret at not having been able to fully enjoy her father while he was still alive (*unfinished business*). In response, the therapist delivers a *continuer* in line 24 (Schegloff, 1982), encouraging Sofia to resume speaking. During a subsequent 0.5 second pause Sofia turns her gaze to the therapist, who softly provides another "`°uh huh.°`" (line 26). Sofia sniffles, bringing a tissue to her nose, while taking two soft quick in-breaths. In overlap, the therapist draws attention to Sofia's erratic breathing, by leaning forward and bringing her hand toward her own chest and directing Sofia to "`st'Take a breath.`" (line 28). Sofia's momentary attention placed on retrieving a tissue to blow her nose may have contributed to a mishearing and Sofia's subsequent clarification request (`pardon? Hh` – line 30), prompting the therapist to repeat "`Take a breath.`" (line 31), this time accompanied by a slight fluttering of her hands in front of her chest, resembling a palpitating motion, and provides an account "`>°cuz°=there's a lot of< fe:eling here.`" (line 33). Through this account, the therapist herself affirms that the *take a breath* directive is a possible conversational device to give the client space to regain control of her emotion by focusing on her breathing, thus sanctioning a pause in the therapeutic intervention of chair work. After another abatement directive in line 35, Sofia seems to comply by taking a deep inbreath, followed by a forceful outbreath (lines 36 and 38).

In sum, emotional intensity modulating directives of sustainment and abatement work to help clients regulate their emotions by drawing attention to their heightened emotional displays. These directives make temporal adjustments to the *progressivity of*

the current sequence in different ways (Stivers & Robinson, 2006). Whereas sustainment directives work to *maintain* the client's level of emotional experiencing, abatement directives temporarily *suspend* the emotion-focused dialogue when clients emotionally flood out.

Discussion

In describing the main principles of emotion intervention in EFT, Greenberg (2010, p.35) states that "change occurs by helping people make sense of their emotions through awareness, expression, regulation, reflection, transformation, and corrective experience of emotion in the context of an empathically attuned relationship that facilitates these processes." This study has examined how some of these emotion intervention practices may operate from an interactional point of view. In particular, we have shown how displays of client upset are sequentially managed both in terms of how upset may be occasioned by prior or concurrent talk, but also in terms of therapist responses as ways to explore and regulate emotion. This three-part structure – 1. Occasioning upset; 2. Displaying upset; 3. Responding to upset – provides a practical interactional frame for understanding how upset emerges, develops, and is negotiated through talk (Hepburn, 2022).

In most of our extracts, upset was occasioned by therapist actions. This occasioning was facilitated by therapists *touching an already exposed nerve*; for example, drawing attention to problems in the here and now through formulations or interpretations, modeling self-critical statements directed to (client's) self during two-chair work. Distress was also found to be launched in-the-moment, as when Sofia voiced her regret to her deceased father. Upset displays performed various kinds of interactional work. First,

they can be seen as being *responsive* to prior actions: therapists drawing attention to a problem (touching an exposed nerve), hearing a self-critical voice (being directed at oneself), and conveying grief, regret, remorse to someone in the here and now. Emotional displays also occasion or mobilize a next action (provide *next opportunities*), depending in part on the intensity of the distress. These next actions from the therapist, for example, would draw attention to the emotional display either by noticing it or by guiding elaboration/exploration of here and now emotional experience through emotional immediacy questions. When distress levels become severely heightened, as for example during chair work, therapist would modulate this intensity in two ways. Whereas *sustainment* directives convey to the client that the level of intensity is right and work to maintain or extend *progressivity of the sequence* (Stivers & Robinson, 2006), *abatement* directives suspend progressivity by directing clients to momentarily regulate emotional intensity, in order for them to continue with emotional-laden talk.

These therapist directives illustrate the specific *emotion-focused* aims of therapy and show how these are markedly different from other institutional contexts where intense emotional displays may surface. For example, we argue that our findings of "Take a breath*."* directives extend understanding of comparable abating directives such as "Take your time*."*, which are commonly found within police interviews with alleged sexual assault victims, child protection telephone calls and reality television, but are absent in analysis of mundane crying in a non-institutional setting (Antaki et al, 2015; Hepburn & Potter, 2007, 2012). By responding with *take your time*, therapists, as recipients of wet sniffs, crying, or extended silence, grant speakers license to proceed at their own pace, thus delaying progressivity by evoking an interactional feature external to the client, that

of *time*. By comparison, *take a breath* directives orient to progressivity by focusing on and drawing attention to a feature of in-the-moment distress embodied by the client — erratic or suppressed breathing. Whereas *take your times* seem to orient to emotion, thus *delaying* the main business of talk and provide a temporary sanction for this delay (e.g., the reporting of the trouble, Hepburn and Potter 2007), a *take a breath* directive orients to embodied emotion *as* the main business of the interaction, emotion as something to be addressed and worked through, while still preventing the emotion from gaining the upper hand.

To conclude, we argue that therapist responses to client upset, in general, index a certain institutional *fingerprint*. In contrast to other institutional contexts identified above (e.g., police interrogations, caller help lines), upset is *not* disruptive for doing (emotion-focused) therapy, but is part and parcel of it. Further, this study also reveals a certain institutional *blueprint*. Our analyses show the variety of response practices that therapists may draw from for further exploring distress, pinpointing its relevance (for the client's life) and, potentially, for moving forward.

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Appendix: Transcription conventions

Symbol	Meaning
+	start/stop of action by client
*	Start/stop of action by therapist
-->	action continues
(1.5)	silence measured in seconds
.hhh	audible inhalation, # of h's indicate length
hhh	audible exhalation, # of h's indicate length
heh/huh/hah/hih	laugh/cry particle
wo(h)rd	laugh/cry particle inserted within word
~word~	tremulous/wobbly voice through text
.shih/.snif	wet sniff
huhh.hhihHuyuh	sobbing
>hhuh<	sobbing—if sharply inhaled or exhaled
((cough))	audible non-speech sounds