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Sarah Knox
Marquette University, sarah.knox@marquette.edu

Clara E. Hill
University of Maryland

Graham Knowlton
Marquette University

Harold Chui

Nathan Pruitt
Marquette University, nathan.pruitt@marquette.edu

See next page for additional authors

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Sarah Knox
Department of Counselor Education and Counseling Psychology, Marquette University;
Clara E. Hill
Department of Psychology, University of Maryland
Graham Knowlton
Department of Counselor Education and Counseling Psychology, Marquette University
Harold Chui
Department of Educational Psychology, The Chinese University of Hong Kong
Nathan Pruitt
Counseling Center, Siena College
Kevin Tate
Department of Counselor Education and Counseling Psychology, College of Education, Marquette University

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Crying often reflects deep sadness, anger, desolation, and empathy. When it occurs in the presence of another person, however, it also involves a communication between those two people (Nelson, 2008). Psychotherapy is a particularly intriguing context for examining such communication, as it frequently includes the expression of intense emotion and "bids" for something from one person to the other (e.g., support, compassion). When therapists cry in the presence of clients, what do they communicate? What do clients communicate when they cry? Of particular interest in the present study was examining these phenomena from the perspective of the different roles in therapy: as the therapist crying with a client, as a client crying with a therapist, and as a client when one's therapist cries. Thus, our overarching question focused on the experience of crying in therapy, whether as a therapist or a client.

Theory About Therapist Crying

Much of the psychoanalytic literature cautions against therapist crying, given the desire for therapists to be a blank slate and concerns that such crying would distract the client and turn the focus to the therapist. Beck, Rush, Shaw, and Emory (1979) warned that therapist crying must be carefully monitored, and may be best done only by experienced therapists "who knew when to give vent to their own feelings" (p. 41). More recently, McWilliams (1994) stated that the psychoanalytic couch helps the therapist hide her/his tears, for the therapist who sits behind the patient "may weep without worrying that the patient will be distracted . . . by the therapist's emotional reactivity" (p. 242).

Those espousing nonpsychoanalytic orientations offer a different perspective. Nelson (2008)suggested that therapist crying must be delicately attuned to the client's attachment needs. In the context of a strong connection with the client, and when the therapist's strength and availability as a care-taker are assured, therapist crying may be experienced by the client "as a deeply empathic response that draws therapist and [client] closer together" (p. 211), or as Van Heukelem (1979)described, "a beautiful way to communicate caring and shared humanity" (p. 90). However, if the client senses therapist fragility, or if the client is a compulsive caregiver highly attuned to others' neediness, therapist crying may overwhelm, unsettle, or distance the client.

Anecdotal Literature About Therapist Crying

Counselman (1997) described her work with a couple, in which the wife became ill with terminal cancer. When Counselman heard of the wife's cancer, she was "shocked and speechless; [she] felt tears come to [her] eyes" (p. 235). Because Counselman's mother had died of cancer, she acknowledged her fear that, should she allow herself to cry in session, she would not have been able to stop, illuminating her own countertransferential reaction. During a later session in which Counselman learned that the wife's chemotherapy was not working, both Counselman and the wife cried, tears that now "felt natural and were for [wife], not my mother" (p. 236). Reflecting on the event, Counselman stated that she "'decided to be open and real' with the couple, which encouraged them to be open and real with each other. [She] learned not to fear crying with a client" (p. 237).

Alden (2001), who was herself blind, described working with a woman in her early 50s who had broken her neck and was now paralyzed. As the client cried, Alden wiped away the client's tears with her finger, stating that to do so with a tissue would have felt too cold and impersonal. Alden was "incredibly moved and humbled and deeply felt the tragedy of this woman. I can still feel my own tears now, so many years later, flowing just as they did when I sat with her" (p. 100). In reflecting on her crying, Alden acknowledged "the desperate need of this woman and my own sense of humility and inadequacy" (p. 100), again perhaps reflecting a countertransferential response based on shared physical challenges.

Rhue (2001) described her work with a 16-year-old female client struggling with depressive symptoms related to her younger sister's accidental death. At first, Rhue fought the tears, fearing that they would overwhelm or frighten the client, or create more guilt for the client, who had been babysitting her younger sister at the time of the accident. As her relationship with the client strengthened, Rhue allowed some of her tears, telling herself "that the fight to withhold them was a losing one and presented an unreal lack of emotion . . ." (p. 123). When Rhue asked how her client felt about the tears, Rhue was surprised to learn that the client believed that the tears meant that Rhue was really listening.

Owens (2005) presented her work with a 13-year-old boy who, at age 5, had become a quadriplegic because of an auto accident. When the client described the accident, Owens was "wracked with feelings of sadness and helplessness . . . my eyes were filled . . . I was close to tears, and I made an instant decision not to fight them back" (p. 294). Her client noticed the tears and appeared concerned. She stated that the client's ability to register her tears was important for him, for the client "managed to get his message through" (p. 300) by moving Owens to tears.

Across these anecdotal vignettes, we see that therapists often cry because they are deeply moved by clients' struggles, struggles that may parallel therapists' own life experiences. They may initially seek to suppress the tears, but then let them come as a visual testament to their own realness and humanity, and as a demonstration of their caring for their clients. Their tears may, in fact, communicate this humanity and caring more powerfully than can words.

Empirical Literature About Therapist Crying

The extant empirical literature also illustrates that therapists at least occasionally cry when working with clients. Pope, Tabachnick, and Keith-Spiegel (1987), for instance, reported that 56% of therapists have cried with clients and do not find such behavior to be unethical.

In an informal survey of crying, Nelson (2005) found that actual crying occurs on few and usually quite memorable occasions in therapists' professional lives. She suggested that therapists might often feel like crying but suppress their tears in session, fearing that their tears would interfere with clients' experience, thinking that crying would threaten clients' ability to trust in and rely on the therapist as a caregiver, would upset clients, and would be experienced by clients as evidence of therapist neediness. In a more positive light, Nelson concluded that therapist crying may express the deep connection a therapist feels with a client . . . "a visible, visceral acknowledgment of attachment . . . [demonstrating that the therapist] is maximally attuned . . ." to the client (p. 180).

More recently, Blume-Marcovici et al. (2013) conducted a survey of therapists' experiences with and attitudes toward therapists' crying in therapy. Among their 684 U.S.-based psychologists, 72% reported having cried at some time with clients. Those who noted a higher tendency, proneness, and frequency of crying in their daily lives were more likely to have cried in therapy. Although women reported crying more in their daily lives than did men, there were no gender differences in crying in therapy with clients. Cognitive–behavioral therapists cried at similar rates in their daily lives as dynamically oriented therapists, but cried less in therapy. In addition, although older therapists cried less in their daily lives than younger therapists, they reported crying more in therapy. Therapists' crying in therapy was perceived to positively influence the therapy relationship, given the sense of authenticity and caring reflected between client and therapist. When the few deleterious effects arose, therapists believed that a role reversal had been evoked by the therapist crying.

In a follow-up study, Blume-Marcovici, Stolberg, and Khademi (2015)surveyed 411 psychologists and trainees regarding their most recent experience of crying in therapy with clients. The researchers found that crying occurred with a diverse group of clients (children, adolescents, and adults, all with a range of diagnoses), happened throughout therapy, and usually occurred when clients were crying. Therapists most often reported feeling sad while crying, and grief was most often the topic of discussion. In 55% of these experiences, therapists thought that clients were aware of the crying, and those therapists who discussed their crying with their clients reported improved rapport as a result of the crying.

Tritt, Kelly, and Waller (2015) surveyed 105 clients with eating disorders whose therapists had cried in therapy. Such crying was generally experienced positively, but clients more often reported a positive impact of crying (greater respect of clients for therapists, increased likelihood of clients expressing emotion, and greater likelihood that clients would engage in therapy in the future) when therapists had a positive demeanor (happiness, firmness, and consistency) rather than a negative demeanor (bored, anxious, and angry).

Blume-Marcovici, Stolberg, Khademi, and Giromini (2015) also examined training and supervision related to therapist crying. The overwhelming majority (96.5%) of their 686 psychologist and trainee participants indicated that psychologists should be trained how to manage their emotions, but only 36.4% had actually received such training. Half had discussed crying as therapists in therapy with a supervisor, whereas one-quarter had never discussed their most recent therapist tears with anyone.

Across these studies on therapist crying, then, we know that most therapists reported at some point having cried with at least one client, did so with a range of clients in terms of age and diagnosis, and that crying occurred across the course of therapy. Therapists reported crying when they were deeply moved or touched by clients or in conjunction with client crying. The crying evoked feelings of sadness and grief. Moreover, therapists thought that the clients were usually aware that they were crying. In addition, therapists often initially sought to stifle their tears, but later allowed themselves to cry in session. Dynamically oriented therapists and older therapists reported crying more often did than their counterparts. The impact of therapist crying was mostly perceived to be positive, with negative effects associated with role reversal (e.g., attention switched from client to therapist). Finally, few therapists had received training regarding crying in therapy.

Limitations of this research nevertheless exist: The surveys, which are the predominant method used, did not examine the internal experience of crying in therapy, and thus do not capture the lived phenomena of those who cried. Other approaches, particularly qualitative research, might elicit richer and more detailed information about such experiences. Much of the nonsurvey research relies on anecdotal or single-case data, and therefore does not illuminate potential patterns of crying across participants. We also suspect that therapists might become more comfortable with crying as they gain experience, but found no empirical studies examining this idea. Thus, despite evidence that the majority of therapists at some point cry in the presence of clients, the phenomenon remains surprisingly unexamined in the literature (Blume-Marcovici et al., 2013). Such events may have a profound influence on the therapy process, and are thus worthy of examination.

Theory About Client Crying

Clearly, crying in therapy is not an unusual experience for clients (Nelson, 2008; Robinson, Hill, & Kivlighan, 2015; Van Heukelem, 1979). Such crying is often considered a barometer of client involvement in therapy, in that crying enables clients to access their emotions and suggests the onset of healing (Robinson et al., 2015). These emotions may also reflect physiological reactions to environmental stimuli that help people determine whether to fight, flee, or remain nonreactive, and are also involved in cognitions and behaviors (Robinson et al., 2015).

Nelson (2005) theorized that when clients cry in therapy, client and therapist engage in a direct experience of attachment and caregiving. Such crying may illuminate clients' earlier attachment-related experiences, as well as their here-and-now attachment with the therapist, who ideally serves as a secure base (Ainsworth, Blehar, Waters, & Wall, 1978) from which clients explore and experience their emotions.

Nelson (2005) also proposed three different types of crying, distinguished by what each is seeking to elicit (empirical support was provided for different types of crying by Robinson et al., 2015). In inhibited crying (noncrying), the crier wants to avoid acknowledgment of the loss and withdraw from the affective experience related to the loss. When inhibited criers do cry, they often stifle their tears, and may reflect avoidant attachment styles, as they seem not to trust their caregivers. Thus, when an inhibited crier does cry with the therapist, such behavior may indicate that the client finally feels safe in the therapy. In the second type of crying (i.e., protest or angry crying), the crier refuses to accept loss and wants others to make the pain disappear. As an example, Nelson (2005)described that expressing tears of protest may resist an employer's harsh remarks, demanding via the nonverbal crying that the unfair treatment cease. Such tears are often perceived by others as angry or bitter, and may push others away. Nelson (2005) linked this type of crying to an anxious-ambivalent attachment style and an indication that the client fears rejection by the therapist. Finally, in sadness or despair crying, clients acknowledge that they cannot avoid loss, and through the crying actually come to accept the loss. Such crying in therapy allows clients to experience their grief with the therapist and tacitly invites the therapist to comfort the crying client and show compassion. Nelson (2005) related this type of crying to a secure attachment style.

Based on their theoretical foundations, specific approaches to therapy also place high value on client expression of emotion, one type of which is crying. In emotion-focused therapy (Greenberg, 2004), for

instance, therapists help clients explore, experience, and regulate their primary or secondary emotions. According to Greenberg (2004), the former reflect an individual's unfiltered responses to a situation (e.g., grieving a loss), whereas the latter denote the thoughts, expectations, and defenses we construct to avoid feeling those primary emotions (e.g., crying when angry). Therapists using emotion-focused therapy thus seek to help clients discern the origins of their secondary crying and foster the expression of the primary crying.

Practitioners of short-term dynamic therapy (McCullough et al., 2003) also focus on emotion regulation by helping clients experience anxiety-provoking affects and teaching them self-regulation techniques to experience the affect in the safety of the therapy relationship. Therapists help clients remove defenses to affect, express feelings appropriately, enhance relationships with others, and improve their self-image, with the ultimate goal of clients allowing themselves to cry when sad and laugh when happy (Robinson et al., 2015).

Empirical Research About Client Crying

Linton (1985) examined a client with severe anxiety, difficulties with emotional expression, and an inability to cry. After viewing videos of crying and engaging in role-plays of crying, the client became desensitized to the affect and was then able to cry; in addition, she learned to regulate her emotions and lessen her anxiety. Using a case study design to examine a client's excessive crying, Crits-Christoph et al. (1996) found that the parents used the client's crying to avoid their own conflicts. Mahrer, Fairweather, Passey, Gingras, and Boulet's (1999) study of 15 sessions of psychotherapy found that, in the presence of strong client feelings, therapists tried to (a) intensify the feelings in either the therapy relationship or the client's sense of self, (b) neutralize the feelings by diffusing them or avoiding confrontation, (c) resolve the feelings by teaching coping skills or normalization, (d) develop the emerging material by exploring affect, or (e) enhance insight and understanding of the feelings. Seeking to empirically test Nelson's (2005) proposed different types of crying (see above), Robinson et al. (2015) had trained judges assess the intensity of inhibited, protest, and despair crying in 347 crying episodes for 40 clients working with 14 therapists in 1,074 therapy sessions. Crying itself occurred once every seven sessions, was most often protest or inhibited in type, and was influenced by client and therapist attachment styles. Finally, Zingaretti, Genova, Gazzillo, and Lingiardi (2017)'s survey of 55 clients found that most (86%) had cried during therapy, and did so approximately once per month. The majority (69%) discussed the crying with their therapist, and half thought that the crying positively affected the therapy relationship. The therapy process was similarly enhanced if clients perceived the crying as a moment of self-understanding or realization that enabled integration of the experiences and feelings related to the crying.

As with the literature on therapist crying, limitations exist here as well. Nelson's (2005) suggestion of links between different types of crying and attachment is based on terms and instruments used in infant, rather than adult, attachment research, and thus may not reflect emotion-regulation strategies used by adults. Mahrer's et al. (1999) work addresses a range of emotions, and thus dilutes a specific focus on crying. Furthermore, as with therapist crying, qualitative research could be helpful for providing a more in-depth examination of the phenomenon of client crying.

Current Study

We sought to build on the existing literature and expand our understanding of therapist crying in psychotherapy, whether in the therapist or client role. In fact, one unique contribution of this work is that we deliberately examined the phenomenon of crying from these different perspectives, for crying may be experienced quite differently depending on the role/position of the crier. Participants as therapists, for instance, may have quite divergent thoughts and feelings about their crying in that role than they do when crying as clients in their own therapy, or when their own therapists cry with them in therapy. Furthermore, having found therapists-in-training quite thoughtful, reflective, and willing to discuss such experiences, we deliberately sought trainees as our participants, as has been the case with other recent research (Hess et al., 2008; Hill et al., 2015; Hill, Sullivan, Knox, & Schlosser, 2007; Stahl et al., 2009). In addition, by having doctoral students as participants, we could begin to examine the role of therapist experience, in that doctoral students may have different experiences crying as therapists than do the more experienced practitioners with whom they work.

We used a qualitative method, specifically consensual qualitative research (CQR; Hill, 2012), to investigate this phenomenon deeply and rigorously. Using semistructured interviews, we asked participants about three specific experiences: a time when, as a therapist, they cried when providing therapy to a client; a time when, as a client, they cried in therapy; a time when their therapist cried when providing therapy to them. In each such experience, we examined the antecedents to the crying, the crying process itself, and the consequences of the crying, in this way "getting inside" the phenomenon and allowing the voices of those who had experienced such crying to emerge in ways that the extant literature does not capture. Our goal was to deeply examine the experience of crying in psychotherapy, from both therapist and client perspectives.

Method

Participants

Eighteen (15 women and 3 men; 16 European American, 2 Latina, 1 Black, 1 Indian, and 1 Jewish [nonmutually exclusive]; ranging in age from 24 to 44 years old [*M* = 30.17; *SD* = 5.64]) U.S. doctoral students (12 in counseling psychology and 6 in clinical psychology) were interviewed by phone. They had completed between 0 to 11 semesters of practicum/clinical training (some were in their first semester of seeing clients; all had seen at least one client; *M* = 5.67; *SD* = 3.34) and had seen between 1 and 300 clients in varied clinical settings (*M* = 67.12; *SD* = 77.99; community clinics, independent practice, university counseling centers, and VA medical centers). They espoused varied theoretical orientations (integrative/eclectic, interpersonal, person-centered, and psychodynamic), had seen between one and five therapists (*M* = 3.11; *SD*= 2.05) for between 40 and 300 sessions (*M* = 118.33; *SD* = 90.31), and reported those therapists as having a range of theoretical orientations (CBT, humanistic, interpersonal, psychodynamic, solution-focused, and systems). Ten described experiences of crying themselves as therapists when providing therapy to clients; 15 described experiences of crying as clients in their own therapy; six described experiences of their therapist crying when providing therapy to them.

Interviewers and Judges

Three researchers interviewed participants and served as judges on the primary team. Two were female counseling psychology professors (a 55-year-old European American and a 68-year-old European American); one was a 30-year-old European American male student in counseling psychology doctoral program with which the first author was affiliated. Three auditors were also part of the project (a 34-year-old Asian male assistant professor trained in counseling psychology, a 40-year-old European American male counseling psychologist on staff at a university counseling center, and a 40-year-old European American male assistant professor in counselor education). All were authors of the study. All had prior experience with CQR, and had worked with at least one other member of the team on prior research projects. Thus, the team enjoyed strong professional relationships with each other. To assess the consensual process, the primary team periodically discussed how the project was proceeding and attended to any concerns or questions. The authors' biases appear in Appendix A.

Measures

Demographic form

The demographic form asked for age, sex, race/ethnicity, professional psychology program/degree and training experience, as well as information regarding participants' experiences as psychotherapy clients (e.g., number of therapists seen and number of sessions). Finally, participants were asked to give their name, phone number, and e-mail address so that a researcher could contact them to schedule the interview.

Interview protocol

All researchers contributed questions for the protocol and participated in revising it consensually. The preliminary protocol was piloted on two nonparticipant volunteers who met the participation criteria, and then modified based on their feedback. The resulting semistructured protocol (i.e., each participant responded to a standard set of questions, and researchers pursued additional topics based on participant answers) began by asking participants warm-up/contextual questions (e.g., overall comfort with crying both outside and within therapy and thoughts about therapists crying in therapy) that are not included in the findings reported here. The interview then moved to the three specific examples of crying in therapy (i.e., when participants as therapists cried in therapy, when participants as clients cried in therapy, and when participants' therapists cried during the participant's therapy). For each specific example, we asked participants to discuss the antecedents to the crying, the crying itself, and the consequences of the crying. The interview closed with questions regarding why participants chose to take part in the study, and their experience of the interview. See the complete protocol in Appendix B.

Procedures for Collecting Data

Recruiting clients

We recruited participants through our professional relationships at universities with which we are/were affiliated or have contacts. The graduate student on the primary team sent potential participants information regarding the study, including the interview protocol, the demographic form, and the informed consent, to multiple sources (e.g., researchers' professional networks, who then often sent it on to their colleagues/networks). Those who chose to take part returned the completed demographic and consent forms to the first author, who assigned participants to one of the

researchers for the interview. Potential participants were told that the study would examine the phenomenon of therapists crying in therapy, whether in the therapist or client role; the types of experiences they would be asked to discuss (they were welcome to participate if they did not have each type of experience, as was the case with some participants who were early in their therapy training); and the approximate time requirements for participation. Inclusion criteria were that participants had to be doctoral students enrolled in clinical or counseling psychology programs who had the experience of crying in psychotherapy, whether as therapist, client, or both, or whose therapists had cried with them in therapy.

Interviewing

Each of the three members of the primary team conducted the audiotaped phone interview with between five to seven participants; interviews lasted between 45 and 75 min. Participants affiliated in any way with a researcher's institution were interviewed by a team member from the other institution.

Transcripts

All interviews were transcribed verbatim (other than minimal encouragers, silences, or stutters). Any possibly identifying information was removed; each participant was given a code number to protect confidentiality.

Procedures for Analyzing Data

Data were analyzed using CQR (Hill, 2012). In CQR, research team members reach consensus through open discussion of data classification and interpretation as they move through the three steps of analysis (domain coding, in which data are organized into topic areas; core ideas, in which data in each domain for each participant are abstracted to capture their essence; and cross-analysis, in which core ideas within each domain but across cases are analyzed to illuminate common themes). The three members of the primary team analyzed all cases together as a team. Rotating teams of two auditors reviewed each step of the data analysis. To ensure trustworthiness and reliability, the primary team returned to the transcribed interview data to resolve any questions of interpretation.

All participants received a draft of the study's results and were asked to ensure that their confidentiality had been maintained. Six participants responded, and none expressed any concerns about confidentiality; their minor editorial suggestions were incorporated into the manuscript.

Results

We followed CQR guidelines in labeling category frequencies (Hill, 2012). Findings that emerged in all or all but one case were labeled general, those that emerged in more than half of the cases (and up to the cutoff for general) were labeled typical, and those that emerged in at least two and up to half of the cases were labeled variant. Note, however, that because only six participants described a time when their therapist cried during one of their sessions, general categories consisted of all six cases in those incidents. Findings that emerged in only a single case were not included in any of the analyses. Finally, because of space limitations, we report variant findings only in the tables, unless a domain consisted only of variant categories.

Participants Crying as Therapists

Of the 18 participants, 10 described crying as a therapist with a client (see Table 1).

Table 1
Domains, Categories, and Frequencies of Findings Regarding Participants Crying as Therapists

Immediate antecedent/trigger to P crying as T	
C discussing distressing personal event	Variant
P and C discussing end of PT	Variant
Participants' thoughts, feelings, or actions when felt tears coming or when cried	
P worried about impact/questioned appropriateness of crying	General
P felt emotional connection with C	Typical
P initially wanted to remain in control of emotions	Typical
P felt comfortable/genuine with own tears	Variant
Participants' thoughts about client reactions before/during crying	
P thought C felt emotional connection with P	Typical
C felt comfortable with P tears	Variant
C initially surprised by P tears	Variant
Extent of crying	
Minimal	General
Reasons for crying	
Because P felt empathic connection	General
Because of countertransference	Typical
Consequences of crying	
Enhanced PT relationship	General
Deepened PT work for C	Typical
P gained self-insight/self-awareness	Variant
Discussion with others about crying	
Discussed with supervisor	Typical
Discussed with C	Variant
Discussed with colleagues/peers/own therapist	Variant
Reflections about crying	
Appropriate to cry	Typical
What P would do differently	
Talk more about event with C	Typical
Nothing	Variant

Note. $N = 10$; General categories = 9–10 cases; Typical categories = 6–8 cases; Variant categories = 2–5 cases; C = Client; P = Participant; PT = Psychotherapy; T = Therapist; Bold = Domain; Nonbold = Category.

Table 1. *Domains, Categories, and Frequencies of Findings Regarding Participants Crying as Therapists*

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Participants' thoughts about client reactions before/during crying	
P thought C felt emotional connection with P	Typical
C felt comfortable with P tears	Variant
C initially surprised by P tears	Variant
Extent of crying	
Minimal	General
Reasons for crying	
Because P felt empathic connection	General
Because of countertransference	Typical
Consequences of crying	

Enhanced PT relationship	General
Deepened PT work for C	Typical
P gained self-insight/self-awareness	Variant
Discussion with others about crying	
Discussed with supervisor	Typical
Discussed with C	Variant
Discussed with colleagues/peers/own therapist	Variant
Reflections about crying	
Appropriate to cry	Typical
What P would do differently	
Talk more about event with C	Typical
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Note. *N* = 10; General categories = 9 –10 cases; Typical categories = 6 – 8 cases; Variant categories = 2–5 cases; C = Client; P = Participant; PT = Psychotherapy; T = Therapist; Bold = Domain; Nonbold = Category.

Client demographics

According to the participants, most of the clients with whom they cried were female (*N* = 7); ranged in age from 18 to early 50s; four were European American, and one each was African American, Korean American, Latino, and Vietnamese American. Clients were seeking therapy for a range of concerns, including depression/anxiety (*N* = 7), interpersonal concerns (*N*= 4), substance abuse (*N* = 3), trauma (*N* = 3), and other (*N* = 3). They were seen at university counseling centers (*N* = 3), community mental health centers (*N* = 2), department clinics (*N* = 2), and independent practice (*N* = 1). Therapy ranged from 1 session to 2.5 years.

Immediate antecedent/trigger for participant crying as therapist

In the first of two variant categories, participants noted that prior to their crying, the client had been discussing a distressing personal event. In one case, the client was discussing her mother's death, father's cancer, and fears of becoming an orphan, all of which left the therapist "heartbroken." In the second variant category, the therapist and client were talking about feelings regarding the impending end of therapy. As an illustration, the end of therapy was hitting one client hard and making him sad. His therapist was "taken aback" at how openly the client expressed his sadness about the therapy ending, and also sensed that the client may have felt abandoned.

Participants' thoughts, feelings, or actions when felt tears coming or when cried

Generally, participants worried about the impact of their crying or questioned the appropriateness of the crying. One participant feared that his crying would "freak out" his client and take the focus away from the client. Another participant worried that she would get "in trouble" with her supervisor for being too disclosing and too "unboundaried" by crying. In addition, participants typically reported feeling an emotional connection with their clients during the crying event. In one case, the participant, after the client described what had been going on for him, felt "no wonder he's [client] so anxious and depressed." In another case, the therapist felt his client "slipping away" and wanted to throw his arms around the client, demonstrating his depth of emotional investment in the client. Typically, therapists also wanted to remain in control of their emotions, as demonstrated by the participant who felt she "needed to keep it together," and by another who thought, "Don't let her see that you're tearing up."

Participants' thoughts about client reactions before/during crying

Typically, participants perceived that their clients felt an emotional connection with them during the crying event. For example, one participant speculated that her client felt heard, accepted, understood, and cared for; another described his client's facial expression during the event as communicating an "unspoken mutual connection."

Extent of crying

Generally, the participants' crying was minimal. Participants described their crying as "brief . . . a few tears," "tears welling up in the corner of [my] eyes," with no "bawling, sobbing, or hiccupping."

Reasons for crying

Generally, participants stated that they cried because they felt an empathic connection with the client. One noted that he could "relate to the client's inability to express [his] emotions" because of masculinity concerns; another stated that she "may have been crying for both of them" and wanted to express the sadness that the client could not. Typically, participants also acknowledged that they cried because of countertransference. In one case, the participant related to her client feeling criticized by her mother because the participant had similar experiences with her own mother; in another case, a participant stated that his "personal issues got triggered," which helped him be more empathic toward the client.

Consequences of crying

Generally, participants felt that their crying enhanced the therapy relationship. For instance, several participants noted that the crying helped them feel more connected with their clients. One participant stated that her crying made the client realize how much the client and the therapy meant to the participant and that the participant was not simply "doing her job." Typically, the crying event also deepened the therapy. As an illustration, after the therapist's crying, one client seemed more comfortable expressing her emotions, which made the therapy deeper and "more real." Another said that after the crying, his client "took the therapy more seriously" and was more committed to "being present."

Discussion with others about crying

Participants typically discussed the crying event with their supervisors. One participant recounted the event to his supervisor a week later, but "no big deal" was made of it; another talked with her supervisor, who normalized the crying and saw it as "a very human reaction."

Reflections about crying

Participants typically felt that it had been appropriate to cry. One stated that it was a "human" event; another asserted that it is okay for therapists to be vulnerable; a third noted that her tears were an "appropriate nonverbal way to communicate her care for the client," and that it was more difficult to ignore or discount crying than if she had simply said, "I care for you."

What participant would do differently

Typically, participants stated that they would talk more about the crying event with their clients. One stated that he wished he had "checked in" with his client to acknowledge and process the crying; another would have explored with her client what it was like to have her therapist cry.

Participants Crying as Clients

Of the 18 participants, 15 described crying as clients in their own therapy (see Table 2).

Table 2
Domains, Categories, and Frequencies of Findings Regarding Participants Crying as Clients

Immediate antecedent/trigger to P crying as C	
P discussing distressing personal event	General
Struggles in interpersonal relationships outside PT	Typical
Graduate school stressors	Variant
Struggles in PT relationship	Variant
Other stressors	Variant
When P felt tears coming and when cried, what P thought, felt, or did	
P felt mixture of comfort/discomfort with own tears	Typical
P got in touch with underlying feelings	Typical
P felt comfortable with own tears	Variant
During crying, what P thought their T's reactions were	
P thought T felt emotional connection with P	Typical
P felt disruption of empathic connection	Variant
Seemed normal part of PT	Variant
Extent of crying	
Substantial	Typical
Minimal	Variant
Reasons for crying	
To express pain/sadness	Typical
To express frustration/anger	Variant
To relieve stress	Variant
Consequences of crying	
Enhanced PT relationship	General
Deepened PT work	Typical
P gained self-insight/self-awareness	Typical
Catharsis	Variant
Evoked positive emotional/behavioral change for P in and outside PT	Variant
T gained insight into P	Variant
Evoked negative emotions in P	Variant
Discussion with others about crying	
Discussed with T	Variant
Discussed with colleagues/peers/family/friends	Variant
Reflections about crying	
Appropriate to cry	Variant
Self-conscious/curious about crying	Variant
What P would do differently	
Nothing	Typical
Let self cry more	Variant
Talk more with T about event	Variant

Note. $N = 15$; General categories = 14–15 cases; Typical categories = 8–13 cases; Variant categories = 2–7 cases; C = Client; P = Participant; PT = Psychotherapy; T = Therapist; Bold = Domain; Nonbold = Category.

Table 2. *Domains, Categories, and Frequencies of Findings Regarding Participants Crying as Clients*

Immediate antecedent/trigger to P crying as C	
P discussing distressing personal event	General
Struggles in interpersonal relationships outside PT	Typical
Graduate school stressors	Variant
Struggles in PT relationship	Variant
Other stressors	Variant
When P felt tears coming and when cried, what P thought, felt, or did	
P felt mixture of comfort/discomfort with own tears	Typical
P got in touch with underlying feelings	Typical
P felt comfortable with own tears	Variant
During crying, what P thought their T's reactions were	

P thought T felt emotional connection with P	Typical
P felt disruption of empathic connection	Variant
Seemed normal part of PT	Variant
Extent of crying	
Substantial	Typical
Minimal	Variant
Reasons for crying	
To express pain/sadness	Typical
To express frustration/anger	Variant
To relieve stress	Variant
Consequences of crying	
Enhanced PT relationship	General
Deepened PT work	Typical
P gained self-insight/self-awareness	Typical
Catharsis	Variant
Evoked positive emotional/behavioral change for P in and outside PT	Variant
T gained insight into P	Variant
Evoked negative emotions in P	Variant
Discussion with others about crying	
Discussed with T	Variant
Discussed with colleagues/peers/family/friends	Variant
Reflections about crying	
Appropriate to cry	Variant
Self-conscious/curious about crying	Variant
What P would do differently	
Nothing	Typical
Let self cry more	Variant
Talk more with T about event	Variant

Note. *N* = 15; General categories = 14 –15 cases; Typical categories = 8 –13 cases; Variant categories = 2–7 cases; C = Client; P = Participant; PT = Psychotherapy; T = Therapist; Bold = Domain; Nonbold = Category.

Demographics

The therapy during which participants cried (not all participants provided complete information) lasted between four months and five years, and took place mostly in private practices (*N* = 12). Participants had sought therapy for a range of concerns, including (participants could report more than one concern) interpersonal concerns (*N* = 7), depression/anxiety (*N* = 4), intrapersonal exploration (*N* = 3), and graduate school stresses (*N* = 2). Most of the therapists were female (*N* = 11) and European American (*N* = 7). They ranged in age from 40 to 70. Participants reported their therapists' theoretical orientations as psychodynamic/interpersonal (*N* = 4), eclectic (*N*= 2), and client-focused (*N* = 1).

Immediate antecedent/trigger for participant crying as client

Generally, participants were discussing distressing personal events prior to crying. More specifically, they were typically talking about struggles in interpersonal relationships outside of therapy. For instance, one participant was describing a traumatic breakup with a romantic partner who had been abusive; another was sharing the "aha" moment he experienced when he found the homemade gift he had given his now-ex-partner in the trash, seeing the gift being discarded as a metaphor for how the partner felt about their relationship.

When participant felt tears coming and when participant cried, what participant thought, felt, or did

Typically, participants felt a mixture of comfort and discomfort with their tears. In one case, a participant allowed herself to "get into it" without pushing her feelings away, but also wanted to be composed and "not break down and start bawling." Another thought his crying was appropriate for what he was disclosing, but worried that his therapist might have thought he cried too much ("You're training to be a mental health professional . . . why can't you get it together?"). As they cried, participants typically got in touch with their underlying feelings. One participant, for example, felt both relief and a greater awareness of his sadness; another was "astonished" at how much she hurt; a third "became herself as a little girl" when she felt sad, abandoned, and confused.

During the crying, what participants thought their therapists' reactions were

Typically, participants thought that their therapists felt an emotional connection with them during the crying. One participant reported that his therapist was "listening intently, graciously, and with her body," sensing that something important was about to be revealed. Another noted that her therapist "had an anguished expression on his face," as if the therapist wanted to fix the participant and "make it all go away."

Extent of crying

Typically, participants' crying was substantial. One described her crying as "intensely bawling, sobbing, holding [her] breath," another as "letting the flood gates open."

Reasons for crying

Typically, participants thought that they cried to express pain or sadness. One participant was not happy, did not like himself, was lonely, and finally allowed himself to cry and feel the depth of his despair. Another indicated that she cried because of an impending loss of someone very dear to her: She felt powerless and helpless because she could not do anything about the loss.

Consequences of crying

Generally, participants reported that their crying enhanced the therapy relationship. Although one participant was "a sobbing mess," she felt her therapist's acceptance and affirmation and that their relationship was strengthened. In another case, crying allowed the participant to feel closer to and more comfortable with his therapist, to feel understood and heard, and more likely to cry again in the future. Typically, participants also reported that their crying deepened the therapy work. For instance, one participant felt less defended and more able to show who she really is to her therapist; in another case, the crying "launched" the therapy into important areas that had not yet been fully examined. Typically, the crying event also led to participants' gaining insight or awareness. For one participant, the crying illuminated the tremendous pressure she felt from a family member, and for another the

crying provided insight into how sad he was about his childhood and how much he continued to carry around the pain from that time in his life.

Discussion with others about crying

In the first of the two variant categories, participants discussed the crying event with their therapist. In one case, the participant and her therapist talked about how the participant was feeling, what the crying signified, and how it felt to cry in session. Participants also variantly discussed the event with colleagues, peers, family, or friends. For instance, one participant shared the event with her mother and husband; another mentioned the event in his practicum class.

Reflections about crying

Participants variantly felt it was appropriate to cry. One participant said it was "absolutely appropriate" to cry, and another remarked that it was "what I needed to do." On the other hand, participants variantly felt self-conscious or curious about their crying after they did so. For instance, one still wondered how his therapist felt about the participant's crying.

What participants would do differently

Typically, participants stated that they would "do nothing differently" regarding the event.

Participants' (Clients') Therapists' Crying

Of the 18 participants, six described their therapist crying in the participants' therapy session (see Table 3).

Table 3
Domains, Categories, and Frequencies of Contextual Findings Regarding Participants' Therapists Crying in Participants' Therapy Sessions

Immediate antecedent/trigger for P's T crying in P's PT	
P and T discussing end of PT	Typical
P discussing distressing personal event	Variant
What P thought T was thinking or feeling before or during crying	
P thought T felt emotional connection with P	Typical
When T started to cry, what P thought, felt, or did	
P felt emotional connection with T	Typical
P felt disconnect from T	Variant
Extent of crying	
Minimal	General
Reasons for crying	
Because T felt empathic connection	General
Because of countertransference	Variant
Consequences of crying	
Enhanced PT relationship	Typical
T modeled for P that T crying appropriate in PT	Variant
P felt caution/concern/discomfort for T	Variant
Evoked negative emotions in P	Variant
Reflections about crying	
Appropriate to cry	Variant
What P would do differently	
Nothing	Variant
Talk more about event with T	Variant

Note. $N = 6$; General categories = 6 cases; Typical categories = 4–5 cases; Variant categories = 2–3 cases; C = Client; P = Participant; PT = Psychotherapy; T = Therapist; Bold = Domain; Nonbold = Category.

Table 3. *Domains, Categories, and Frequencies of Contextual Findings Regarding Participants' Therapists Crying in Participants' Therapy Sessions*

Immediate antecedent/trigger for P's T crying in P's PT	
P and T discussing end of PT	Typical
P discussing distressing personal event	Variant
What P thought T was thinking or feeling before or during crying	
P thought T felt emotional connection with P	Typical
When T started to cry, what P thought, felt, or did	
P felt emotional connection with T	Typical
P felt disconnect from T	Variant
Extent of crying	
Minimal	General
Reasons for crying	
Because T felt empathic connection	General
Because of countertransference	Variant
Consequences of crying	
Enhanced PT relationship	Typical
T modeled for P that T crying appropriate in PT	Variant
P felt caution/concern/discomfort for T	Variant
Evoked negative emotions in P	Variant
Reflections about crying	
Appropriate to cry	Variant
What P would do differently	
Nothing	Variant
Talk more about event with T	Variant

Note. *N* = 6; General categories = 6 cases; Typical categories = 4 –5 cases; Variant categories = 2–3 cases; C = Client; P = Participant; PT = Psychotherapy; T = Therapist; Bold = Domain; Nonbold = Category.

Therapist demographics

As described by the participants (not all reported these data), the therapists who cried in session with the participant were European Americans (*N* = 3) ranging in age from 30 to 60. Two were men and two were women, and five saw the participant in an independent practice setting. The therapy lasted between six sessions and five years, and participants reported a number of presenting concerns, including interpersonal concerns (*N* = 5), depression/anxiety (*N* = 2), and other (*N* = 6).

Immediate antecedent/trigger for participants' therapist crying in participant's therapy

Typically, therapists cried during discussions about the ending of therapy. In one case, the therapist and client were talking about the client's imminent move to a new city and what life would be like after terminating the therapy; in another case, the therapist offered a Skype session or further contact with the client in case the client needed it, and then teared up at the end of this final session.

What participant thought therapist was thinking or feeling before or during crying

Typically, participants imagined that their therapists felt an emotional connection with the participant. One thought her therapist was feeling sad that the relationship was ending and would likely miss the client; another felt that his therapist was empathizing with him as he discussed troubling events, and felt sad for the client.

When therapist started to cry, what participant thought, felt, or did

Typically, participants also felt an emotional connection with their therapists. As one participant described, he felt empathy for his therapist in the moment and was very touched; another stated that seeing her therapist become emotional meant a lot to the participant.

Extent of crying

Generally, participants described the therapists' crying as minimal. One described it as "tearing up but no actual tears," another as his therapist "breaking down a bit," and a third as "fleeting and brief tears."

Reasons for crying

Participants generally believed that their therapists cried because of their strong empathic connection with participants. As one example, the participant sensed her therapist was happy and proud of the participant's progress, but sad about the imminent end of therapy. Another reported sensing that his therapist felt frustrated at the participant's lack of progress and at his continuing to not feel understood and heard by the therapist, and wanted to convey that he (therapist) did indeed understand and hear the client.

Consequences of crying

Typically, participants felt that the crying enhanced the therapy relationship, with one participant stating that the tears led to "a nice, special ending . . . and made [me] feel that therapy had been an important personal experience." Another participant remarked that the tears were "visible proof" that the participant had affected the therapist and that they had a good relationship.

Reflections about crying

Variantly, participants felt the crying was appropriate. One person asserted that it was "very appropriate for my therapist to demonstrate emotion" toward the participant after a year of therapy, and noted that the crying felt authentic and did not distract from the therapy. Another reported that the crying actually "cemented our work together" and was a "seal of approval."

What participant would do differently

Variantly, participants noted that they would not do anything differently regarding the crying event. However, others variantly wished that they had talked more about crying with the therapist. One participant, for instance, acknowledged that she wished "there had been more time to talk about it, more time to process it."

Discussion

Crying in psychotherapy indeed appears to represent deep emotion, whether felt personally or as an empathic connection with the other person, and thus seems to be experienced quite distinctly depending on the role of the crier. In fact, one of the primary ways in which this study adds to the literature is by examining crying from the different perspectives of therapist and client. First, we discuss findings related to each of the three types of crying events (participant crying as therapist, participant crying as client, and participants' therapist crying). Then, we integrate the findings across events, seeking to arrive at a deeper understanding of the phenomenon of crying in psychotherapy. These discussions focus primarily on general and typical results.

Importantly, the participants in this study were doctoral students in counseling and clinical psychology. This population is particularly interesting because doctoral students are on the cusp of becoming therapists, and as such engage in substantial self-reflection about their role. They can empathize

greatly with clients, are often self-critical about how to be therapists, and look to their own therapists as role models.

Participants Crying as Therapists

As therapists, participants worried about how their crying might affect their clients, the appropriateness of crying, and often sought to control their emotions. Perhaps, as Counselman (1997) noted, these therapists-in-training feared they would not be able to stop crying if they allowed themselves to start, or feared that their tears would upset or overwhelm their clients (Nelson, 2005; Rhue, 2001). This combination of concerns yielded restrained crying, and perhaps reflects theoretical admonitions against therapists crying with clients (Beck et al., 1979; McWilliams, 1994). Many also experienced an emotional or empathic connection with their clients as they cried, similar to that described by Counselman (1997) and Alden (2001). Some crying arose from therapists' countertransference (similar to Counselman, 1997), reflecting the emotional contagion of therapeutic work. Furthermore, the crying seemed appropriate, strengthened the therapy bond, and deepened the therapeutic work, which reflects findings that clients often experience therapist crying as a powerful empathic reaction that renders their connection stronger and reinforces the humanity of each (Blume-Marcovici et al., 2013; Counselman, 1997; Nelson, 2008; Pope et al., 1987; Rhue, 2001; Van Heukelem, 1979). Although the crying was discussed in supervision, therapists wished they had talked about it more with their clients, perhaps noting an opportunity for immediacy (Hill et al., 2014; Hill & Knox, 2009), both of which are new findings.

Participants Crying as Clients

As clients, participants often cried when sharing difficult personal experiences, supporting Nelson's (2008) assertion that adult crying is stimulated by separation from or loss of attachment figures. As they cried, participants felt both comfort and discomfort with their tears, were able to access the pain and sadness evoking the tears, sensed that their therapists felt emotionally connected with them as they cried, and usually cried quite a bit (both in terms of intensity and duration), echoing the various forms of crying (i.e., inhibited, protest/angry, sadness/despair) found in Robinson et al. (2015). As above, the crying enhanced the therapy bond, deepened the work, and elicited greater insight and self-awareness, similar to the findings of Zingaretti et al. (2017).

Participants' (Clients') Therapists' Crying

Therapist crying in participants' sessions was usually triggered by discussions of termination, which evoked the mutual empathic connection between therapist and participant. The therapists' crying was rather muted, but strengthened the therapy bond. The subdued nature of the crying echoes Nelson's (2008) acknowledgment that therapists may seek to suppress their tears in session so as not to interfere with clients' own processing and intrapersonal experiences. Paralleling the findings of participants' crying while providing therapy to their own clients (see above), this crying also yielded positive effects on the therapy relationship: It personified an empathic response that drew therapist and client closer together (Blume-Marcovici et al., 2013), reflected the attachment between therapist and client (Nelson, 2008), and likewise depicted their shared humanity (Van Heukelem, 1979).

Integrating the Findings

These therapists-in-training were understandably concerned about the impact of their crying on their clients, and thus often tempered this expression of emotion. Nevertheless, the crying yielded positive effects, although therapists wished they had discussed the event more fully with their clients. Crying in their own therapy as clients was triggered by discussion of difficult relational experiences, and rather than restraining their emotions (as above), they allowed themselves to fully access the pain and sadness related to those experiences, leading to rather intense crying. Here, too, such emotional expression fostered positive effects. A specific trigger—discussion of termination—also elicited their therapists' crying, and although this crying nurtured positive effects, it, too, was muted (as had been participants' own crying when in the therapist role). Across all three types of crying events, participants noted the presence of a strong empathic connection between therapist and client.

It seems, then, that in the therapist role, crying with clients is quite subdued and restrained, likely out of due concern for its potential impact on clients. When in the client role, the crying was noticeably less inhibited, enabling the crier to more freely access and express powerful emotions. Regardless of the role, crying yielded beneficial effects, both intra- and interpersonally.

Given our interest in examining the potential role of therapist experience on crying, we wondered how the findings regarding these doctoral-student participants' crying as therapists might compare with those of their therapists crying in participants' own therapy. Because we do not know the experience level of participants' therapists, however, we must be tentative in drawing any conclusions. Overall, the two sets of findings are quite parallel. The antecedents were similar (discussion of distressing personal events or termination), as were thoughts about the emotional connection between therapist and client before or during the crying, the muted nature of the crying itself, the reasons for crying (empathic connection and countertransference), the event's strengthening the therapy relationship, the later reflections about the crying (it was appropriate to cry), and the desire to have discussed the crying more fully with the other member of the therapy dyad. In the role of therapist, however, participants worried about the impact and appropriateness of their crying and sought to remain in control, concerns not found when they described their own therapists crying with them in therapy. Such fears likely reflect these neophyte participants' understandable anxiety about how such an event might affect the therapy process and relationship. Finally, when their therapists cried with them, participants reported some degree of discomfort (caution, concern) and negative emotions, which again may reflect their lesser experience . . . and perhaps reduced comfort . . . with such potentially provocative therapy events.

Limitations

European American women constituted the majority of the sample, and thus the results may not depict the experiences of men or of those who come from different racial/ethnic backgrounds. Regarding gender, there is indeed a gender gap in psychology doctoral students: Cope, Michalski, and Fowler (2016) reported that, across all psychology doctoral students, 72.1% are women and 27.9% are men. Our gender ratio exceeded this figure, but is consistent with our experience obtaining participants in recent projects. In addition, our participants were all clinical or counseling psychology doctoral students, and therefore may not reflect the experiences of those not in the mental health professions, nor of those with greater experience. Each participant had received the protocol in

advance so that s/he could think about her/his crying experiences in therapy (whether as therapist or client); those who received the protocol but chose not to take part may have had different experiences. We have data, based on retrospective recall, from only one member of the therapy dyad, and thus do not know how the other member of the dyad experienced these crying events. We asked participants to report on events from the past, and thus their reflections or interpretations of these events during the interview may differ from those at the time of the events themselves. We also did not examine participants' experiences of their own clients crying in therapy, nor did we gather specific information about the therapies themselves. Interviews were conducted by phone, which may have affected the type of information shared. Finally, we allowed participants to select the event they wished to discuss, without limiting them to the most recent, most typical, or most intense such event, for instance. Whereas other research (Blume-Marcovici, Stolberg, and Khademi, 2015) asked participants to report their most recent experiences of crying in therapy (as a therapist), our participants were free to choose any such event, even if not the most recent, and thus may offer a different perspective.

Implications for Research

Despite the findings revealed by this study, more remains to be learned about crying in therapy. Given that most of our sample consisted of European American women, it would be wise to examine this phenomenon with samples that differ with regard to race, ethnicity, and gender. Important cultural differences in how such crying is experienced may well exist. We also captured only one side of the crying experience in this study. How did these therapists' clients, for instance, experience the therapists' crying? We may have some sense of how therapist crying is experienced by clients in the third type of event we examined. Furthermore, how does the status of the therapy relationship play a role? For instance, would strong versus tenuous relationships elicit different responses to crying? How does the timing of crying affect its reception: Would crying early in therapy have a different impact than crying later in therapy? Does therapist crying serve as a model for client crying, and thus might it help stimulate client expression of affect? To what extent might personality factors influence the experience of crying? Does therapist experience level influence her/his comfort with, and then allowance of, crying in therapy? Relatedly, how does therapist crying change over the course of a career?

Implications for Training and Practice

We know that participants are rightly concerned about how their crying, as therapists, may affect clients. More explicit discussion of such events in training and supervision, then, may help trainees better understand both the stimuli for such crying, as well as the potential effects, echoing the recommendations of Blume-Marcovici, Stolberg, Khademi, and Giromini (2015). Such discussions may be especially prudent as trainees approach termination, a phase of therapy that may more frequently elicit crying. As with other potentially provocative events in therapy (e.g., immediacy and therapist self-disclosure), direct discussion of the motivations for and repercussions of such interventions may enable therapists to manage them more effectively. We also note participants' wish that they had discussed their crying, as therapists, more fully with their clients. Thus, we recommend that such discussions occur: After such a potentially powerful event in therapy transpires, it behooves therapists

to allow their clients to talk fully about how they experienced the event. The fruits of such a discussion may well enhance the therapy relationship and process.

When participants were in the client role, they reported largely positive effects of crying intensely while discussing distressing events. As such, therapists' normalizing, empathizing with, or perhaps even nurturing such client crying may be beneficial, especially given the finding that some participants wished they had let themselves cry even more. Relatedly, some participants wanted to talk more with their therapist about their crying as clients, adding further impetus to the potential benefits of discussing such events.

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APPENDICES

APPENDIX A: Author Biases

All authors were asked to respond to the following six prompts in an effort to illuminate their potential biases regarding crying in therapy: (a) How comfortable, in general, are you with crying?; (b) Please describe an experience you had, as a therapist, of crying with a client; (c) Please describe an experience you had, as a client, of crying with a therapist; (d) Please describe an experience you had, as a client, of your therapist crying with you; (e) What, if any, training did you receive about crying in therapy?; and (f) How appropriate do you feel it is for therapists to cry with clients? During data analysis, authors were mindful of their own and others’ biases and sought to minimize any undue influence they may have had on the interpretation of the data.

As a group, the researchers expressed relative comfort with crying, but a few also acknowledged that they did so infrequently and/or that some of the messages they received as children were not to cry or to cry less. Only one reported crying, as a therapist, in session with a client, though two others noted that they had been close to tears on occasion with clients. All but one who had been in therapy (one researcher had not been in therapy) reported that they had cried with their therapist; none reported having their therapist cry in session. None reported any direct training in graduate school about therapist crying in therapy, though the topic was occasionally addressed in clinical settings (on practicum/internship, in supervision); the message communicated in such conversations was encouragement to be thoughtful and careful about such behavior, and to consider the potential effects of therapists’ crying on clients. Finally, with regard to the appropriateness of therapists crying in session, most indicated that therapists need to use caution as they reflect on the stage and nature of the therapy relationship, the reason/impetus for the crying, whom the crying may serve, the therapists’ ability to control the crying, and the potential effects of the crying on the client and the therapy.

APPENDIX B: Interview Protocol

Thank you for your participation in this study of crying experiences in individual therapy. We are grateful for your gift of time to this project to help us learn more about these phenomena.

Just as a reminder [state here, or just prior to First Specific Example section]: We will ask you about three distinct crying experiences. In the first, we will ask you to describe a time when you, as a therapist, cried when seeing an individual client. Second, we will ask you to describe a time when you, as a client, cried in an individual therapy session with your therapist. Third, we will ask you to describe a time when your therapist cried during an individual therapy session with you, when you were the client. If you do not have an example for each type of experiences, you are still very much welcome to participate. Finally, you must be a doctoral student in a clinical or counseling psychology doctoral program (up to and including predoctoral interns).

Opening/Contextual Questions

First I'd like to ask you some contextual questions regarding therapists crying in session while providing therapy to clients.

1. Tell me about how comfortable you feel crying, and how often you cry in your life
    - In general
    - In therapy
2. Given your approach to therapy, what are your thoughts about therapists crying in therapy?
3. What, if any, training or supervision have you received about therapist crying?

First Specific Example: You, as a therapist, cried when seeing an individual client

Now I'd like you to talk about a specific example of when you cried in a session with an individual client within the last two years. If you have had more than one such experience, please choose the most salient one to discuss. Before we begin with the questions, just take a few moments to put yourself back in that setting . . . to get back in touch with that experience.

Antecedents

1. Please provide some basic information about the client and therapy (e.g., C demographics, length/duration of therapy, focus of therapy, therapy relationship, at what point in therapy the crying occurred, and setting of therapy).
2. What was going on in the therapy immediately before you began to cry (i.e., what were the circumstances that elicited the crying)?
3. Once you knew that the tears were coming, what do you recall feeling or thinking?
4. What do you think the client was feeling or thinking before your crying?

Crying Process

1. Please describe the crying itself . . . Paint the picture of the crying incident (e.g., amount of tears, how long crying lasted, who was in the room, any touching of client, and any other nonverbal responses).
2. What were you feeling or thinking during the crying?
3. What do you think the client was feeling or thinking about your crying?
4. What, if any, visible reactions did you notice in the client when you cried?
5. In what way were your own personal issues triggered by the client's situation?
6. In retrospect, what are your thoughts about why you cried?

Consequences

1. How did the crying seem to affect the client?
2. How did the crying affect the therapy?
3. How did the crying affect you?
4. Tell me about any discussion you had about this incident with the client, and how that discussion went.
5. Tell me about any discussions you had with others about this event, and how those discussion(s) went.
6. As you reflect back on this incident, what thoughts come to mind (e.g., appropriateness, effects, benefits, and harms)?

7. Is there anything you would do differently regarding this event?
8. Is there anything else about this incident that you'd like to share?

Second Specific Example: You, as a client, cried in an individual therapy session with your therapist

Now I'd like you to talk about a specific example of when you, as a client, cried in an individual therapy session with your therapist within the last two years. If you have had more than one such experience, please choose the most salient one to discuss. Before we begin with the questions, just take a few moments to put yourself back in that setting . . . to get back in touch with that experience.

Antecedents

1. Please provide some basic information about the therapist and therapy (e.g., T demographics, length/duration of therapy, focus of therapy, therapy relationship, at what point in therapy the crying occurred, and setting of therapy).
2. What was going on in the therapy immediately before you began to cry (i.e., what were the circumstances that elicited the crying)?
3. Once you knew that the tears were coming, what do you recall feeling or thinking?
4. What do you think the therapist was feeling or thinking before your crying?

Crying Process

1. Please describe the crying itself . . . Paint the picture of the crying incident (e.g., amount of tears, how long crying lasted, who was in the room, any touching by the therapist, and any other nonverbal responses).
2. What were you feeling or thinking during the crying?
3. What do you think the therapist was feeling or thinking about your crying?
4. What, if any, visible reactions did you notice in the therapist when you cried?
5. In retrospect, what are your thoughts about why you cried?

Consequences

1. How did the crying seem to affect the therapist?
2. How did the crying affect the therapeutic relationship and your thoughts about the therapist?
3. How did the crying affect you?
4. Tell me about any discussion you had about this incident with the therapist, and how that discussion went.
5. Tell me about any discussions you had with others about this event, and how those discussion(s) went.
6. As you reflect back on this incident, what thoughts come to mind (e.g., appropriateness, effects, benefits, and harms)?
7. Is there anything you would do differently regarding this event?
8. Is there anything else about this incident that you'd like to share?

Third Specific Example: Your therapist cried during an individual therapy session when you were a client

Now I'd like you to talk about a specific example of when your therapist cried during an individual therapy session when you were a client within the last two years. If you have had more than one such

experience, please choose the most salient one to discuss. Before we begin with the questions, just take a few moments to put yourself back in that setting . . . to get back in touch with that experience.

Antecedents

1. Please provide some basic information about the therapist and therapy (e.g., T demographics, length/duration of therapy, focus of therapy, therapy relationship, at what point in therapy the crying occurred, and setting of therapy).
2. What was going on in the therapy immediately before your therapist began to cry (i.e., what were the circumstances that seemed to elicit the crying)?
3. What do you think the therapist was feeling or thinking before s/he began to cry?

Crying Process

1. Please describe the crying itself . . . Paint the picture of the crying incident (e.g., amount of tears, how long crying lasted, who was in the room, any touching by therapist, and any other nonverbal responses).
2. What were you feeling or thinking during the crying?
3. What, if any, visible reactions did you notice in the therapist when s/he cried?
4. In retrospect, what are your thoughts about why your therapist cried?

Consequences

1. How did the crying seem to affect the therapist?
2. How did the crying affect the therapy?
3. How did the crying affect you?
4. Tell me about any discussion you had about this incident with the therapist, and how that discussion went.
5. Tell me about any discussions you had with others about this event, and how those discussion(s) went.
6. As you reflect back on this incident, what thoughts come to mind (e.g., appropriateness, effects, benefits, and harms)?
    - What do you think your colleagues would think about your therapist's crying?
    - How did/does this incident affect your thoughts about crying with your own clients?
7. Is there anything you would do, or wish had been done, differently regarding this event?
8. Is there anything else about this incident that you'd like to share?

Closing Questions

1. Why did you choose to participate in this interview?
2. What was your experience of the interview?
3. Is there anyone else you would recommend to participate in this study?

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