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A Grounded Theory Inquiry into Crying in Women Dealing with the Emotional Stress of Personal Crisis

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A Grounded Theory Inquiry into Crying in Women Dealing with the Emotional Stress of Personal Crisis

A Dissertation Presented for the
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Mary Bess Griffith
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DEDICATION

I dedicate this dissertation to my husband, Curt, without whom this dissertation would not have happened. He pushed, nudged, cajoled, and forced me forward, always with my best interests at heart. I know that I am more than I could have ever been because of him. I also dedicate this to my daughter, Betsy, and her daughter, Lanigan, both of whom I love with all my heart and hope will be proud of what Mom/GaGa has accomplished. The other family member that I would like to dedicate this work to is my 91-year old mother, Gladys, who is hoping this is my last degree! She has encouraged me through every one, from my BSN in 1977, my MSN in 1985, my post-Master's FNP in 1995, to this PhD in 2017. I would also like to dedicate this dissertation to the Bethel University Nursing Department Faculty and Staff. They have suffered with me, encouraged me, celebrated with me, and supported me throughout this endeavor. 'Many thanks to Dayna, Jenny, Delecia, Ashley, Holly, Tammy, Edna, and Keisha!

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ABSTRACT

The belief that crying leads to healing is so widely held and of such longstanding that many healthcare professionals—including nurses, physicians, psychiatrists, and psychologists—accept it as fact even though there is little substantiating scientific evidence. Crying is commonly believed to be an essential factor in restoring mind-body equilibrium after physical and/or emotional trauma has been experienced. If, as has been hypothesized by many scientists and healthcare practitioners, emotional crying is a biopsychosocial healing modality, then specifics of its therapeutic praxis, including limitations and ambiguities, should be incorporated into nursing education and practice. In this grounded theory study, the meaning and functions imparted to crying by women who cried after experiencing stress in a variety of crisis situations and settings was revealed in semi-structured interviews. Analysis of this data permitted realization of the *Tipping Point Theory of Crying*, a new grounded theory explanatory of the stress-related crying process. This theory shares similarities with other theories of crying, but its empirical perspective offers a fresh, more subtly nuanced appraisal of how crying is indispensable to a processual sequence that involves stress relief concomitant with the attenuation of crying; restoration of cognitive clarity that leads to accepting and adapting to a re-envisioned reality inclusive of the crisis event; and a new state of psychophysiological equilibrium necessary for self-preservation and "getting back to life." Included in study results were findings that further illuminated how women deal with crying in different social settings, why crying during sad movies is qualitatively different than the emotional crying associated with stressors personally endured, why women in our culture try hard to control crying, why women cry alone, how women define different types of crying, how emotional crying at non-crisis levels may be amenable to self-regulation, and how crying in response to overwhelming emotional

upset can be empowering. Analysis of the data provided by study participants revealed numerous potential investigative opportunities that are likely to lead to the advancement of holistic nursing teaching and practice. In addition to the theoretical, clinical and educational implications of study findings, opportunities for additional research, both quantitative and qualitative, are elaborated.

Key words: Grounded theory, crying, women, stress, crisis, nursing, emotions

PREFACE

Like many people and perhaps most nurses (Fooladi, 2005, 2006; Lipe, 1980; Lutz, 1999; Teisan, 2003), I had always assumed that crying was a healing physiological response to stressful psychosocial situations, that it helped relieve stress or somehow assisted people in coping with difficult situations. This assumption was longstanding and predated my nursing education and subsequent career as a registered nurse (RN). It was not until I began reading the scholarly, professional, and popular literature about crying that I came to realize there was a paucity of scientific evidence to support my heretofore unfounded belief that crying functioned as a stress-relieving therapeutic.

Unexpectedly, the scholarly, professional, and popular literature on crying brought back memories of times I had cried and how experiences such as mine had been the subject of research and scholarly inquiry. I recalled a time from my childhood when I overturned while riding my bicycle and severely and painfully scraped my knees. My mother attempted to soothe me by holding me and telling me not to cry, everything was going to be all right. As I recall, her concern and compassion did not alleviate the pain of my injuries. I did finally stop crying when the pain from my scraped knees subsided to a level that I could tolerate.

A second crying experience that came to mind occurred when I was in high school. I did not receive an award I was expecting. I cried bitterly and effusively at the perceived injustice. This time, no comfort was forthcoming from my mother. She reacted to my emotional outburst of tears by turning away from me and making a determined and obvious effort not to notice me. This time, crying did not result in anyone, not even my mother, coming to my aid. Even worse, I felt that my mother was ashamed of me and was embarrassed because my crying, given the

situation, was inappropriate. The way she purposely distanced herself from me, both physically and mentally, intensified my anguish.

Another incident of crying happened during a counseling session. The counselor encouraged me to cry, to put the past behind me so that I could move on with my life. Obviously, he thought that crying would provide an emotional release essential to my mental well-being. At the time, crying did improve my mood, but it did not help in putting the past behind me.

Each of these incidents correlated with one or more of the principal theories concerning the putative benefits of crying. The bicycle accident brought my mother to my aid. Her supportive actions were illustrative of the attachment theory of crying (Cornelius, 2001; Frijda, 2001; Hendriks, Croon, & Vingerhoets, 2008; Hendriks, Nelson et al., 2008; Kottler, 1996; Vingerhoets et al., 2001). Attachment theory hypothesizes that crying communicates a need for help and functions to solicit that help. The failure to receive an award I expected exemplified the overflow theory of crying, in which tears and stress accumulate in direct proportion until a tipping point is reached (Breuer & Freud, 1895/1955; Kottler, 1996; Sadoff, 1966). In this case, my disappointment, confined in an emotional reservoir, emptied as my tears overflowed and then burst through a dam of repressed feeling. This draining of negative emotion should have permitted me to accept the perceived injustice and move past it. (Consistent with a symbolic interaction perspective, attachment theory [Cornelius, 2001; Frijda, 2001; Hendriks, Croon, & Vingerhoets, 2008; Hendriks, Nelson et al., 2008; Kottler, 1996; Vingerhoets et al., 2001] would maintain that because my mother saw my crying as socially inappropriate, she withheld her support for the need I was communicating.) Lastly, my counselor was obviously relying upon the catharsis theory of conflict resolution (Adamson, 1980; Breuer & Freud, 1895/1955; Levitz,

2006; Norton, 2011; Sadoff, 1966; Scheff, 1979, 2007). By crying, he believed I could purge my system of negative emotional affect and return to a state of psychological equilibrium.

In considering the evident differences in each of these crying incidents and the scientific community's theories seeking to explain them, it became apparent to me that I should have had some serious reservations about the dictum that crying heals. In this regard, it is remarkable that the functioning of an otherwise logical, analytical, and informed intelligence can be so easily pre-empted by an unconfirmed folk belief. And even though this folk belief is firmly entrenched in the popular mind, I found myself questioning this presumption. Having read a great deal of the research investigating the biopsychosocial aspects of crying, I can no longer hold to the certainty that crying heals. Nonetheless, I do hold to the certainty that crying means and does something (Cornelius, 2001; Hunt, 1992; Vingerhoets, Bylsma, & Rottenberg, 2009), that it has some as-yet-to-be determined or verified function or functions. It is hoped that this research will add to the extant body of knowledge regarding stress-related crying, and that it will serve as a jumping-off point for additional qualitative and quantitative research into a phenomenon that is, I believe, of significant importance to the science and practice of healthcare, especially nursing.

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CHAPTER ONE

INTRODUCTION AND GENERAL INFORMATION

Introduction

One of the more enduring folk beliefs in Western culture is that crying is healthy. That is, crying helps in maintaining a mind-body psychophysiological balance by providing an outlet for stress-related emotion. This belief, yet to be confirmed by research, is widely held by many healthcare professionals (e.g., Kottler, 1996; Knight, 2014; Labott, 2001; Rydé, Friedrichsen, & Strang, 2007; Schiedermayer, 1990; Teisan, 2003; Zengerle-Levy, 2006) as well as the general public (e.g., Cornelius, 2001; Fooladi, 2005; Frey, 1985; Kottler & Montgomery, 2001; Lutz, 1999; Murray, 2009). Quantitative research investigating the phenomenon of crying has yielded inconclusive and often contradictory results (e.g., Cornelius, 2001; Gross, Fredrickson, & Levenson, 1994; Labott & Martin, 1987; Nelson, 2008; Patel, 2001; Vingerhoets & Scheirs, 2001).

As a number of scientists and practitioners (Frey, 1985; Griffith, Hall, & Fields, 2011; Hunt, 1992; Vingerhoets, Boelhouwer, Van Tilburg, & Van Heck, 2001; Vingerhoets, Bylsma, & Rottenberg, 2009) have concluded, quantitative research into crying has resulted in, as Frey (1985) phrased it, "more questions than answers" (p. 6). For example, why do women cry more frequently than men? Why do people cry in response to emotions opposite in valence such as joy and sadness? Why do some people cry when others do not when exposed to the same emotional stimulus? Why do some people report feeling better after crying and others report feeling worse? Why do people differ in the crying patterns exhibited in response to emotional stress? Does crying have psychophysiological healing properties? Is there a spiritual component

to crying? Is crying an adaptive evolutionary response to dangerous levels of stress or situations requiring assistance? Can people control their crying? If so, how? Should crying be controlled? Should crying be discouraged? Encouraged? Why do basal, irritant, and emotional tears differ in chemical composition? Is this composition the same for men and women? Does the composition of emotional tears vary depending upon the perceived severity of stress-inducing factors? Is the chemical composition of emotional tears the same for emotions opposite in valence? These are just a few of the questions regarding crying that have arisen as quantitative researchers have attempted to find answers to the what, where, when, why, how, and how much of this multifarious and confounding emotional response.

Hunt (1992), in her mixed methods study of crying in women with cancer, suggested a possible explanation for the lack of success quantitative researchers have had in providing definitive answers to the preceding questions. She pointed out that quantitative researchers, while acknowledging the complexity of the biopsychosocial aspects of the phenomenon, have tended to focus on crying in a single context, either the biological, psychological, or social. Tacit in her observation is that quantitative research designed to examine crying has been self-limiting. By extension, this line of thinking implies that quantitative research into crying might benefit from the revelation of fresh perspectives that have the potential to expand the horizon for scientific exploration into this little understood phenomenon. A qualitative research methodology such as GT offers possibilities for unearthing those fresh perspectives (Corbin & Strauss, 2008, 2015). This is because GT methods are conducive to disclosing the meaning that an individual gives to her perception of reality and how that influences her interpretations of the reactional actions-interactions-emotions appropriate to that reality (Corbin & Strauss, 2008, 2015).

The limited number of qualitative studies of crying in the literature generally support the idea that crying is (or can be) a healthy psychophysiological or psychosocial response to strong emotions and stress (Fooladi, 2005, 2006; Hunt, 1992; Rydé et al., 2007; Rydé, Strang, & Friedrichsen, 2008; Zengerle-Levy, 2006). Because the psychophysiological efficacy of emotional crying appears to be largely unexplored territory for qualitative analysts and the results of quantitative research investigating this subject have been inconclusive, this GT study was undertaken to surface potential linkages explanatory of the relationships between crying, emotion, and stress. The linkages thus identified are reflective of the context, intervening and causal conditions, actions-interactions-emotions, and consequences (Corbin & Strauss, 2008, 2015) associated with and attributable to the crying experiences studied. Moreover, the GT approach to examining emotional crying permitted a fresh appraisal (Corbin & Strauss, 2008, 2015) of the firmly established but unsubstantiated belief that crying has therapeutic value. In consequence of this fresh appraisal, a theory grounded in and explanatory of participant experiences was constructed. Affiliated conclusions and recommendations for nursing teaching and practice and future research were developed as well.

Before elaborating on study conduct and presenting findings, certain background information is germane. Hence, I first define crying. Then, emotions and crying are considered from a historical perspective. Following that, I continue by: (1) discussing the problem, purpose, and aim of this research; (2) stating the research question that defined and bounded this GT inquiry; (3) synopsizing the origins of GT; (4) noting the assumptions underlying sample selection; (5) and linking the significance of this research to the science and practice of holistic nursing.

Definition and Historical Perspective

Crying has been described by Turton (2002) as an experience characterized by uncontrollable sobbing or wailing, the full flow of tears and mucous, deep breathing and gasping, and involuntary shudders occasionally accompanied by chest pain. There are, however, many variants of crying (e.g., silent, weeping, wailing, sobbing), and not all involve Turton's full flow of tears and heightened level of sympathetic arousal. A more useful definition of cry(ing) can be found in *The American Heritage Dictionary*. In defining cry as "to sob or shed tears because of grief, sorrow, or pain; weep," this reference work notes the origin of cry as Middle English *crien*, from Old French *crier*, from Vulgar Latin *critāre*, and from Latin *quirītāre*, to cry out. Synonyms given for cry are weep, wail, keen, whimper, sob, and blubber. The same source defines weep as "to shed (tears) as an expression of emotion; to express grief or anguish for, lament; to express emotion, such as grief or sadness, by shedding tears." The etymology for weep is *wepen* from Middle English, from Old English *wēpan*. *The American Heritage Dictionary* also states that "Cry and weep both involve the shedding of tears; cry more strongly implies the accompanying sound." As is the case with much of the literature addressing crying and emotional expression, usage in this paper conforms to the convention that crying and weeping are synonymous with the shedding of tears in an emotional context (Darwin, 1872/1998; Griffith et al., 2011; Hunt, 1992; Labott, 2001; Labott & Martin, 1988).

Classical and religious literature are replete with examples of crying and weeping. It is these examples that provide initial insights into the complexities of crying, of its many aspects, of its subtly nuanced contextual shadings. The emotions or emotional states associated with crying that are directly stated or can be inferred from classical and religious literature include fear, pain, sorrow, loss, mourning, grief, lament, sympathy, regret, remorse, guilt, despair,

distress, desperation, disappointment, shame, humiliation, frustration, acceptance, humility, relief, repentance, joy, and love (requited and unrequited). Consider first the ancient text *The Epic of Gilgamesh* (standard Akkadian ed., trans. 1989), which may be the oldest written story in the world (estimated to have been written between 2,750 to 2,500 B.C.E.). In Tablet XI, Gilgamesh, the fifth King of Uruk, breaks down into weeping "with tears streaming down his face" when he realizes a snake has carried off the magic plant he had gone to great lengths to acquire. The plant, described as like a boxthorn, had the power to render anyone who consumed it immortal. With its loss went Gilgamesh's quest for immortality, eternal youth, and elevation to divine status.

The Iliad (Homer, trans. 1898), the oldest work in Western literature (estimated to have been written about 800 B.C.E.), tells the story of the Greek conquest of Troy after Helen, wife of Menelaus, is willingly kidnapped by Paris. In it, Helen weeps for what she has abandoned to be with Paris: "her former husband, her city, her parents" (p. 57). Later, she weeps again, but this time in sorrow and regret for the misfortune she has brought upon Troy. Andromache, wife of the Trojan hero Hector, also weeps, but she weeps because of the death she knows awaits her husband as he leads the Trojan army against the vengeful Greeks.

After Hector's defeat at the hands of Achilles, Troy eventually falls to a stratagem of Ulysses, that is, the fabled Trojan Horse. The sacking of Troy complete, Ulysses begins a long and harrowing journey home, a journey chronicled in *The Odyssey* (Homer, trans. 1900). In Book V, the immortal nymph Calypso takes pity on Ulysses, with whom she was much enamored, when she finds him crying "with his eyes ever filled with tears, and dying of sheer home-sickness." His despair made Calypso sorry for him, so she provided him with tools to build a raft and the provisions necessary to leave her idyllic island. Book X of *The Odyssey*

relates several instances of weeping, both by Ulysses and his men. The first instance of weeping occurs when Ulysses falls asleep at the helm of his ship. His men, greedy for what they believe are valuable gifts in a tightly bound sack given to Ulysses by Aeolus, open the sack and loose howling winds that carry them back out to sea just as they were about to make landfall in Ithaca, their homeland. Ulysses weeps because of the perfidy of his trusted companions, and they weep out of shame, sorrow, consternation, regret, and despair because it is their ignominious treachery that has prevented them from reaching home at long last. Other instances of weeping in Book X happen when Circe turns some of Ulysses' men into pigs and again when she returns them to human form. The emotions expressed by Ulysses and his companions at these times included fear, dismay, despair and, lastly, joy and rejoicing. Incidents of weeping recounted in *The Odyssey* are not restricted to Ulysses and his companions. In Book II, Telemachus bursts into tears in frustration, humiliation, and shame because he cannot protect his father's estate from the excesses and encroachments of his mother's suitors. In Book XXIII, both Ulysses and his wife, Penelope, weep as they are overcome with emotion when they are at last reunited.

Being reunited with loved ones or comrades is a recurrent theme in ancient literature. In Book I of *The Aeneid* (Virgil, Trans. 1697), Aeneas weeps at the fate of Troy and the loss of 13 of his 20 ships until Venus, his mother, assures him that he will be soon rejoined by 12 of those lost ships with crews intact. But even gods and goddesses cry: Prior to reassuring Aeneas of the safety of his lost comrades, Venus weeps because she fears that Jove has reneged on his promise to build a Roman state from the remnants of Troy's greatness. Told to dismiss her fears by her father Jove, Venus guides Aeneas to Carthage, where he weeps again when he is reminded of Troy's destruction by murals painted on that city's walls.

In Book II Elegy XVIII of *The Amores*, the Roman poet Ovid (c. 3-8 BC/2001) wrote, too, of Aeneas and the tears of queen Dido when he left her to continue his quest to find a new home for the refugees of once great Troy. In Book I Elegy IV of *The Amores*, Ovid wrote of his own tears when, at the end of a dinner party, he knows his lover, Corinna, will soon be in the arms of her husband. Dismayed, he pleads to her:

> But still whatever fortune brings tonight, tomorrow
> to me, with constant voice, deny you gave him anything! (p. 11)

The futility of crying about events past that cannot be undone is perhaps best personified in the words of the twelfth century Persian poet, Omar Khayyám (1859/1992), in the LI quatrain of the *Rubáiyát*:

> The Moving Finger writes; and, having writ,
> Moves on: nor all thy Piety nor Wit
> Shall lure it back to cancel half a Line,
> Nor all thy Tears wash out a Word of it. (p. 69)

Like ancient literature from Eastern Mediterranean countries and the Middle East, major religious writings, especially the Bible, Qur'an, and the Ras Shamra texts, originating between the fourteenth century B.C.E. and the seventh century A.D., also relate incidents of crying, weeping, and tears. As Hvidberg (1962) contends in his analysis of the fourteenth century B.C.E. Ras Shamra clay tablets found at the site of ancient Ugarit, practices of ritualized weeping in early Phoenician-Canaanite festivals, celebrations, and religious rites likely induced the assimilation of similar practices by the Israelites who migrated into the regions occupied by the Canaanite peoples. (Note: The Phoenician-Canaanites were the Philistines of the Old Testament.) The Phoenician-Canaanites worshipped the storm god Aliyn Baʿal who, as "the soul

of vegetation" (Hvidberg, 1962, p. 19), provided rain and enabled rich harvests. After being challenged by Baʿal, Mot (god of death) swallows him and takes him to the underworld. With Baʿal confined to the underworld, there is no rain. A severe drought ensues. The drought is only ended when the virgin goddess Anat, Baʿal's sister and consort, ventures into the underworld and slays Mot. With Mot vanquished, Baʿal escapes the underworld and, resurrected, he causes it to rain and restore the fertility of the fields. Baʿal's death and resurrection were marked by the Phoenician-Canaanites with annual, ritualized festivals (Hvidberg, 1962). His death, mourned during the fall equinox, was an occasion for rites of weeping and sorrow. His return, coincident with Mot's demise and celebrated in the spring, symbolized the renewal of Nature's bounty and was an occasion for expressing great joy and ritualized laughter.

As previously noted, it is likely Phoenician-Canaanite cultic traditions and rituals influenced the religious practices of the invading Israelites (Hvidberg, 1962). This was especially true of ritualized weeping as a form of worship, supplication, and atonement. Examples of ritualized weeping, weeping to win God's (Yahweh's) favor, weeping for joy, and weeping in mourning can be found in several places in the Bible (King James version, Cambridge Ed.). Hunt (1992) mentions Isaiah 17:10; Samuel 12:15; Joel 1:2-12; Kings 20:1, 22:19; Psalms 6:7; Jeremiah 31:7-9; Ezra 5:13, 20 and 6:31; Isaiah 30:19, 35:10, 60:60, 65:19; and John 11:35. The last verse is "Jesus wept." In this the shortest verse in the Bible, Jesus is reacting to the death of Lazarus, Mary's brother.

In all, there are 237 occurrences of weeping in the Bible (Biblos, n.d.). These include instances of lamentation and mourning, fear, adoration, sadness, disappointment, joy, forgiveness, despair, grief, and supplication. The Al-Qur'an (Ahmed Ali, trans. 1984) contains similar instances of weeping or sobbing. In 11:106, those doomed to hell "will be sighing and

sobbing." In 12:16, Joseph's brothers weep false tears as they tell their father that a wolf devoured him. In 17:109, Believers are told to weep in humility as they kneel before Allah. In 19:58, the offspring of Abraham and Israel are described as weeping in adoration when they receive revelations from God.

In his autobiographical *Confessions*, St. Augustine (1960) recounts numerous instances of weeping. Reflecting upon his childhood, Augustine recalls weeping when he read of Queen Dido's suicide by sword. Revisiting his later youth, he speaks of his mother's tears as she wept daily because "she lamented for my perdition" (p. 91). After the death of his close and dear companion, Augustine remembers the "sweet sorrow" of his grief and asks of the Lord:

> Whence is it, then, that sweet fruit is plucked from life's bitterness, from mourning and weeping, from sighing and lamenting? Does sweetness lie there because we hope that you will graciously hear us? This rightly holds for our prayers, since they contain our desire of attaining you. But does it hold for that grief and mourning over what was lost, with which I was overwhelmed? I did not hope that he would come back to life, nor did I beg for that by my tears; I only sorrowed and wept, for I was wretched and I had lost my joy. Or is weeping itself a bitter thing, and does it give us pleasure because of distaste for things in which we once took joy, but only at such times as we shrink back from them? (p. 99)

About the same time St. Augustine (1960) was writing his *Confessions*, Gregory of Nyssa (361/1995) was speculating on the origin of tears. He posited that grief led to closing of the body's pores. This, in turn, resulted in compression of the viscera, driving humid vapor upwards toward the head and cerebral membrane. These humid vapors, exceeding the

space available in the brain's cavities, were expelled by pores at the base of the brain through the eyes as drops of moisture, i.e., tears.

Weeping, crying, and tears received little literary (or scientific) attention in Europe as the continent sank into the intellectual regression of the medieval period, sometimes referred to as the Dark Ages (The Middle Ages, n.d.). The medieval period began with the fall of the Western Roman Empire (Lot, 1961; Wallace-Hadrill, 1962) and lasted from the fifth to the fifteenth century. A reawakening of interest in the arts, sciences, and letters sparked the Renaissance, a cultural movement that began in Italy in the fourteenth century (History of the Renaissance, n.d.). From that time to the present, weeping, crying, and tears accompanying emotional display have been liberally depicted in poetry, prose, and theater (e.g., the works of William Shakespeare, Michael Drayton, Baldassare Castiglione, John Donne, Michel de Montaigne, John Milton, Lord Byron, Alfred Lord Tennyson, Robert Browning, Edgar Allen Poe, John Vance Cheney, Sylvia Plath, Maya Angelou, and Langston Hughes).

In the sciences, Descartes (1649/2010) attributed tears to vapours given off by the eyes. He hypothesized that vapours are given off by many parts of the body, but that the eyes give off more vapours than any other body part "because the optic nerves are so big and there are so many little arteries by which the vapours get there" (Part II, p. 35). He also addressed the differences between tears caused by an irritant to the eyes and tears of sadness: "sadness alone won't produce tears; the quantity of these vapours has to be increased at the same time by some other cause" (Part II, p. 36).

Two centuries later, Darwin (1872/1998) took note of irritant tears, but his work on how man and animals express emotions foreshadowed a new interest in crying as an emotional response in humans. His observations of his crying infant children presaged the attachment

theory of crying, although he personally regarded emotional tears as a non-adaptive byproduct of emotional expression. Still, a seeming majority of the quantitative research studying emotions and crying within the last 75 years has its foundations in Darwin's definitive work on the expression of emotions. Unfortunately, that research has yet to adequately explain the function of crying as an emotional response (Frijda, 2001; Vingerhoets & Cornelius, 2001; Kottler & Montgomery, 2001; Vingerhoets et al., 2009).

Problem, Purpose, and Aim

Problem

The essential problem addressed in this study consists of several elements : (1) the conflicting results from quantitative investigations into the purported healing powers of crying (e.g., Bindra, 1972; Borquist, 1906; Frey, 1985; Labott & Martin, 1987, 1988; Vingerhoets & Becht, 1997; Vingerhoets et al., 2009); (2) the complexity of a phenomenon that is influenced by biological, psychological, and social factors (Frijda, 2001; Cornelius, 2001; Cornelius & Labott, 2001; Vingerhoets et al., 2009; Vingerhoets & Scheirs, 2001); (3) the scarcity of healthcare qualitative studies that deal with crying (e.g., Fooladi, 2005, 2006; Hunt, 1992; Rydé et al., 2007; Rydé et al., 2008; Zengerle-Levy, 2007); (4) the continuing speculation that crying is a healing modality (Adamson, 1980; Bagby, 1999; Cornelius, 2001; Fooladi, 2005; Hendriks, Nelson, Cornelius, & Vingerhoets, 2008; London, 2007; Murray, 2009); and (5) the lack of understanding and attention to crying in health profession education curricula (Kukulu & Keser, 2006; Lutz, 1999; Vingerhoets et al., 2009). Vingerhoets et al. (2009) points out that crying is a subject that should be but is not included in healthcare texts. Speaking from more than 30 years of experience in nursing education, I can attest that crying is not covered in nursing curricula at any level, nor is it addressed in nursing textbooks (e.g., Carpenito, 2013; Meleis, 2010;

Newfield, Hinz, Tilley, Sridaromont, & Maramba, 2007; North Carolina Concept-Based Learning Editorial Board, 2011; Potter & Perry, 2009; Taylor, Lillis, & LeMone, 2005).

In summary, emotional crying is not well understood, either in function or process (Frey, 1985; Vingerhoets et al., 2009). Research results have underscored the multidimensionality of the phenomenon of crying, but whether crying has beneficial (or harmful) biopsychosocial effects remains to be established (Kottler & Montgomery, 2001; Vingerhoets, Cornelius, Van Heck, & Becht, 2000; Vingerhoets et al., 2009). It is the problematic nature of the efficacy of crying as a therapeutic modality that gave purpose to this study.

Purpose

The purpose of this GT study is to begin a systematic program of qualitative inquiry into the phenomenon of crying. The objective of this research program is the discovery of empirical evidence explanatory of an emotional response whose function and significance remain unclear. If, as has been hypothesized by many scientists and healthcare practitioners, emotional crying is a biopsychosocial healing modality, then specifics of its therapeutic praxis, including limitations and ambiguities, should be incorporated into nursing education and practice. The same is true if empirical evidence indicates crying has little or no value in the course of mind-body-spirit healing. Vingerhoets et al. (2000), in summarizing the status of research into the function and origin of emotional tears, observed that: "Most research until now has not been theory driven but may best be described as exploratory, descriptive, and unsystematic" (p. 354). This statement applies particularly to quantitative research efforts into the phenomenon of crying. However, qualitative research into crying, while limited, suggests that a research program based upon GT methodology, a practical derivative of symbolic interactionism, has the potential to shed light on the meaning emotional crying holds for those who cry (Blumer, 1969; Corbin & Strauss, 2008,

2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Beginning with this study, successive GT inquiries should progressively augment the knowledge base relative to the function and origins of emotional crying and how this information can be of benefit in continuously improving patient care.

Aim

The aim of this study was to develop an empirically derived theory that advances the practice of nursing and expands the body of scientific knowledge attending the biopsychosocial processes involved when crying accompanies the stress resulting from an emotional crisis. As a starting point in this program of inquiry, I chose to study women who had experienced crying following a recent emotional crisis. These women were interviewed to collect empirical data on how they felt before, during, and after crying. The interviews were conducted with the intent of eliciting participant descriptions of: (1) the event or condition that precipitated crying, (2) the context (personal, family, work) of that event, (3) pertinent situational factors, (4) type of crying experienced, and (5) perceived biopsychosocial status before, during, and after the crying event.

The Research Question

A GT inquiry typically begins with an area of interest rather than a research question (Corbin, 2009; Corbin & Strauss, 2008, 2015; Glaser, 1967, 1992). If there is a research question, it derives from the identified area of interest, and it is the research question that determines the appropriate investigative methodology (Corbin & Strauss, 2008, 2015; J. M. Corbin, personal communication, July 31, 2013; Strauss & Corbin, 1990, 1998). In this case, the area of interest was, in the broadest sense, stress-related emotional crying. This led to asking the general question: **What happens when women dealing with the emotional stress of personal**

crisis cry? That is, what processes are involved when a woman cries in response to the stress of personal crisis? In what ways are these crying experiences contextualized? Do women who cry in stressful situations report positive or negative changes in psychophysiological well-being? Because GT research questions identify the phenomenon to be investigated and have an action or process focus, GT was an appropriate methodology for studying these questions (Corbin & Strauss, 2008, 2015; J. M. Corbin, personal communication, July 31, 2013; Strauss & Corbin, 1990, 1998). While GT methodology precludes beginning a GT inquiry with a specific question, inquiry into the more general question (or area of interest) should lead to a narrowing of focus that eventually results in a theory explanatory of the lived experience of study participants. And because the GT approach to qualitative research is grounded in and follows the path(s) dictated by the data, the resultant theory may or may not directly answer the general question that initiated the study (Bryant & Charmaz, 2007; Charmaz, 2006, 2009; Corbin & Strauss, 2008, 2015; Creswell, 2013; J. M. Corbin, personal communication, July 31, 2013). In this study, the path dictated by the data led to the interpretative construction of a theory both descriptive and explanatory of processes implied by the general question. This theory should prove useful in clarifying whether crying has therapeutic value in releasing emotional stress. It should also prove useful in explicating the process (Brown, 2011) involved when women cry as a response to the emotional stress of personal crisis. At a minimum, the theory induced from this research provides additional information pertinent to the resolution of, as Frey (1985) termed it, "The mystery of tears."

The Origins of Grounded Theory

The sociologists who discovered and developed GT, Barney Glaser and Anselm Strauss, came from very different research and philosophical backgrounds. Glaser studied descriptive

statistical methods and quantitative research techniques under Paul Lazarfeld and Robert K. Merton at Columbia University at a time when positivists dominated the sciences (Charmaz, 2006, 2009; Stern, 2009a; Strauss & Corbin, 1990). Of importance for Glaser's later collaboration with Anselm Strauss was that "Columbia tradition also emphasized empirical research in conjunction with the development of theory" (Strauss & Corbin, 1990, p. 25).

Anselm Strauss was a product of the Chicago Tradition in qualitative research, a tradition that emphasized pragmatism and symbolic interactionism. At one time or another, the faculty at the University of Chicago included pragmatists John Dewey, Charles H. Cooley, W. I. Thomas, and George Herbert Mead, all of whom had in turn been influenced by the works of Charles Sanders Peirce and William James (Strauss & Corbin, 1990). Herbert Blumer, one of Mead's students, was largely responsible for formulating the sociological perspective of self and society he termed symbolic interactionism (Blumer, 1969; Lutters & Ackerman, 1996; Stern, 2009b). Strauss's world view, steeped in pragmatism, with its focus on practical solutions for problematic situations, and symbolic interactionism, with its emphasis on meaning and how it is emerged, made him an ideal partner for Glaser in their joint ventures into research and the discovery of GT (Charmaz, 2006; Corbin & Strauss, 2008, 2015; Stern, 2009; Strauss & Corbin, 1990, 1998).

Following the discovery of GT, Glaser and Strauss took GT in separate directions (Morse, 2009), directions later termed "Glaserian" and "Straussian" by Phyllis Stern (2009b). This divergence was not apparent until 1990, when Strauss and Juliet Corbin, who worked with him over a 16-year span, published *The Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* In this work, Strauss and Corbin set forth GT methodology that was based in symbolic interactionism and more prescriptive than earlier works on GT (Glaser,

1978; Glaser & Strauss, 1967; Strauss, 1987). Three more editions of *Basics* were published by Corbin (Strauss & Corbin, 1998; Corbin & Strauss, 2008, 2015), all after Strauss died in 1996. In the last two editions of *Basics*, Corbin (2008, 2015) tempered the prescriptive and objectivist approach to GT of earlier works (Strauss & Corbin, 1990, 1998) by acknowledging that postmodernism and feminism had transmuted her epistemological perspective. And, she departed from Glaser's insistence that theory emerges, agreeing with constructivists that theory is constructed from how data is interpreted by both researcher and participant (Charmaz, 2006; Corbin, 2009; Corbin & Strauss, 2008, 2015). In discussing the differences between emerged and constructed theory with Dr. Corbin (personal communication, July 31, 2013), she commented that concepts emerge from data, but the conceptualization of the relationships between and among these concepts are constructed in the sense that the interpretation defining those relationships stems largely from the theoretical sensitivity of the researcher.

Assumptions

An assumption basic to this study was that emotional stress is experienced in a variety of situations and circumstances; that is, crises associated with self, family, friends, and/or work. These might include:

1. Death of a family member, long-time friend, beloved pet, or a valued antagonist.
2. Separation from a loved one, divorce, loss of job, financial problems, extreme mental or physical fatigue, or dealing with serious injury or illness.
3. Family member injury or illness, problems with children, abusive or addictive behavior by a family member, home foreclosure, or property losses arising from a natural disaster.

4. Problems at work such as too heavy a workload, unrealistic deadlines, abusive boss and/or co-workers and/or customers, failure to get a planned promotion or pay raise, or insufficient time off.

Some stress-inducing crises can include many of the aforementioned circumstances. Moreover, stress experienced in the face of personal crisis is situational. The effects of stress in a given situation may be mitigated, for example, by the affected individual's perceived seriousness of the crisis, coping skills, social support, physical and mental health, and prior experience in dealing with stressful situations (Cornelius, 2001; Folkman, 1997; Folkman & Lazarus, 1988; Kottler & Montgomery, 2001; Lazarus, 1966).

Other assumptions of relevance to this study were:

1. Many women cry as a response to the emotional stress of personal crisis.
2. Compared to men, women cry more frequently and are more likely to be exposed to stress-related situations that precipitate crying (Bekker &Vingerhoets, 2001; Vingerhoets et al., 2009; Vingerhoets & Scheirs, 2000).
3. Participants will be able to recall and articulate their experience of crying in response to the emotional stress of a personal crisis.
4. Participants will be willing to share their experience of crying in response to the emotional stress of personal crisis.
5. Data saturation and sample diversity (in terms of crises experienced) will be possible because a sufficient number of women within the geographic area selected for the study will likely volunteer to be interviewed.
6. The accuracy of participants' recollection of past events will be adequate for theorizing.

Limitations

Limitations attendant to this study were primarily those related to the initial sample and GT sampling procedures. GT investigations begin with a sample that is either purposive, convenient, or both (Corbin & Straus, 2008, 2015; Polit & Beck, 2010; Stern & Kerry, 2009; Strauss & Corbin, 1990, 1998). In this study, the convenience sample consisted of adult women 21 to 69 years of age who had volunteered to share stress-related crying experiences. All these women self-identified as white, college-educated, professionals who were employed full-time. These women were solicited from area organizations and groups that were largely female in membership. Based upon sample demographics, solicitation within these organizations and groups may have resulted in the unintentional exclusion of less privileged women as determined by race, education, and socioeconomic status. This did not preclude the construction of a credible theory based upon the comparative analysis of collected data (Corbin & Strauss, 2015; Glaser, 1998). For informational purposes, it should also be noted that study results (the grounded theory and subsidiary findings) are based on a sample of adult American women from the immediate geographic area (West Tennessee) with its attendant area-specific sub-culture. Lastly, the theory constructed from the data collected and analyzed during the course of this study is generalizable to similarly situated women, but the study itself is not repeatable in the quantitative sense.

While not repeatable, the validity and reliability of a GT are based upon criteria that may seem odd to the quantitative researcher. Per Corbin (Corbin & Strauss, 2015), the criteria of validity and reliability are too closely related to quantitative research to be useful in explaining the results of qualitative research. She prefers to evaluate GT by determining its *credibility*, a term borrowed from Glaser and Strauss (1967). To Corbin, credibility "reflect(s) participants',

researchers', and readers' experiences with phenomena, but at the same time, the explanation the theory provides is only one of many possible 'plausible' interpretations from data" (p. 346). In operationalizing the idea of credibility, I found it useful to rely upon Glaser and Strauss's explanation of *applicability*; that is, does the theory have "**fit**, **understanding**, **generality**, and **control** (p. 23). The theory generated from this research meets requirements for fit, understanding, generality, and control. It fits the substantive area of crying in response to emotional stress, it was understandable to the participants, it was sufficiently general in that it could be applied to the phenomenon investigated in different contexts, and it could be controlled in that contexts and conditions affecting the phenomenon can be manipulated. (See Chapter 3 for a more detailed discussion of fit, understanding, generality, and control as it applies to the GT derived from this research.)

Significance to Nursing

The assumed cathartic effect of crying as a therapeutic release of stress and pent-up emotions (Bylsma et al., 2008; Cornelius, 2001; Dugan, 1989; Hendriks, Rottenberg, & Vingerhoets, 2007; Nelson, 2005, 2008) is widely held and of longstanding (Bagby, 1999; Dugan, 1989; Fooladi, 2005; Kottler, 1996; Lutz, 1999). Laypersons and many healthcare professionals—including physicians, nurses, psychiatrists, psychologists, and professional counselors—tend to accept the largely unsupported belief that crying has healing properties, both physiological and psychological (Bagby, 1999; Fooladi, 2005; Garcia, 2006; Lipe, 1980; Murray, 2009; Nelson, 2005, 2008; Schiedermayer, 1990). Still, the overwhelming popular conviction that crying is an essential component of emotional healing should not be ignored. In this regard, it is important to note that although the healing power of crying has not been conclusively demonstrated, it has not been conclusively discounted.

Conclusively demonstrated or not, the unquestioning supposition of many healthcare professionals that crying is a self-medicating healing modality remains. If crying does exert a restorative influence on biopsychosocial imbalances, then nurses need to understand how its effects can be utilized to maximize the benefit accruing to the patient and his or her family members. Although normal crying is typically a spontaneously occurring phenomenon, it does not occur absent context or meaning. The meaning it holds for the person crying must be more fully understood, in both its social and cultural contexts, if its purported benefits are to be accessed (Cornelius & Labott, 2001; Kottler & Montgomery, 2001). Importantly, crying also serves a communicative function (Kottler, 1996; Vingerhoets et al, 2009). That is, a patient's crying may be signaling pain, discomfort, distress, or the need for support and comfort (Fooladi, 2005, 2006; Rydé et al., 2007; Teisan, 2003; Zengerle-Levy, 2006). Conversely, a patient's crying may be signaling the desire for privacy so that his or her emotional distress is not observed by others (Rydé et al., 2007).

Nurses are in a position to provide salubrious interventions, helpful advice, and psychological support based upon an understanding of crying and how it influences the biopsychosocial interactions that are impacting the patient's mental, physical, and spiritual idiosyncratic homeostasis (Fooladi, 2005, 2006; Lipe, 1980; Rydé et al., 2007; Zengerle-Levy, 2006). Mention of the spiritual component of an individual's state of being is included here because, according to Griffith et al. (2011) crying, as a cathartic, "… appears to bridge the divides between mind and body, mind and spirit, and body and spirit." (p. 176). Fooladi (2005), Garcia (2006), Zbilut (1980), and Zengerle-Levy (2006), nurses describing the holistic nature of their practice, discuss healing in terms of mind, body, and spirit symbiotic interactions and interdependencies. Similarly, Hunt (1992) writes of how crying allows existential angst to be

lived “in terms of the body” (p. 177). Transcendence is evidenced in a “unity of connection with all that exists or by simply accepting things as they ‘Are’… it is at this boundary of ‘between’ that crying occurs” (p. 177). Crying that heals the spirit was also explored by Bagby (1999), Dugan (1989), and Kottler (1996). This led them to contend that spiritual transformation, transcendence, reawakening, and enlightenment can be achieved through crying and tears.

If crying has therapeutic value, then ways in which that value can be accessed, maximized, and managed is important to the practice and science of holistic nursing (Griffith et al., 2011). Among healthcare professionals, nurses spend the most time with patients and their families and loved ones (Vingerhoets et al., 2009; Zengerle-Levy, 2006). They may cry themselves in response to overwhelming situational emotions they experience as caregivers (Lipe, 1980; Teisan, 2003; Wagner, Hexel, Bauer, & Kropiunigg, 1997; Zengerle-Levy, 2006). Thus, it behooves the nursing profession to have as full an understanding as possible of the processes underlying crying and emotional expression. Understanding how—or even if—crying can help those in physiological or psychological distress reduce or eliminate the associated body, mind, and spirit related stressors acting to compromise the individual’s optimal state of wellness may be as essential to the art and practice of nursing as is understanding how various drugs and medications act to mediate the effects of an illness trajectory or restore homeostasis and mental stability.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

In grounded theory research, a recommended strategy is to postpone a review of subject area literature addressing fact and theory until such time as the analytic core of the theory emerges or is discovered (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The concern here is that a premature review of the literature may bias the process of theory discovery. Ideally, the researcher enters the GT inquiry without preconceptions based upon ideas, concepts, or hypotheses found in the literature. This concern does not, however, preclude consideration of the literature that suggested the area to be investigated, nor does it restrict analysis and discussion of the state of the science (SOS) foundational to the subject area. In fact, some degree of familiarity with subject area scholarly, professional, and popular literature is basic to the enhancement of the researcher's theoretical sensitivity (Corbin & Strauss, 2008, 2015; Glaser, 1978; Strauss & Corbin, 1990, 1998).

In this study, SOS assessment involved consideration of the phenomenon being investigated (crying), an underlying concept of interest (crying that heals or CTH), and the study sample (women who have cried in response to the emotional stress of a personal crisis). My knowledge of the SOS involving crying was initially based upon a review and analysis of the scholarly, professional, and popular literature conducted in the preparation of the concept evaluation of CTH (Griffith et al., 2011) per the methodology for concept evaluation proposed by Morse, Mitcham, Hupcey, and Tasón (1996). Since that time, I have expanded my study of the literature on crying to broaden my knowledge of the hypothesized therapeutic value of crying

and the implications this might hold for the science and practice of holistic nursing. While it might seem that by doing so, I have violated one of the fundamental tenets of grounded theory (i.e., the stipulation that one should enter into the investigation without preconceptions based in existing scholarship), this is not the case.

The possibility of formulating preconceptions about crying and its effects, therapeutic or otherwise, is confined by the literature itself. As previously stated, the literature on crying is inconclusive and contradictory (Hunt, 1992; Vingerhoets et al., 2009). This is because, in part, the scientific literature on crying and the purported therapeutic value of crying is based upon observation-based anecdotal accounts, various theories, retrospective studies, and laboratory experiments that used sad movies to elicit emotional tears (e.g., Frey, 1985; Gross et al., 1994; Kraemer & Hastrup, 1988; Labott & Martin, 1988; Labott & Teleha, 1996). Apart from six studies (Fooladi, 2005, 2006; Hunt, 1992; Rydé et al., 2007; Rydé et al., 2008; Zengerle-Levy, 2006) I found in my literature searches, qualitative research on crying appears to be limited. And, much of the literature on crying involves the study of infants. These sources were of little value to this study. Infants cannot describe, relate, or reflect upon the experience of crying. And, although crying is of interest to multiple disciplines, most research involving adult crying seems to have been accomplished in the fields of anthropology, sociology, and psychotherapy (psychology, psychiatry, counseling). Very little of the research into crying has addressed the science and practice of nursing.

In short, while crying has been a subject of interest for several thousand years, very little is known about the processes fundamental to its function or effects. Thus, I entered into this study without conscious preconceptions regarding the concepts and categories that awaited discovery in the data I planned to collect and analyze. Still, I was not a blank slate: I did have a

great many questions stemming from my own experience and reading the scholarly, professional, and popular literature. Admittedly, I do believe that CTH is appropriately classified as a concept, but I when I undertook this study, I could not state with any degree of certainty that it was a concept of genuine significance to the scientific community. Participating in the evaluation of CTH was, however, the impetus for my desire to better understand the complexities of crying and how knowledge of this uniquely human phenomenon (Borquist, 1906; Darwin, 1872/1998; Frey, 1985; Frijda, 2001; Lutz, 1999; Vingerhoets & Cornelius, 2001) might contribute to the science and practice of holistic nursing.

Studying the literature used in evaluating CTH provided me with an appreciation and understanding of the numerous variables associated with the biopsychosocial aspects of crying. Subsequent to the CTH evaluation, I continued searching the literature for additional information on crying, particularly as it related to emotions, stress, and catharsis. In turn, this led me to look for research that theorized about the putative benefits of crying as an emotional release of stress. The accumulated literature resulting from these searches laid the groundwork for this GT study.

Literature Searches

In reviewing the literature for information relevant to the concept evaluation of CTH, I relied upon electronic databases, the Internet, and the reference sections of scholarly research articles to identify additional sources, in particular, books that might be of interest. Initially, I searched the Cumulative Index to Nursing & Allied Health (CINAHL) Plus with Full Text and the Medline/PubMed databases for peer-reviewed articles using crying, tears, weeping, healing, holistic healing, adult, adolescent, therapeutic, therapy, and health as search terms both individually and in combination (Griffith et al., 2011). I also searched the Internet for scholarly, professional, and popular literature and commentary using the same terms. The Arts and

Humanities Citation Index (A&HCI), Thomson Reuters (ISI) Web of Knowledge, the Science Citation Index Expanded (SCI-Expanded), and Social Sciences Citation Index (SSCI) databases were searched for scholarly articles with crying in the title in the subject areas of general medicine, internal medicine, psychiatry, psychology, and psychoanalysis. In toto, these searches resulted in the selection of 54 sources for inclusion in the manuscript on CTH concept evaluation (Griffith et al., 2011). Of these sources, 44 were scholarly (24 articles, 9 books, and 11 book chapters), five were professional, and five were popular.

After the CTH concept evaluation paper (Griffith et al., 2011) was published, I realized I wanted to learn more about the purported cathartic effects of crying, crying as an attachment behavior, and crying as an emotional response. With that in mind, I have periodically accessed the CINAHL, PubMed, and PsychINFO databases and searched them using the terms crying, catharsis, catharsis theory, emotions, stress, attachment, and attachment theory both individually and in various combinations. My primary intent with these searches was to keep abreast of research investigating crying and to determine if there were new or revised theories of crying that might foreclose or limit the scope of my intended research. My first post-CTH search of the literature identified six sources dealing with theories of crying. Three of the theory articles dealt with catharsis theory (Kraemer & Hastrup, 1988; Norton, 2011; Scheff, 2007) and one with attachment theory (Nelson, 2008). The article by Nelson (2008) turned out to be a book chapter. I expanded my source material library by mining the reference sections of this literature to uncover sources that dealt with crying and emotions I did not have and acquired them. Once I had read the sources thus obtained, I repeated the mining and acquisition process. Recent literature searches have not turned up much in the way of new research into crying, although I did find a few scholarly articles I did not have (Efran & Greene, 2012; Montagu, 1959; Parvizi,

Anderson, Martin, Damasio, H., & Damasio, A., 2001; van Hemert, van de Vijver, & Vingerhoets, 2011). Perusing the Internet for new items of interest yielded transcripts of interviews with Maurice Mikkers and Ad Vingerhoets, both of whom have made important contributions to the study of tears and crying (Mathews, 2015a, 2015b). Internet searches also produced two items about crying intended for popular consumption (Knight, 2014; Paulson, 2016). (The articles by Mathews [2015a, 2015b] and Paulson [2016] contained no new information relevant to this study and are not referenced elsewhere in this paper.)

As in my literature searches for the CTH concept evaluation (Griffith et al., 2011), sources dealing with subjects younger than 18 years were excluded. (There were several reasons for this exclusion. First, there is very little literature dealing with subjects between the ages of 2 and 18 years [Vingerhoets et al., 2009; Zeifman, 2001]. Second, crying in children younger than 2 years of age is primarily a survival mechanism that serves to solicit care [Darwin, 1872/1998; Vingerhoets et al., 2009; Zeifman, 2001]. Third, I had concerns that subjects younger than 18 years may not possess the mental and emotional maturity necessary to accurately assess stress-induced psychophysiological conditions.) This new literature, in combination with literature cited in the CTH concept evaluation, comprised the sources for an SOS analysis of the research into crying and its hypothesized therapeutic value.

In summarizing the SOS in crying research, I discuss the catharsis, attachment, two-factor, biochemical, and multi-dimensional theories of emotional crying; comment on the model of crying proposed by Vingerhoets et al. (2000); synopsize what is known about the physiology of tears; elaborate upon the various types of crying; consider crying related to cultural norms; review qualitative studies of crying; and offer commentary on the significance of crying to the science and practice of nursing.

Theories of Crying

The overwhelming acceptance of crying as a healing phenomenon that has persisted for nearly 2,500 years (Aristotle, 1984) constitutes a theory of crying in and of itself. In my opinion, it is the enduring, collective nature of the belief in the healing power of crying that has motivated the theorizing and quantitative research directed toward establishing and understanding the underlying causes and resultant effects of this phenomenon. As previously acknowledged, much has been discovered about crying, but a great deal more remains to be discovered. This is evidenced by the theories and model that attempt to explain crying.

Catharsis Theory

The generally accepted definition of catharsis is "the purging of emotions or relieving of emotional tensions" (Blysma, Vingerhoets, & Rottenberg, 2000, p. 1165). The belief that crying is an emotional response that results in catharsis, or a purging or discharge of negative tensions, originated with Aristotle (1984). He suggested that those who attended theatrical drama could rid themselves of the painful emotions stemming from observing the performance by crying, thereby achieving catharsis. Breuer and Freud (1895/1955) were the first to propound a theory of catharsis in which "energetic reaction" to a stressor leads to "cry(ing) oneself out" or functions to "blow off steam" (p. 8). In the case of crying leading to catharsis, Breuer and Freud proposed a hydraulic theory of crying and emotion. As pressure from an emotional stimulus built up over time, tears also built up. Once the crisis in the patient's emotional condition was reached, the tears stored in the lacrimal ducts overflowed and crying occurred. The initiation of crying coincided with the zenith of the emotional crisis. With the crisis averted, emotional healing could begin and a return to psychophysiological homeostasis facilitated.

The cathartic method for treating hysteria originated with Breuer's therapeutic interventions with patient Fräulein Anna O. between 1880-1882 (Breuer & Freud, 1895/1955). Discovered more by accident than design, Breuer realized that his patient, in recalling a repressed memory of trauma and consciously voicing the details of that memory, was no longer subject to its symptoms. Freud called this discharge of the repressed traumatic memory *abreaction*. His theory of abreaction was the direct antecedent of psychoanalysis (Strachey, 1955). To Breuer and Freud (1895/1955), the symptomatic relief of a traumatizing incident (s) resulting from the cathartic method referred to any energetic reaction, not just crying, that brought about abreaction. The essential point here is that relief occurred: Cornelius (2001) concluded that crying that brought about the resolution of a problem did, in fact, result in catharsis.

Even though most people, if questioned, would agree that crying is essential to releasing the stress associated with pent-up emotions, research to bolster this belief has failed to conclusively establish the presumed cause and effect linkage between crying and catharsis (Frey, 1985; Gross et al., 1994; Kraemer & Hastrup, 1988; Labott & Martin, 1988; Labott & Teleha, 1996) and has, in some instances, yielded mixed and/or contrary results (Bylsma et al., 2008; Cornelius, 2001; Levitz, 2006; Scheff, 2007). The lack of conclusive support for a catharsis theory of crying (or other energetic reaction) has led some researchers to look elsewhere in their endeavors to explain the presumed therapeutic value of crying. For example, Bolstad (n.d.) suggests that misery is best obviated, not by a good cry, but by a change in life style that eliminates the source of that misery.

Attachment Theory

When Nelson (2005) began practice as a psychotherapist in the late 1960s, she discovered there was nothing in the psychological literature that addressed crying. Surmising that crying might play an important therapeutic role in psychotherapy, she subsequently investigated attachment theory (Bowlby, 1980) as a possible basis for developing a theory of crying in psychotherapy. In the context of attachment theory, crying is viewed as a method of communicating distress to others (Kottler, 1996; Kottler & Montgomery, 2001; Nelson, 2005, 2008). The crying person is essentially signaling that he or she is experiencing a stressful situation and requires the comfort and support of other people, such as family members, friends, or professionals. Attachment theory maintains that if comfort and support from other people is forthcoming, then this acts to relieve the crying person's stress and helps them reestablish an optimal state of wellness. While noting that "crying plays a crucial role in the therapeutic dialogue" (p. 212), Nelson (2008) claims that a theory of crying based on attachment leads to an understanding of the meaning of crying, the ability to distinguish different types of crying, and the ability to identify attachment and caregiving styles.

Two-Factor Theories

Oddly enough, there are two two-factor theories. One is a cognitive theory of weeping; the other, the overflow or hydraulic theory discussed in the section on catharsis theory. Both two-factor theories involve the creation of arousal (stress-related emotion) and the subsequent reduction in arousal; hence, two factors. In the hydraulic/overflow model, the two factors or stages are: (1) the accumulation of emotions until they reach a crisis level, and (2) "then overflow, as either tears or laughter" (Labott & Martin, 1988, p. 206). Labott and Martin (1988) note that in the hydraulic/overflow model, tears and the overflowing emotions are one and the

same. In the cognitive theory of weeping, tears merely signal the shift from increasing arousal to decreasing arousal (Efran & Spangler, 1979; Efran & Greene, 2012).

In testing the propositions foundational to the cognitive theory of weeping, Labott and Martin (1988) showed a film with an uplifting beginning and a sad and unexpected ending to 47 female undergraduate volunteers, divided into three groups. One group viewed the entire film (activation, incongruity, and resolution segments), another viewed the film from where the incongruity was introduced, and the third group watched a neutral film. In defining activation, Labott and Martin stated that this was the point at which the film's narrative schema was established. Incongruity occurred when events derailed the film's plot, or narrative schema, as initially conceived. Resolution occurred when the incongruity was accepted and replaced the initial narrative schema.

The results of Labott and Martin's (1988) study yielded some support for both two-factor theories. As predicted by both the overflow and cognitive theories, arousal antedated weeping. However, results did not show that the initiation of crying precipitated a reduction in arousal as predicted by overflow theory. The trend in the direction of reduced arousal was nonsignificant. For the group that saw the entire film, the final scene evoked the highest stress and depressed mood. This group reported that they felt better after weeping, but not during.

As Labott and Martin (1988) pointed out, limitations to this study included self-report data and associated drawbacks, the fact that about half the subjects had already seen the stimulus movie, and the indeterminate nature of schema trip points. After analyzing the data from this study, Labott and Martin concluded that neither the overflow nor cognitive theory was likely to provide definitive insights into weeping.

Biochemical Theories

Frey (1985) discovered and/or confirmed a variety of chemicals in tears, and the composition and concentration of these chemicals seemed to be dependent upon the type of tears secreted. In comparison to irritant tears, the chemical composition of emotional tears revealed significantly higher protein concentrations. This was even though the volume of emotional tears was greater than that of irritant tears. Other chemicals in tears included the hormones prolactin and corticotropin (adrenocorticotropic hormone or ACTH) and the endorphine leucine-enkephalin. Based on the observations that women cry more frequently than men and women exhibit higher prolactin concentrations in their tears, Frey hypothesized that higher prolactin levels lowered the threshold for crying. This hypothesis has not been confirmed (Kottler & Montgomery, 2001), although a study by Vingerhoets, Assies, & Poppelaars (1992) found no evidence that higher prolactin levels affected the onset of weeping.

Frey's (1985) discovery of ACTH in human lacrimal glands suggested that this hormone could be a factor in stimulating tear secretion. While not a consideration in emotional tearing, the presence of ACTH in the lacrimal glands may lead to treatment for dry eye syndrome and the over production of tears in people with a decreased crying threshold.

The presence of leucine-enkephalin in both irritant and emotional tears caused Frey (1985) to speculate as to why a chemical from the endorphine family was found in the lacrimal glands. Because endorphines modulate pain sensation, Frey posited the presence of leucine-enkephalin in tears might have something to do with the diminishment of stress-related emotional pain. To my knowledge, this hypothesis has not been tested.

Perhaps the most important result of Frey's (1985) research was the finding that the lacrimal gland had manganese concentrations 30 times higher than blood serum. After learning

that high manganese (a toxic element) concentrations can alter mood, he found some justification for an earlier hypothesis that tears serve an excretory function in that they clear toxins from the body (Frey, Desota-Johnson, Hoffman, & McCall, 1981). Again, this has not been established, but it remains a topic worthy of further investigation.

Hypotheses that suggest crying has positive effects on physiological well-being are not limited to emotional tears. Without distinguishing between the different types of tears, Montagu (1959) posited that weeping in humans—as opposed to tearless crying—is an adaptive evolutionary response that Darwin overlooked. Montagu attributed bacteriostatic function to tears because they contain lysozyme, an enzyme with bactericidal properties, and because they are wet. His hypothesis was that crying simultaneously lubricates the nasal mucosa with tears containing lysozyme while stimulating the mucosa to secrete even more lysozyme. Both actions work in tandem to inhibit the growth of harmful bacteria (and possibly viruses) that would otherwise thrive on a dry mucous membrane. I found no evidence to support Montagu's hypothesis, but it is possible that improvements in tear collection and assay methods may permit its testing in the future.

Multi-Dimensional Theories of Crying

As is evident from the previously discussed theories, none exhibit the scope and depth necessary to adequately describe the complexities of a multi-dimensional phenomenon such as emotional crying (Kottler & Montgomery, 2001; Vingerhoets et al., 2000; Vingerhoets et al, 2009). Understanding the functions of crying requires knowledge of a number of variables and related factors. Conceptually, crying can be characterized through the GT processual sequence of properties and dimensions, context, causal and intervening conditions, and actions/interactions/emotions (Corbin & Strauss, 2008; 2015; Strauss & Corbin, 1990, 1998).

Each property, e.g., intensity, frequency, and duration, is temporal in dimension. Context accounts for situational variables such as the interaction and influence of biopsychosocial factors (Corbin, 2008, 2015). For example, what is the physical status of the person crying? What is her mental state? How do personality and character traits impact proneness to crying? What gender role is manifest? Was anyone else present and if so, who? What triggered the crying event and how is the event affected by intervention strategies activated by the crying person or others present? What social conventions and cultural norms compel the appraisal of the crying event? What meaning does the crying event hold for the person who is crying? What course might the crying event take, with and without intervention? In short, crying is an intricately fabricated and subtly nuanced phenomenon that is unlikely to be explained by any theory that fails to take into account a myriad of variables, all of which are temporally intertwined to degrees that are unpredictable and difficult to accurately assess (Vingerhoets et al., 2009).

Comprehensive Model of Adult Crying

One of the persistent problems complicating the study of crying has been the lack of a model that incorporated the components, variables, and factors influencing the phenomenon's causes and effects (Vingerhoets et al., 2000). In 2000, Vingerhoets et al. proposed a synthesis model of crying inclusive of both situational and biopsychosocial factors. This model addressed the interaction of these dynamics with the perceived environment. Emotions result from the individual's appraisal of that environment. This appraisal takes into consideration the social and physical features of the situation. Also relevant to this appraisal are the individual's characteristics, including emotional state, personal goals, and prior experience in like circumstances (Vingerhoets et al., 2000). A key aspect of the model appears to be the degree to which the individual feels he or she can cope with or control situational aspects. Vingerhoets et

al. (2000) posit that the appraisal thus formulated activates "emotion programs" (p. 360). These programs, also called emotion syndromes, are "patterned, biologically and socially based collections of responses that include physiological, expressive, experiential, and behavioral components" (Vingerhoets et al., 2000, p. 360). Significantly, the individual can modulate, modify, or inhibit the emotion program response should a reappraisal of situational and personal variables result in a revised assessment of the environment. Crying then, as an emotional response, is an individual encounter and interaction with self and environment that may be transformed by that individual's continuous reappraisal of and acclimation to the situation. The outcome of these situational appraisals and reappraisals is dependent upon the emotion program in operation at any given point in time. And while the model does account for the possibility that crying can act as a healing modality, both physiologically and psychologically, it does not explain why, how, or if healing actually occurs. Interestingly, in proposing this model of crying, Vingerhoets et al. (2000) offer the conclusion "that crying is an emotional response that needs to be conceptualized in much the same way as emotions in general" (p. 360). This quote caused me a good deal of consternation in trying to make sense of what Vingerhoets and his colleagues meant. I attempted to rationally assess how crying might simultaneously be both an emotional response and an emotion without success. Happily, clarification was forthcoming in a later article (Vingerhoets et al., 2009). The preceding quotation should have read, "… the same way as emotional responses in general." That, I understand and agree with.

The Physiology of Tears

One area of information that may be essential to optimal patient wellness has to do with the physiology of tears. Although Darwin (1872/1998) viewed human crying as an involuntary response, he believed the only purpose served by tears was to lubricate and cleanse the eyes and

that emotional tears were merely incidental to crying. However, modern laboratory equipment and scientific analytical techniques lend support to a different assessment of tears; oddly, an assessment more in keeping with his theory of natural selection.

All types of tears—basal, irritant, and emotional—contain hundreds of proteins whose purpose appears to be related to the surface viscosity of the tear film (Millar, 2006; van Haeringen, 2001). Basal tears are generated continuously and have antibacterial properties. Per Frey (1985), their purpose is to lubricate and help protect the eye. Irritant tears have a watery consistency to aid in flushing the eyes after exposure to chemicals or foreign objects (Frey, 1985). Compared to emotional tears, irritant tears contain substantially less serum protein by volume and contain no natural elements (Frey et al., 1981). Of the three types of tears, the physiological profile of emotional tears is the most complex. Emotional tears differ in chemical composition and volume in comparison to basal and irritant tears (Frey, 1985). These tears contain large quantities of hormones, specifically prolactin and ACTH, which are also secreted by other organs as a normal response to stress. Emotional tears also contain increased amounts of manganese and potassium. Frey noted that these elements, by-products of the stress response, act as bodily toxins. This implies that stress-related emotions can have a negative effect on physiological health and well-being. Frey hypothesized that emotional tears serve an excretory function in ridding the body of these toxins. Because most tears are reabsorbed into the nasal cavity, Lutz (1999) questions this hypothesis. Still, the unique chemical composition of emotional tears may indeed function as a component of a yet-to-be determined stress reduction process indispensable to an individual's return to psychophysiological equilibrium. The question here is whether emotional tears function to rid the body of toxins accumulated in the lacrimal

glands by a process yet undiscovered or if emotional stress somehow produces elemental toxins that must be discharged.

A neuroanatomical factor that figures into the speculation that stress can cause the buildup of elemental toxins in the lacrimal glands that are discharged by psychogenic tearing is the innervation of the lacrimal system (Frey, 1985; van Haeringen, 2001). Per van Haeringen (2001), the lacrimal system is innervated by both the sympathetic and parasympathetic systems and these systems may regulate tear secretion. He states: "Within the lacrimal gland, parasympathetic fibres terminate on the surface of the secretory cells and about the myoepithelial cells of the ducts. The sympathetic supply terminates about the arteries and the arterioles serving the gland" (p. 24). These facts lead to the presumption that emotional crying in response to stress is affected by both components of the autonomic nervous system (Frey, 1985; van Haeringen, 2001). In responding to stress, the body releases toxins into the blood supply and the lacrimal glands while the sympathetic nervous system restricts blood flow to the lacrimal glands, thereby limiting their excretory function. At some point in the emotional arousal resulting from the stress, the arousal peaks and lacrimal system innervation transitions from sympathetic to parasympathetic. When this happens, psychogenic tearing occurs (Frey, 1985; van Haeringen, 2001). Because the parasympathetic nervous system is responsible for maintaining the body's at rest status, or homeostasis, it seems logical to associate emotional crying with the restoration of psychophysiological equilibrium (Frey, 1985; Selye, 1974; Vingerhoets & Scheirs, 2001). As previously discussed, Frey (1985) theorizes psychogenic crying physically discharges harmful stress-related toxins that have accumulated in the lacrimal glands thereby serving a function essential to the restoration of homeostasis.

Types of Crying

In the concept evaluation of CTH, types of crying were characterized as therapeutic or non-therapeutic by Griffith et al. (2011). Descriptions of these categories follow.

Therapeutic Crying

In evaluating CTH as a concept, Griffith et al. (2011) noted that its primary characteristic was that it must have therapeutic effect. This effect might be a cathartic abreaction of negative affect; the discharge of toxic, stress-related elements; the reception of aid and/or comfort; or the communication of empathy. The problem in assessing the aforementioned characteristic is two-fold: (1) determining if crying had a therapeutic effect and (2) quantifying that effect. No convincing solution has been discovered for either part of this problem. Part of the difficulty in solving the preceding problem is the ethical consideration. If it were ethical (and moral) to inflict physical pain or psychological distress on test subjects, then many of the questions about crying and its purported healing properties might be easily answered. Tears could be collected as they flowed so that volume and chemical composition could be accurately measured and analyzed and various biological measurements (respiratory rate, heart rate, blood pressure, skin conductivity, etc.) could be continuously monitored and evaluated. But because it is not ethical (or moral) to intentionally inflict pain on test subjects, that limits experimental research to testing hypotheses on the therapeutic effects of crying in laboratory settings.

Laboratory experiments testing hypotheses about the therapeutic value of crying have heretofore relied upon having subjects watch sad movies (e.g., Frey, 1985; Gross et al., 1994; Kraemer & Hastrup, 1988; Labott & Martin, 1988; Labott & Teleha, 1996). All the subjects who cried during the movies reported feeling worse, both physiologically and psychologically, after crying. Nonetheless, these experiments did demonstrate the difficulties with testing hypotheses

related to crying and healing. They also demonstrated the difficulties that might be associated with trying to evaluate the effects of subjects not crying when under emotional duress.

Just as common as the belief that crying serves an emotional safety valve and is thus "good for you," is the belief that suppressing crying is unhealthy and leads to a variety of disagreeable physical ailments such as headaches, ulcers, hypertension, and insomnia (Vingerhoets & Scheirs, 2001; Vingerhoets et al., 2009). Hover (1979) adds asthma, migraine, alcoholism, colitis, and heart disease to the list of physical illnesses that can result from suppressing emotional expressions of stress.

Further commentary on the ill effects of restraining the discharge of pent-up emotional turmoil is offered by Dugan (1989). Dugan maintained that stress can be—and must be—alleviated by using either laughter or crying as the discharge mechanism. His message is directed at nurses, whom he challenges: "learn to integrate laughter and tears practically and appropriately into nursing care, thereby increasing work satisfaction and facilitating emotional healing" to "manag[e] personal and professional stress" (p. 18). Dugan goes on to present a list of the physical, emotional, and mental signs (adapted from a 1983 lecture by Annette Goodheart) that indicate the inappropriate suppression of stress. In addition to those already mentioned, physical signs include "muscle tension, bruxism, lower resistance, colds, cold sores, stomach acidity, stomach tightness, and fatigue." Emotional signs include "irritability, exhaustion, boredom, anxiety, depression, withdrawal, helplessness, and lethargy." Mental signs include "pessimism, less concentration, pickiness, tunnel vision, mental errors, and forgetfulness" (p. 21).

Of course, not all emotional crying is related to negative stress. Consider, for example, that one may cry out of joy, relief, excitement, or gratitude. Griffith et al. (2011) and Hunt

(1992) suggest that crying in these instances might still be related to the release of negative stress if the crying resulted from the fact that something bad that might have happened did not. As Nelson (2008) states: "Even tears of joy may represent losses averted or losses mixed with gains." (p. 206)

Non-Therapeutic Crying

In addition to types of crying where healing does not appear to be a direct issue, there are several types of crying that have nothing to do with healing in any context. These types of non-therapeutic crying include pathological crying (PC) (Parvizi, Anderson, Martin, Damasio, H., & Damasio, A., 2001; Shaibani, Sabbagh, & Khan, 2001; van Haeringen, 2001), crying because of pathological grief (Drell, Fuchs, Fishel-Ingram, Greenberg, Griffies, & Morse, 2009), and crying intended to deceive, control, and/or manipulate (Lutz, 1999; Vingerhoets et al., 2000; Vingerhoets et al., 2009). PC is not related to emotional expression or emotional disturbance (Parvizi et al. 2001; Shaibani et al, 2001). Rather, PC is reflective of "certain neurological disorders such as stroke, multiple sclerosis, Parkinson's disease, and motor neuron disease" (Shaibani et al., 2001, p. 267). Crying associated with pathological grief is seen in those who are unable to accept the loss of a loved one and experience repeated crying events over long periods of time. This type of non-productive crying may continue for years and affords the suffering person no emotional relief or closure (Drell et al., 2009; Hogan, Greenfield, & Schmidt, 2001). Crying intended to deceive, control, and/or manipulate is used as a ploy to gain an advantage, win an argument, or deflect attention (Lutz, 1999; Vingerhoets et al., 2000). Also falling under the classification of what may appear to be non-therapeutic crying is ritual weeping characteristic of grief displays in some cultures. Under certain circumstances, crying display rituals prescribed by cultural norms may not have any identifiable relationship to healing, although these displays

may function to create a sense of community and reaffirm shared beliefs (Becht, Poortinga, & Vingerhoets, 2001; Fooladi, 2005; Grambo, 1971; Kukulu & Keser, 2006; Vingerhoets & Scheirs, 2001; Wellenkamp, 1988).

Crying Related to Cultural Norms

Crying has a cultural component that can dictate when and if it is appropriate to cry, the purpose(s) to be served by crying, and the correlation of gender to situational crying. This is especially true in non-western societies. Grambo (1971), in summarizing historical and extant folk traditions of ritual crying from Scandinavia, Russia, the Balkans, the Middle East, India, Africa, and Indonesia, concluded that "ritual crying is always culturally conditioned" (p. 66). He also noted that in addition to functioning as a demonstration of sorrow, ritual crying often had magical qualities. In the latter case, the magical aspects of crying were intended to increase the earth's fertility so that harvests would be bountiful (cf. Hvidberg, 1962; Wellenkamp, 1988). In the former case, ritual crying exhibited the sorrow associated with the death of a family member before, during, and after burial ceremonies. Forms of ritual crying were also employed to mark the pending marriage of a maiden and at weddings. Significantly, Grambo noted that a view prevalent in many of the folk traditions he researched was that too much crying could be unhealthy or sinful or, from a supernatural perspective, dangerous.

In an ethnological study of the Toraja of highland South Sulawesi, Indonesia, Wellenkamp (1988) related how these indigenous people expressed grief following a death or in other circumstances. Interestingly, the Toraja belief system involves an "implicit 'cathartic' theory of emotion" (Wellenkamp, 1988, p. 486) that equates "heat" with emotional upset and "coolness" with the calmness of normal existence. They believed that emotional turmoil marked by strong emotions results in heat, and "is antithetical to the 'coolness' of health" (Wellenkamp,

1988, p. 492). Strong emotions are therefore harmful because they cause confusion and a decrease in the state of consciousness. And while the Toraja believe that excessive crying is detrimental to health, they encourage wailing and weeping at funerals as a safe way for mourners to express grief (Wellenkamp, 1988).

Wailing is a traditional way in which some communities express grief and cope with bereavement (Gamliel, 2007; Grambo, 1971; Kottler, 1996; Wellenkamp, 1988). Gamliel (2007) maintains that wailing has two aspects, socio-ritual and therapeutic. In the Yemenite-Israeli community he studied, professional wailers, always women, helped bereaved families mourn their dead. Oddly, professional wailers seldom cry when performing, but those who are skilled at the art of tunefully intoning an extemporaneous memorial narrative elicit copious tears from family members present. Mourning in this way functions to maintain a sense of community and belonging while allowing the bereaved family to begin its acclimation to life without the deceased. For Jews, religious law prescribes that "close relatives (nuclear family) of the dead 'sit *shiva'"* (Gamliel, 2007, p. 1504). *Shiva*, Hebrew for seven, means that close relatives follow a specified pattern of mourning for 7 days after the death of a family member. The first 3 days of this period are referred to as the "days of tears" (Gamliel, 2007, p. 1504). This is the time when women of the family are permitted to wail in tearful explication of their grief.

Women also figure prominently in Turkish crying displays (Kukulu & Keser, 2006). The Turks, predominantly Muslim, believe crying is unmanly, and this is apparent in the fact that Turkish women cry much more frequently than do Turkish men (3.5 times in a 4-week period for women; 1.1 times in a 4-week period for men). Still, it is acceptable for men to cry at funerals, although guests are not allowed to cry during the burial itself (Kukulu & Keser, 2006).

According to Kukulu and Keser (2006), Turkish women cry when trying to make the bride cry prior to her wedding, when male relatives join the army, and often during religious activities.

Crying during religious activities is fundamental to the weeping exhibited by members of a Taiwanese Buddhist charismatic group known as Ciji (Huang, 2003). The profuse weeping among Ciji members is in sharp contrast to other Chinese who, in general, maintain tight control over their emotions (Huang, 2003). Describing themselves as "people who love to cry" (Huang, 2003, p. 73), Ciji members often experience spontaneous, uncontrolled crying and sobbing. This crying invariably occurs in the presence of the group's founder and leader, the Venerable Zhengyan, a charismatic Buddhist nun. As Huang (2003) notes: "A phenomenon that pervades all Ciji activities is uncontrolled, nonverbal crying" (p. 75). Curiously, male members—about 30% of the Ciji membership—of the group cry very little, whereas female members cry often, copiously, and sometimes dramatically. Huang (2003) hypothesized that the excessive, but accepted crying among Ciji's female members "conveys multiple interpretations that are organized around a discourse that stresses femininity and contains a transformative capacity in the followers' identity" (p. 85).

Although crying by the Ciji membership is not, in and of itself, ritualistic, it is a predominant feature in the group's rituals (Huang, 2003). Crying in what might be termed the Ciji sub-culture has no particular form or definitive thematic profile. This diverges from the recurrent themes present in the ritual crying extant in cultures previously discussed and, presumably, in other cultures as well. These themes included catharsis, the dangers of crying too much or too little, formally defined periods for mourning, the primary role of women as wailers or weepers, and social accommodation of self and community. Catharsis is achieved through ritual wailing and weeping that permits a psychophysiological outlet for bereavement. Crying

too little or too much can result in unhealthy emotional suppression or societal disapproval and subsequent isolation. Formal periods of mourning, e.g., 30 or 40 days (Grambo, 1971), or sitting *shiva* (Gamliel, 2007), prescribe how long it is appropriate (and required) to remain in a state of bereavement. As might be expected, given gender roles that are somewhat universal: Women, regardless of culture, assume the primary responsibilities for wailing and weeping. Crying in men expressing grief is generally accepted, but this is usually limited by tradition to extent and settings.

A relatively recent study of culture and crying done by van Hemert, van de Vijver, and Vingerhoets (2011) examined prevalences and gender differences from data collected during the International Study on Adult Crying (ISAC) across 37 countries (Becht & Vingerhoets, 2002). This study suggested that crying, when analyzed by country, had less to do with distress than "being connected with emotional expression and personality" (p. 423). Analysis of data on an individual level that looked at when the last crying episode occurred, proneness to crying, and how these two variables related to various country characteristics such as wealth, political freedom, and individualism showed a positive correlation between crying and these characteristics. Crying was also positively related to individual subjective well-being and extraversion. In short, men and women cry more frequently and view crying more positively if they live in countries "that are wealthier, more egalitarian, more democratic, and more individualistic" (van Hemert et al., 2011, p. 424). This appears to be counter-intuitive as it seems logical to assume that people living in less affluent countries—and who are likely to be less affluent themselves—would be more likely to cry than those living in more affluent countries. Somewhat similarly, van Hemert et al. found that women living in countries where they had power roughly equivalent to that of men cried more often than did women living in

countries where their power was limited. Taking into account cultural norms and the degree to which people feel free in expressing emotions, van Hemert et al. concluded that the aforementioned patterns are predictable on a country-wide basis.

Qualitative Studies of Crying

The few qualitative studies I found that addressed crying stressed its implications for nursing practice and multi-dimensionality in origin, empirical meaning, and therapeutic value. Two of these studies (Rydé et al., 2007; Rydé et al., 2008) relied upon Gadamer's hermeneutic approach to analysis and interpretation (Malpas, 2014); two were ethnographic studies (Fooladi, 2005, 2006); and one employed an interpretative phenomenological method (Zengerle-Levy, 2006).

Rydé et al. (2007) studied crying in cancer patients in palliative home care in Sweden. Rydé et al. (2008) investigated family members of the cancer patients studied in 2007. In the study of cancer patients in palliative home care, Rydé and her colleagues Strang and Friedrichsen (2007) were interested in determining the significance crying held for 14 of those patients. Their hermeneutic analysis of the data gleaned from interviewing these patients yielded three different dimensions of crying: (1) intense and despondent crying, (2) gentle, sorrowful crying, and (3) quiet, tearless crying. (Note: Rydé et al.'s [2007] dimension of tearless crying contradicts the general notion that crying in adult humans denotes the presence of tears.) The intense and despondent crying was associated with immediate, urgent needs; the gentle, sorrowful crying with an awareness of emotional discharge; and the quiet, tearless crying with protection. This led Rydé et al. (2007) to conclude that crying might be either a positive or negative emotional response. They opined that medical professionals needed to be aware of the different dimensions of crying to determine whether palliative care patients need comfort or privacy.

In their study of the crying experiences of family members involved in palliative home care, Rydé et al. (2008) looked at whether family members cried alone or with someone. As in the previous study (Rydé et al, 2007), three primary categories emerged: (1) the act of crying requires certain prerequisites, (2) crying triggers are circumstantial, and (3) family members try to hide their crying from the patient. The prerequisites for crying included attitude, courage, time, feeling secure, honesty, and trust. Crying triggers included uncertainty, exhaustion, and sympathy displayed by others. Family members trying to hide their crying did so for the sake of the patient and to strike a positive balance between grief and suffering. Based upon these results, Rydé et al. (2008) concluded that "crying may be an efficient strategy for family members in palliative care to express their suffering and to gain new energy to continue" (p. 345). Rydé et al. (2008) also observed that nurses witnessing crying in a palliative care setting relied upon intuition to determine the appropriate intervention.

Zengerle-Levy's (2006) interpretative phenomenological study involved investigating the link between nurses caring for families of critically burned children and the effects that caring had on the ability of those children to adjust and adapt to an unfamiliar environment while in the throes of agonizing and traumatizing bodily injury. In the conduct of this research, she examined the experiences of 16 pediatric nurses working in a pediatric burn intensive care unit. Her focus was on identifying holistic healing practices that benefited these severely injured children. Primary among the identified practices was the "support, nurturance, and guidance families receive from nurses during their children's hospitalization" (p. 23). Per Zengerle-Levy, the emphasis on attending to the needs and concerns of the burn victim's family is inseparable from the efficacy of care provided to that victim. This is because children—perhaps especially those who have been horrifically injured—in unfamiliar places under frightening and painful

circumstances look to their families for clues that give meaning to what is happening to them. The injured child requires reassurance from her parents or other close family member that she is in a safe environment and that what is happening is intended to help her. This reassurance may be directly rendered by touch, talking, and by remaining at the child's bedside. It may also be indirectly rendered when the child observes her nurses interact positively with family members. If family members are comfortable around the child's nurses and show they are through their demeanor, interaction, and trust, this will be communicated to the child, who will interpret these actions as indications of normalcy, safety, and sanctuary.

Zengerle-Levy (2006) noted that caring for these children also helped their family members deal with the trauma of having a child who had been severely burned. Significantly, Zengerle-Levy emphasized that experience was essential to nurses' understanding of how to best care for the patient and support his or her family members. In many cases, nurses became close to the patient and her family members. The concern nurses had for patients and their family members in these instances was sometimes displayed in the form of tears as they cried with the family. Zengerle-Levy observed that nurses who shared of themselves in this manner believed that it "helped families in their journeys toward wholeness" (p. 22). Helping the families of children who have been severely burned get back to life is an aspect of holistic nursing practice that can only be accomplished by nurses who, as Zengerle-Levy phrased it, are "authentically available" (p.22).

Also interested in holistic nursing practice, Fooladi (2005, 2006) conducted ethnographic studies of crying in Pakistani men and women and in American women experiencing postpartum blues. Specifically, she hoped to develop insights into how knowledge of crying might enhance the practice of holistic nursing care. Both studies evolved from Fooladi's personal experiences.

While in Pakistan as a consultant to a university in Karachi, she was brutally assaulted and robbed by three men (Fooladi, 2005). Two days later, as she was attempting to get a temporary passport at the American embassy, she was asked to provide two passport photos and pay an $85 fee. As she had been robbed, she had no money. At that point, Fooladi broke down into uncontrollable sobbing. A uniformed Pakistani woman came to her and silently consoled her until, an hour later, she had cried herself out. Fooladi, upon discovering her rescuer spoke very little English, characterized her mental state in this telling passage:

> At that point, I realized that my tearful language did not require English proficiency or any response. I needed someone to recognize my agony, validate my disappointment, and assure [sic] my wounded feelings. In my tears, I found serenity. The outcry of my soul liberated me from dark shadows of hate and lingering resentment…. I felt light, free, and ready to face the daily challenges. (p. 252)

Fooladi's (2005) harrowing experience inspired her to investigate the perceptions of Pakistani men and women held about the act of crying and its after effects. Consistent with her own experience, she discovered spiritual, cultural, and psychosomatic themes in the crying of both men and women. Noting that study participants interpreted crying from gender- and culture-specific viewpoints, Fooladi concluded the nursing profession would benefit from a better understanding of both human emotions and the messages conveyed by tears.

Fooladi's (2006) ethnographic study of American women who had experienced postpartum depression was motivated by her own postpartum blues after the birth of her first child. The thematic analysis of the raw data from this investigation revealed: (1) postpartum health was improved by crying and breastfeeding, (2) postpartum mental health was negatively affected by lactation suppression, and (3) postpartum blues were associated with prior pregnancy

loss (Fooladi, 2006). Noting that "The postpartum period is a lonely time for most women in the United States" (p. 210), Fooladi observed that study findings and the relevant literature "highlight the basic principle of woman's need for a supportive environment to give birth, breastfeed, and cry without hesitation" (p. 210).

A Phenomenological Perspective of Crying

Hunt's (1992) ambitious mixed methods investigation of the lived experience of women with cancer was a source of relevance to this study. She was interested in discovering how the emotional expression of crying imparted meaning "to the cancer patient's surrounding life-world" (p. 8). Hunt's hypothesis was that crying in cancer patients was a phenomenon reflective of a person/world interface. Consistent with the catharsis view of crying, she posited that crying signaled a disturbance in the body's biological, psychological, and social equilibrium that required a realignment of biopsychosocial relationships to reestablish homeostatic balance.

Hunt's (1992) sample included 49 women, 27 of whom had cancer. The 22 women without cancer were the comparison group. Her study was divided into three stages. In the first stage, each subject completed three questionnaires, one related to body image and two related to how personal characteristics related to emotionally expressive style. Each subject also kept a journal of crying behavior (type, frequency, and intensity) over a 30-day period. Hunt used one-way analysis of variance (ANOVA), Pearson product moment correlations, and *t*-tests to determine relationships between and among these variables. In the second stage, all participants were asked to provide a written description of one of the crying episodes from the aforementioned 30-day period. These descriptions were analyzed using content analysis techniques. The third stage consisted of having 16 women (11 with cancer) participate in open-ended phenomenological interviews in which they described crying experiences, regardless of

when they had occurred. These interviews were transcribed and evaluated using hermeneutic techniques.

Quantitative results from Hunt's (1992) study indicated that women with cancer and a poor body image have difficultly describing feelings and distinguishing the source (body or feelings) of emotional arousal. These same women also tended to have a "more concrete, reality-based cognitive style" (Hunt, 1992, p. 118). In women who had cancer, crying intensity and frequency were found to be positively correlated, although neither crying intensity nor frequency could be predicted by any single variable or interaction of the variables in this study. Both women with and without cancer evidenced an inverse relationship between age and crying intensity and frequency. Episodic crying and age were negatively correlated, although this correlation was influenced by whether women with cancer belonged to a psychosocial support group. Women with cancer who did not belong to a support group reported crying less frequently and with less intensity as they aged than did those who belonged to a support group.

While the quantitative findings from this study were not especially illuminating, the qualitative findings yielded a wealth of information in the form of grounding perspectives, themes, and categories (subthemes) that described aspects of participants' crying event(s). Crying events were grounded in participant views of "The Way Things Are Supposed to Be" and "Things Are Different Now" (Hunt, 1992, p. 122). The three themes Hunt induced from the phenomenological interview data were "Being Separate From," "Barrier," and "Being in Unity With" (Hunt, 1992, p. 124). The subthemes associated with these themes were: Being Separate From – Tension and Loss; Barrier – Control and Immersion; and Being in Unity With – Letting Go and Connecting.

The grounding perspectives of The Way and Things Are Different were representative of participants' view of the immediate world and their role(s) in the context of that world. The Way is the *before* of crying; Things Are Different is the *after*. These two states are, in one sense, an exemplification of being of or not of the world. Being not of the world is a result of the tension and/or loss associated with Being Separate From. According to Hunt (1992), the tension experienced by women in this study arose from both internal and external events. Typically, this tension built slowly and in doing so, compromised relationships and made situational involvement difficult because of internally experienced pressures. Loss, the other subtheme of Being Separate From, refers to the loss of control, loss of connection, and loss of awareness. Loss of control is initiated by external constraints and expectations over which there is limited or no control. Loss of connection can occur with the death of a loved one and the resulting fear of nonbeing. Loss of awareness is an internal disconnection from the self characterized by being out of touch with one's actions, interactions, and emotions.

Barrier, the second theme emerging from Hunt's (1992) study, is a consequence of Being Separate From. Characteristic of the Barrier subtheme of Control were women who blocked or controlled their emotions in the face of strain and anxiety. These women feared marginalization, isolation, or being subverted in some manner by the situation with which they were confronted. On the other hand, women who experienced Immersion were likely to actively challenge the Barrier. These women let themselves be completely absorbed by their emotions, thus enabling them to move past tension and grief to reestablish balance in their lives.

The theme Being in Unity With was exemplified by the subthemes Connecting and Letting Go. Connecting is emblematic of being in touch with one's self, with others, and with objects in one's world. Connecting is active in the sense that the women who connected did so

by purposely seeing the world in positive terms, engaging others in social interaction, and appreciating things for what they are, have been, and may yet be. Letting Go was seen as a healthy reaction to things in one's life over which one has no control, being accepting of or moving away from problematic situations, and being open to new experiences and opportunities. Hunt (1992) noted that Letting Go might involve self-transformation and the empowerment of a revitalized perspective of life and living.

The results from Hunt's (1992) study hold specific meaning for this study. The quantitative findings, while of interest, did not provide any specific insights into the emotional effects of crying. The hermeneutically derived phenomenological themes and categories are, however, important in the sense that they confirm the complexity of crying as a biopsychosocial experience. Furthermore, Hunt's conclusions from her research findings accentuate the need for qualitative research in exploring and examining subtly nuanced phenomena that impinge upon the existential meaning of the lived world. Crying, a physiological manifestation of underlying emotion, is intricately enmeshed in the person's actional, interactional, and emotional interfaces with the surrounding environment. As Hunt points out, the nature of these interfaces affects the person's attempts to resolve problematic issues in a manner that sustains continued existence (Being) or, at least, provides a semblance of that possibility.

From the standpoint of a GT investigation of crying, the phenomenological themes and subthemes Hunt (1992) developed from interpretations of her study data are of value in that they provide a preview of impressions that might be extant in both open and theoretical coding. Certainly, the themes and subthemes originating with this study will augment the GT researcher's theoretical sensitivity by enriching the perspectives through which empirical data may be assessed, conceptualized, and integrated.

Summary

As shown earlier in this chapter, research into crying and its effects has been almost entirely quantitative. The dearth of qualitative research has left a critical void in the scientific knowledge of crying. In consequence, understanding what crying means to the individual is a subject with important avenues of investigation as yet undiscovered and unexplored. Without a well of empirical knowledge founded in the lived experiences of those who have cried as a response to intense emotion or even physical pain, the means for identifying areas that would benefit from additional research, quantitative or qualitative, are limited. In the absence of detailed data from those who have experienced crying firsthand, the art and science of nursing practice may be deprived of information essential for restoring and maintaining optimal patient wellness levels.

Research investigating the phenomenon of crying and the commonly held belief that crying has healing powers has been inconclusive and/or contradictory (e.g., Cornelius, 2001; Gross et al, 1994; Labott & Martin, 1987; Nelson, 2008; Patel, 2001; Vingerhoets & Scheirs, 2001). Observation-based reports of the effectiveness of crying as a therapeutic technique in psychotherapy and counseling are anecdotal; hence, their scientific value is limited by the specificity of observations and the observer's skill in interpreting what has transpired (Vingerhoets et al., 2009). Laboratory studies of crying have all indicated that crying leaves subjects worse off than they were before crying (Frey, 1985; Gross et al., 1994; Kraemer & Hastrup, 1988; Labott & Martin, 1988; Labott & Teleha, 1996). The analyses of retrospective survey data on crying have yielded mixed results with some subjects claiming that crying improved their emotional well-being and some subjects claiming that crying left them depressed and miserable (Bindra,1972; Borquist, 1906). Despite the lack of hard scientific evidence

establishing the therapeutic value of crying, many healthcare professionals, especially psychologists, counselors, and nurses, continue to champion the healing power of crying (Knight, 2014; Fooladi, 2005; Rydé et al., 2007; Schiedermayer, 1990; Teisan, 2003; Zengerle-Levy, 2006).

It is difficult (and unwise) to disregard the opinions of healthcare professionals who are trained clinical observers and keenly attuned to the biopsychosocial well-being of their patients and, in some cases, the patient's family members. This does not mean healthcare professionals have a comprehensive understanding of crying. The meaning a nurse imparts to a patient's crying may not be the meaning symbolized by that patient. Or, the healthcare professional, not understanding how to react to a crying patient, may dismiss or ignore that crying (Wagner et al., 1997). Still, many nurses firmly believe that crying is an effective therapeutic for helping those in emotional distress discharge the negative effects of emotional imbalance. These nurses may encourage and support patient crying because they assign holistic value to crying. To them, crying, acting as an agent for the restoration of biopsychosocial homeostasis, may offer a means of strengthening core mind-body-spirit interconnectedness and interdependencies. Nursing, a holistic discipline steeped in the art and science of patient care (Engebretson, 1997/2009; Newman, 1992/2009), is in a position to maximize the presumed therapeutic benefits of crying if the ways in which they contribute to patient health and well-being can be identified and incorporated into practice.

The jury is still out on the results of the scientific inquiry into the therapeutic value of crying. A crucial missing piece of the crying research puzzle is the limited number of relevant qualitative studies. This qualitative inquiry into crying broadens the visible research horizon of this clearly consequential phenomenon. Its findings include a theory that is explanatory of the

meaning participants gave to the crying experienced in response to the emotional stress of personal crisis. Inextricable to this theory is a multi-dimensional description of the interdependent, processual relationships existing between stress, emotions, and crying. The findings from this study offer fresh appraisals of and recommendations for future research, nursing education, and nursing practice.

CHAPTER THREE

METHODS

Overview

Why Grounded Theory

As previously expounded, much remains to be discovered about crying. Given the practical difficulties and ethical concerns that limit options for quantitative research into crying, it is reasonable to turn to qualitative methods to further investigate this meaningful human reaction to emotional states (DePoy & Gitlin, 2005; Lincoln & Guba, 1985; Knight, 2014, Vingerhoets et al., 2009). In this regard, GT methods seemed the most appropriate means for discovering the what, when, why, and how of crying (Corbin & Strauss, 2008, 2015). This is because GT methods lead to the creation of a theory elucidatory of the meaning study participants imbue in their experiences, including antecedents, situational context, action-interaction-emotions, and outcomes or consequences, both actual and anticipated (Corbin & Strauss, 2015). Process is implicit in a theory grounded in the interpreted meaning individuals give to reality as they perceive it, and process connotes agency in purposeful, consequential temporal activity (Corbin & Strauss, 2008, 2015; Dewey, 1903; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998).

Corbin and Strauss's Approach to Grounded Theory

The GT method employed in this study was that of Corbin and Strauss (2015). This method is a refinement of that presented in the three previous editions (Strauss & Corbin, 1990, 1998; Corbin & Strauss, 2008) of the *Basics of Qualitative Research*. Of note is that the third and fourth editions of *Basics* were written solely by Juliet Corbin several years after the passing

of Anselm Strauss. She credits Strauss as co-author of the third and fourth editions because some portions of both books reflect work she and Strauss collaborated on in the earlier editions. The primary differences between the first two editions of *Basics* and the last two editions are that Corbin is less prescriptive in the analytic procedures employed in developing GT; the epistemological influences of feminism, postcontructivism, postmodernism, and critical theory (in particular, reflexivity) in her current approach to GT are acknowledged; a new chapter explaining the philosophical foundation for Straussian GT has been added; and, perhaps most importantly for the beginning researcher, several chapters are devoted to explication of an actual GT analysis from concept identification to theoretical development.

Corbin (Corbin & Strauss, 2008, 2015) suggests her approach to GT provides easy-to-follow procedures that are intended to aid the first-time GT researcher, which I am. However, she cautions that even first time researchers must be flexible, adaptive, and creative in the application of procedures that are meant as a guide, not a recipe.

Although there are a number of GT methodologies currently in use (e.g., Charmaz, 2000, 2005, 2006; Clarke, 2003, 2005; Corbin & Strauss, 2008, 2015; Glaser, 1992, 1994, 1996, 1998, 2001, 2003, 2005, 2007; Glaser & Strauss, 1967; Stern, 1995; Strauss & Corbin, 1990, 1998), Corbin's (Corbin & Strauss, 2008, 2015) has its foundations in the original GT publication, *The Discovery of Grounded Theory* (Glaser & Strauss, 1967), and subsequent clarifications and refinements (Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990, 1998). Of note is that Strauss's 1987 book was influenced by the dimensional analysis method of qualitative analysis initially proposed by Leonard Schatzman (Schatzman & Strauss, 1973).

Unlike Glaserian GT, which holds that GT is emerged, Corbin's (Corbin &

Strauss, 2008, 2015) Straussian GT takes a constructivist view of GT. Agreeing with Glaser that everything is data and data is all, Corbin (personal conversation, July 31, 2013) acknowledges that the conceptualization and integration of that data rests with the researcher. Importantly, the data are what the study participant perceives to be real and how that perception creates an individual reality. The researcher's theoretical sensitivity, shaped by knowledge of the professional and non-professional literature and professional and personal experience, is reflected in an interpreted categorization of data and identification of the concomitant core category (Clarke, 2003, 2005; Corbin & Strauss, 2008, 2015). My theoretical sensitivity has been shaped by professional experience as a practicing RN, healthcare executive, and nursing educator; personal experiences of crying and observing others cry; and extensive knowledge of the literature, professional and non-professional, that addresses crying and emotions. Both my experience and knowledge of the literature convinced me that crying and its connection to stress-related emotion is an ideal subject for GT inquiry. Information clarifying my choice of GT methodology for this study is included in the rest of this chapter, where I go on to discuss methods and methodology; further develop the historical, philosophical, and theoretical underpinnings of GT briefly summarized in Chapter 1; reflect upon my own research perspective or worldview; identify sampling considerations and parameters; describe sample demographics; provide information about how interviews were conducted and steps taken to ensure participant confidentiality; explain how data was analyzed, conceptualized, and integrated into an overarching theoretical scheme; and detail the resources used in the conduct of this study.

Methods and Methodology

There is a difference in how research is conceived and conducted, that is, between the underlying methodology and the methods elemental to that methodology. Mautner (2005) provides the following definitions of method and methodology:

> Method, from the Greek *meta* with + *hodos* way, is the way to do something; not the same as methodology. Methodology is the discipline which investigates and evaluates methods of inquiry, of validation, of teaching, etc. (p. 388)

Corbin and Strauss (2015) define methods as "Techniques and procedures for gathering and analyzing data" and methodology as "a way of thinking about and studying social phenomena" (p. 3). In short, methods are the procedures and guidelines that direct the collection, organization, analysis, and interpretation of data. Methodology is the process that governs the manner in which methods are determined and operationalized. A particular methodology has its foundation in the epistemological, ontological, and axiological mantles that reflect and preside over the researcher's ways of knowing; the ways in which the internal and exterior worlds are experienced, perceived, and responded to; and the ways values and biases influence, directly and indirectly, the methodology's application (Chinn & Kramer, 2005, 2015; Corbin & Strauss, 2008, 2015; Creswell, 2013; Denzin & Lincoln, 2011; Guba & Lincoln, 1994).

Philosophical and Theoretical Underpinnings of GT

Introduction

Epistemologically and ontologically, the prototypical GT methodology (Glaser & Strauss, 1967) was buttressed in the pragmatist philosophy of knowledge and the theoretical perspective of symbolic interactionism viewed through a positivist/postpositivist lens. As

originally explicated by Glaser and Strauss (1967), GT offered a definitive inductive approach to qualitative analysis intended to discover and develop objectivist, empirically derived theory. This approach reflected Glaser's positivist background in descriptive statistics and quantitative approaches to sociological research acquired while he was a graduate student at Columbia University and Strauss's education, training, and experience as a qualitative researcher (Corbin & Strauss, 2008, 2015; Stern, 2009a). Of note is that Strauss's experience included being a member of the sociology department faculty at the University of Chicago from 1952-1958 and his close association with other symbolic interactionists of the Second Chicago School (Bryant & Charmaz, 2007; Lutters & Ackerman, 1996; Strauss & Corbin, 1990, 1998; Stern, 2009b). While several researchers (e.g., Bryant & Charmaz, 2007; Charmaz, 2009; Strauss & Corbin, 1990, 1998; Stern, 2009a, 2009b) have tended to emphasize the contrasts in Glaser's quantitative and Strauss's qualitative training and research perspectives, their fruitful collaboration in the discovery of GT was, in my opinion, secured by a number of essentials. First, and perhaps foremost, both men were sociologists with common interests, that is, processes used by people to resolve problematic issues, the application of rigorous analytical procedures in studying those issues, the inductive development of theory based on the conceptualization of empirical data, personal engagement with data sources through field research, and making positive contributions to the advancement of sociology as a science. Second, as a sociologist, Glaser was certainly familiar with the works of John Dewey, George Herbert Mead, and Herbert Blumer. This familiarity would have provided him common ground, both epistemologically and ontologically, for his collaboration with Strauss. Third, the influence of John Dewey on Columbia's Sociology Department may have been formative, if not patent, in that department's approach to research. After leaving the University of Chicago in 1904, Dewey became professor of philosophy at

Columbia, a position he held until his retirement and appointment as Professor Emeritus in 1930 (McDermott, 1973). Although retired from teaching, Dewey remained in New York City, continuing his work in philosophical inquiry until his death in 1951 (McDermott, 1973).

The influence Dewey and Mead had on Anselm Strauss, co-discover of GT with Barney Glaser, was discussed briefly in chapter 1. Strauss was a product of the Chicago Tradition in Symbolic Interactionism, also labeled the Chicago Tradition and Chicago Interactionism (Corbin & Strauss, 2008, 2015). The Chicago Tradition evolved from what had come to be called the Chicago School of Sociology (Bowers & Schatzman, 2009; Lutters & Ackerman, 1996) or, more simply, Chicago School sociology (Bryant & Charmaz, 2007). The original styling "Chicago School" is attributed to William James (1904). He was referring to the University's Department of Philosophy (which also encompassed the University's Psychology and Education Departments) in response to the publication of *Studies in Logical Theory* (Dewey, 1903), a compendium of nascent thought primary to pragmatism's essential philosophical distinctiveness. Dewey, who had been a friend and colleague of George Herbert Mead since 1884, was appointed "professor of philosophy and chairman of the Department of Philosophy, Psychology, and Education at the University of Chicago" (McDermott, 1973, p. xvii) in 1884, a position he held for 10 years. Fortuitously, the scope of his responsibilities permitted him to surround himself with thinkers from a multitude of fields—including biology, psychology, and sociology—whose collaboration produced an emergent philosophy of knowledge that examined human activity from the viewpoints of those disciplines (James, 1904; McDermott, 1973).

Dewey and his pragmatist collaborators laid the groundwork for envisioning the theoretical perspective of symbols as meaning advocated by George Herbert Mead (1932, 1934). Subsequently, Herbert Blumer (1969) gave this new perspective the title *symbolic interactionism*

and explicated its premises in greater profundity. Relating Blumer's thinking to GT, Adele Clarke (2009) "argues(s) for a grounded theory grounded in symbolic interactionist sociology… to be understood as a 'theory/methods package'" (p. 197). In making this argument, Clarke recognizes that how knowledge is obtained and retained and the actuality of that knowledge are inseparable. This is a valid point: Both pragmatism (a philosophy of knowledge) and symbolic interactionism (a theoretical perspective of sociology) contemplate epistemological and ontological issues from an experiential stance grounded in the individual's (and hence, society's) perpetual reconstruction of reality (Blumer, 1969; Dewey, 1973; Mead, 1934, 1959).

Epistemology

One need only compare the language of pragmatism to that of GT to see the nexus between them. Experience, process, change, situation, action, interaction, concept, category, reconstruction… all are integral to the description, understanding, and application of GT. Experience is focal to understanding the pragmatic view of how knowledge is assimilated and preserved (Dewey, 1973; James, 1904). That experience is acquired through actions encapsulated in processes directed toward the resolution of problematic situations that are disrupting the current, albeit it temporary, constancy of existence. Experience evolves as each new problematic situation is resolved by the deconstruction of activity previously appropriate and the reconstruction of that activity into a newly devised course of action (Dewey, 1973). In its initial form, this new course of action may or may not suffice; hence, it may be modified or revised in progress, possibly several times, before stability is again achieved. Experience, and therefore individual and collective knowledge, expands in perpetuity as the status quo is continually disturbed by the occurrence and resolution of problematic situations (Dewey, 1973).

Pragmatism is considered John Dewey's philosophy, although he credits Charles Sanders Peirce as its originator and William James for several important contributions to its scope and depth (Dewey, 1973). Dewey himself was, as James (1904) observed: "a pure empiricist" (p. 1). Expounding on this observation, James goes on to say about Dewey and his "new system of philosophy":

> There is nothing real, whether being or relation between beings, *which* is not direct matter of experience. There is no Unknowable or Absolute behind or round the finite world. No absolute, either, in the sense anything eternally constant; no term is static, but everything is process and change. (p. 1)

To Dewey, experience represented an embodied process wherein growth gives meaning to living, to life. As McDermott (1973) notes: "Dewey's philosophy had as its starting point the transaction of the organism with the world" (p. xxviii). Dewey (1973) captures the transaction of humans with the surrounding world in this telling conception:

> Life itself consists of phases in which the organism falls out of step with the march of surrounding things and then recovers unison with it—either through effort or by some happy chance. And, in a growing life, the recovery is never mere return to a prior state, for it is enriched by the state of disparity and resistance through which it has successfully passed. (p. 525)

This is, once again, a conception of experience, but Dewey has voiced it in an existential form. To Dewey, existence was subject to action(s) that gave meaning to concepts. His explanation of the relationship between concepts and existence was that:

> … there is a scale of possible applications to existence, and hence a diversity of meanings. The greater the extension of concepts, the more they are freed from the

> restrictions which limit them to particular cases, the more is it possible for us to attribute the greatest generality of meaning to a term. (pp. 43-44)

This passage exemplifies the idea of a core category, a notion indispensable to the elaboration of a theory grounded in experiential data.

Finally, Dewey's (1973) explanation of "pragmatic method" application appositely summarizes the epistemic significance of pragmatism to the discovery of GT and its importance to qualitative inquiry:

> It affords a means of discovering the implications for human life of philosophical conceptions which are often treated as of no importance and of a purely dialectical nature. It furnishes a criterion for determining the vital implications of beliefs which present themselves as alternatives in any theory. (p. 47)

In a later chapter, Dewey adds: "There is no knowledge without perception; but objects perceived are known only when they are determined as consequences of connective actions" (p. 585).

Ontology

Perception is at the crux of how GT researchers render what is known, what is real. The dictum "perception is reality" (Lee Atwater, n.d.) has both epistemological and ontological meaning in much the same way as does experience. Dewey (1903) maintained that "Reality must be defined in terms of experience… there is no reasonable standard of truth (or of the knowing function) in general, except upon the postulate that Reality is thus dynamic and self-evolving…" (p. x). In short, reality is both time and space dependent and functions as a basis for acquiring and possessing knowledge as well as its temporal truth (Mead, 1959).

In addition to the foregoing exposition of the philosophic confines of reality and experience expressed by Dewey (1903), Corbin (Corbin & Strauss, 2008, 2015) makes explicit several assumptions about the nature of the world and its relation to Straussian GT. These assumptions are attributed to Dewey (1929), Mead (1932, 1934), Blumer (1969), and Strauss (1993). Taken in toto, these assumptions depict a world undergoing continual transformation where meaning is relative and changeable, where truth is adapted to the constraints of temporality and space, where meaning undergoes constant construction and reconstruction as people adjust to changing situations, and where meaning is derived from symbolic representations (communication and language) of human action, interaction, and emotion (Mead, 1934, 1959).

Mead's (1934) depiction of the "self as an object to itself" (p. 136) permitted the postulation of internal and external worlds. In the internal world, individuals can communicate with themselves as objects. This is the essence of self-consciousness, and it is dependent upon the participation of the individual in social environs where the perceptive attitude of others regarding the individual as an object is apparent through communication "in the sense of significant symbols" (Mead, 1934, p. 139). Consistent with pragmatism, Mead (1934) relates action to interaction and the meaning of action/interaction sequences to time, location, and experience. The interpretation of the outcomes of action/interaction events is based in the perspectives and perceptions of those involved. These perspectives and perceptions are subject to change as contingencies arise in response to action/interaction (Dewey, 1929). Further complicating the course of action/interaction is that emotion is always embedded in action and cannot be separated from it (Dewey, 1929).

Actions/interactions/emotions have consequences, sometimes unintended. The review and evaluation of these consequences may lead to the discernment of unanticipated conditions that require additional action/interaction (Dewey, 1929). Interaction presupposes the existence of a social world where action may represent the combined will of a group (Strauss, 1993). If agreement concerning prospective action cannot be immediately reached, then negotiation must be attempted. The communication (symbols) enabling negotiation within group members must have shared meaning to be understood (Blumer, 1969; Strauss, 1993).

Reality is conditional upon shared meaning (Blumer, 1969). Meaning, in the form of symbols, is the elemental force that organizes, bonds, and sustains a social group and the society of which it is part. Societies, like the world, are intricately constituted of the multiple perspectives of its individual members (Blumer, 1969). Combined, these multiple perspectives constitute social experience, the accumulation of knowledge through adaptations to the perpetual generation of the problematic situations emblematic of the existential cosmos to which mankind belongs. The ways in which problematic situations are resolved lead eventually to the formulation of social values. These values as well as those attributable to the experiences and viewpoints obtained from exposure to "social, political, cultural, racial, gender-related, informational, and technological" (Corbin & Strauss, 2008, p. 8) influences shape the individual's interpretative framework or worldview, that is, values.

Axiology

Axiology is the study or philosophy of values, and in qualitative research it is generally construed to mean how the researcher's values may influence or bias research results. Typically, personal values the qualitative researcher brings to an investigation are disclosed so that those reading study results can make their own value judgments relative to the validity or usefulness of

that research. This disclosure of axiological assumptions communicates how researchers "… 'position themselves' in a study" (Creswell, 2013, p. 20). In its current forms, GT methodology and methods are grounded in a multiplicity of axiological assumptions derived, in the main, from the researchers' worldviews. This is especially true of Corbin's (Corbin, 2009; Corbin & Strauss, 2008, 2015) approach to GT studies.

Since the discovery of GT, its methodology and methods have undergone a series of transformations (Bryant & Charmaz, 2007; Charmaz, 2006, 2009; Clark, 2005, 2009; Corbin, 2009; Corbin & Strauss, 2008, 2015; Glaser, 2001; Strauss & Corbin, 1990; 1998). These transformations are reflective of Morse's (2009) observation that "Grounded theory is not a prescribed method… [it] is a way of thinking about data" (p. 18). Acknowledging this, Corbin (Corbin, 2009; Corbin & Strauss, 2008, 2015) has observed her own approach to GT has evolved to embrace aspects of constructivism, feminism, and postmodernism. For her, this has sanctioned a paradigmatic expansion of GT's positivist/postpositivist origins to include value-oriented theory development.

To the postpositivist, values in the form of researcher bias and theoretical preconceptions are excluded—at least, to the extent possible—from exerting an influence upon research (Creswell, 2013). Epistemologically, the postpositivist worldview rejects the positivist notion of complete objectivity on the part of the researcher; ontologically, the positivist position that reality is both real and apprehendable is also rejected (Guba & Lincoln, 1994). That is, the postpositivist researcher accepts the impossibility of complete objectivity in rendering the results of scientific inquiry (Burke, 2009; Creswell, 2013; Guba & Lincoln, 1994). While postpositivists differ from positivists in that they attempt to reject rather than accept cause and effect propositions based upon a priori theories and hypotheses, they also recognize the putative

reality inherent in such propositions can be difficult to quantify and impossible to definitively establish (Burke, 2009; Creswell, 2013; Guba & Lincoln, 1994; Mackenzie & Knipe, 2006). This is because even the probability that replicated findings are true is only valid so long as nothing new, in both the perceptual and scientific senses, has emerged that might change the interactions between (or the form or existence of) the variables under scrutiny. A logical extension of this awareness is the acknowledgment that reality exists in the eye of the beholder, thus absolute reality can never be truly apprehended. Consistent with the indeterminate, imperfect nature of a reality conceived in a multiplicity of individual perceptions is the comprehension that the researcher cannot totally separate from the research process (Burke, 2009; Chinn & Kramer, 2015; Corbin & Strauss, 2008, 2015; Creswell, 2013; Guba & Lincoln, 1994; Mruck & Mey, 2007).

Implicit in the initial rendering of GT by Glaser and Strauss (1967) is the acceptance of the postpositivist position that reality is a composite of individual perceptions: It can never be absolutely discerned as a unitary formulation and the investigator cannot achieve total objectivity in research pursuits. Still, Glaser and Strauss cautioned against approaching qualitative research with theoretically derived preconceptions:

> Substantive theory faithful to the empirical situation cannot, we believe, be formulated merely by applying a few ideas from an established formal theory to the substantive area. To be sure one goes out and studies an area with a particular sociological perspective, and with a focus, a general question, or a problem in mind. But he can (and we believe should) also study an area without any preconceived theory that dictates, prior to the research, "relevancies" in concepts and hypotheses. (p. 33)

Consonant with this stance, Strauss and Corbin (1990) suggest that qualitative researchers keep an open mind and refrain from letting personal prejudices and values contaminate the collection, analysis, and interpretation of empirical data leading to theory discovery:

> Not that all our assumptions, experience, and knowledge are necessarily bad, in and of themselves… It's just that we have to challenge our assumptions, delve beneath our experience, and look beyond the literature if we are to uncover phenomena and arrive at new theoretical formulations. (p. 76)

For Corbin (Corbin & Strauss, 2008, 2015), it is imperative that the interpretative nature of qualitative research be conceded and embraced in order to secure a worthwhile research product, a product that expands and extends scientific knowledge and has a beneficial impact on the course of human existence. Consequently, she asserts that GT, as a qualitative methodology, should not be static, either in application or in consideration of refinements in paradigmatic reasoning. As Morse (2009) states, "… this *way* [GT] *of thinking about data* cannot be standardized…. grounded theory is not being *performed* in exactly the same way each time it is used" (p. 14). This is a viewpoint with which Corbin is in complete agreement. She applauds fellow GT scholars and practitioners Charmaz (2006) and Clarke (2005) for adapting GT methodology to accommodate contemporary constructivism and postmodernism. Corbin acknowledges her current approach to GT research has been shaped by their thinking as well as the gender equality and situated knower perspectives of the feminist worldview.

The question of whether investigators can employ a multiplicity of worldviews in their research endeavors, according to Creswell (2013), "… may be related to research experiences of the investigator, his or her openness to exploring using differing assumptions, and the acceptability of ideas taken in the larger scientific community of which he or she is a part"

(p.19). An alternate perspective is offered by Guba and Lincoln (1994): "Whatever their differences, the common breakaway assumption of all these variants [alternative inquiry paradigms] is that of the value-determined nature of inquiry—an epistemological difference" (p. 109). Guba and Lincoln take the position that each alternative inquiry paradigm (e.g., postpositivism and constructivism) stands alone because of its underlying epistemology. Expressing doubts regarding the ability of the researcher to work from a worldview embodying several paradigms, Creswell offers support for this position. To my mind, these views overlook the flexibility of qualitative research processes and presuppose a certain limiting of the human capacity for adaptive thinking. It is, prima facie, counter-intuitive to reject the divergences in GT methodology initiated by several members of the so-called "second generation" of GT researchers, that is, Janice Morse, Juliet Corbin, Adele Clarke, Barbara Bowers, Phyllis Stern, and Kathy Charmaz (Morse et al. 2009). These divergences are perhaps best illustrated by considering Corbin's (Corbin & Strauss, 2008, 2015) paradigmatic shift in her approach to GT.

At first glance, it may seem that Corbin's (Corbin & Strauss, 2008, 2015) worldview confluence of postpositivism, feminism, constructivism, and postmodernism is untenable. This, however, is not the case. All these paradigms exhibit certain epistemological and ontological similarities, not the least of which are the processes by which people formulate and conceive their own realities. It is from these formulations and conceptions—attained through experiential perceptions—that contextual, social, derivative, and situational suppositions result in personal judgments about truth, existence, and purpose.

The role that experience plays in the accumulation of knowledge and the ways in which reality is conceptualized is central to the pragmatist philosophy of knowledge (Dewey, 1973). The language of GT has pragmatism and symbolic interactionism as its sources, and the

influence of this language can be found in the feminist, constructivist, and postmodernist worldviews. All three paradigms accept that reality is an individual creation based upon how actions and interactions within situational and social contexts are interpreted (Creswell, 2013; Guba & Lincoln, 1994). All three paradigms acknowledge the researcher's presence in the interpretation or construction of theory from data, data that represent constructions by study participants so they might have some degree of understanding (and control) of what is happening to and around them. All three paradigms acknowledge the importance of process, change, and social interaction in creating as well as changing reality. Inherent in this last acknowledgement is that the fabrication and mutability of reality is both transactional and transcendent (Cohen & Crabtree, 2006). Granted, constructivist researchers are more concerned with how people develop meaning from the events and circumstances confronting them (Charmaz, 2006; Corbin & Strauss, 2015; Creswell, 2013; Polit & Beck, 2010) than are either feminists or postmodernists. It must also be granted that feminists place greater emphasis on the role of the researcher as a "situated knower" and "in how gender situates knowing subjects" (Anderson, 2012, p. 1). And postmodernists deny the existence of an absolute truth (as do pragmatists) while maintaining that reality (truth) is relative to the person making its determination… even though that determination is erroneous (Creswell, 2013; Postmodernism, 2014). Even so, each of these paradigms recognizes the indeterminate, interpretative nature of reality while placing differing emphases on the values of and roles played by the researcher and study participants (Creswell, 2013; DePoy & Gitlin, 2005; Guba & Lincoln, 1994).

Personal Worldview – Researcher's Perspective

As Stern (2009) and Charmaz (2006) point out, Glaser and Strauss (1967) wrote for a positivist audience because of the then predominance of quantitative researchers steeped in that paradigm. Both men have been categorized as postpositivist in outlook (McCallin, 2009); even Corbin remonstrated that she had been labeled a postpositivist (Corbin & Strauss, 2008, 2015). But she also pointed out that researchers change over time, especially because of personal intellectual development stemming from professional interactions and staying abreast of developments in philosophy, research, and the sciences. When I began my doctoral studies, I was a postpositivist. But, like Corbin, I have changed as time has passed, most particularly because of my PhD studies at the University of Tennessee, Knoxville. Today, I find my worldview, especially as a qualitative researcher, colored by feminism, constructivism, and postmodernism in much the same way as is Corbin's (Corbin & Strauss, 2008, 2015).

As a quantitative researcher, I consider myself an enlightened empiricist. While I believe most things can be quantified in one way or another, I also maintain that quantification of something, no matter how accurate, will not necessarily result in a complete picture (Burke, 2009; Creswell, 2013; Guba & Lincoln, 1994). As a nurse, I am a firm advocate of evidence-based practice that is constantly improved through the implementation of positive incremental change or technological advances, that is, continuous improvement (Griffith, 2011). Continuous improvement acknowledges the time dependency of current practice, as does the branch of statistics—statistical process control or SPC—used to evaluate process functioning. Inherent in the practice and utilization of SPC is the realization that, left unattended, processes will deteriorate with a resultant degradation in the quality of process output (Deming, 2000). Also inherent in the science of SPC is the understanding that processes can be improved and any

improvement in a process results in a higher quality of output. Importantly, improving processes, that is, increasing quality, results in decreased costs (Crosby, 1979; Deming, 2000). This may seem counter-intuitive until one recognizes that increased quality results in decreases in defective output, whether the output is a product or a service, and a decrease in defective output reduces costs far more than the expenditures required to increase quality in the first place (Crosby, 1979; Deming, 2000). Simply put, scientifically determined evidence-based practice is essential to the delivery of the quality healthcare, and it is also cost-effective.

There is no doubt quantitative research using statistical methods like SPC is critically important to the science of healthcare, and that includes the science of nursing. However, there is more to nursing than scientifically based best-practices. The practice of nursing involves both art and science. I maintain that the art of nursing practice can benefit from qualitative appraisal and assessment that looks beyond the numerically quantifiable aspects of patient care. Unexplored or inadequately addressed issues both inimical and favorable to healthcare delivery—suppositions about the efficacy of certain therapeutics, recurring problematic situations, and managerial concerns such as nurse retention—are prime topics for qualitative research. I also maintain that qualitative research can reveal new opportunities for scientific exploration best investigated by quantitative methods.

As a qualitative researcher, I acknowledge that reality is an imperfect construct dependent upon how the individual or particular groups perceive the world at a point and place in time (Blumer, 1969; Guba & Lincoln, 1994; Mead, 1932). This perception is the result of any number of things which may be influencing those attempting to understand the world around them, e.g., background beliefs, social situations, gender considerations, cognitive styles, embodiment, and economic or political influences (Anderson, 2011; Corbin & Strauss, 2008,

2015; Creswell, 2013; Guba & Lincoln, 1994; Olesen, 2007). At one time, I would have steadfastly argued a process that cannot be measured does not exist. Now, I concede that not everything can be measured, nor can everything be evaluated per a common numerical standard. As a postpositivist, I looked for reasons to reject the status quo so that I could improve upon it. But I also recognized that the status quo is relative and may exist only in the eye of the beholder. (As Byrne observed: "Everything is in a state of flux, including the status quo" [Part II, saying 461].) There are many important aspects of human existence (e.g., psychological responses to stress, the biopsychosocial effects of crying, individual perceptions of reality) that cannot yet be measured and may never be measured. Until then, the general method of GT, incorporating either qualitative or quantitative inquiry or both, can aid in understanding that which cannot be directly quantified.

The subject of this study, crying in women dealing with the emotional stress of personal crisis, falls into the "cannot be directly quantified" classification. Thus, an alternative method of investigation was required; i.e., a qualitative study using GT methods. Empirical data for this GT study were collected by interviewing a convenience sample of women willing to share their experiences of crying when dealing with the emotional stress of personal crisis.

Sample

Overview

The theory presented in the next chapter is based upon the analysis of data collected in the conduct of ten interviews. These interviews were accomplished over a period of 9 months with 10 of the 14 women who volunteered to participate in and met inclusion requirements for the study. Each of these women had experienced emotional stress related to a personal crisis that had occurred within 90 days of volunteering to share her experiences. The data derived from

these ten interviews were sufficient for identification of the theory's core category, data saturation, and integration of the main categories subordinate to and exegetical of the core category. This permitted the creation of a theory grounded in and explanatory of the meaning study participants gave to the act of crying when dealing with the emotional stress of personal crisis.

Sampling in GT

In GT, sample size is not specifically defined other than to say it should be large enough to saturate all categories with enough data to ensure conceptual density and conceptual specificity (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Glaser (2002, 2005) contends even small samples are adequate for theory emergence so long as category saturation is achieved. Charmaz (2005) notes that the number of cases may not be the same as sample size, which implies that some participants may be interviewed more than once. In discussing sample size with J. M. Corbin (personal conversation, July 31, 2013), she emphasized that the overriding concern in determining appropriate sample size for a typical GT study is that it be sufficient to adequately saturate all categories, including the core category.

Sample Parameters

Study inclusion and exclusion criteria and the rationale for these criteria are presented in the following paragraphs.

Inclusion Criteria

Inclusion criteria for the women who participated in this study were as follows:

1. Participants must be a volunteer and be between 21 and 69 years of age.

2. Crisis and associated emotional stress that precipitated the crying event must have happened within past 90 days.
3. Participants must be recovered from the emotional trauma of the crisis event. That is, the participant does not think talking about the crisis, emotional stress, and crying will result in psychological or physiological discomfort greater than that already experienced as part of normal, everyday life.
4. Participants must be willing to share full details of their crisis, emotional stress, and crying experiences with the primary investigator during an in person, one-on-one interview.
5. Participants must be willing to sign an informed consent to participate in research form and provide limited demographic information.

Exclusion Criteria

Exclusion criteria for the women who participated in this study were as follows:

1. Crying in response to stress-related crisis must not have been in any way intentional. That is, the participant must not have purposely cried hoping to elicit another person's sympathy or support.
2. Participants must not be receiving counseling or care regarding the stressful event that preceded the crying experience.
3. Participants must not be experiencing any lingering emotional trauma associated with the crisis event (as exhibited by an inability to perform normal activities of daily living and maintain emotional control).
4. Participants must not be hoping that participation in this study will provide any sort of therapeutic benefit in dealing with the effects of the crisis event.

5. Participants must not be subject to outbursts of crying that have no apparent psychophysiological antecedent. That is, the participant must not have been told by a healthcare professional that she experiences pathological crying.
6. Participants must not expect (and understand they will not receive) compensation of any kind for study participation.
7. Participants must not expect (and understand they will not receive) compensation for healthcare expenses related to psychological or physiological treatment for trauma claimed to have occurred because of participating in the study.

Most of the preceding inclusion/exclusion criterion are self-explanatory; others deserve further explication. For instance, there were several reasons for excluding men from this study. Men and women express emotions differently, especially in crying frequency, with women reporting crying more often than men (Bekker & Vingerhoets, 2001; Hastrup, Kraemer, Bornstein, & Trezza, 2001; Vingerhoets et al., 2009). Women are also more likely than men to cry because of conflict or stressful situations (Bekker & Vingerhoets, 2001; Vingerhoets et al., 2009). In short, men and women cry for different reasons. Lastly, I had concerns regarding male domination of healthcare and social sciences research and the impact this has had and is having on women. From a feminist epistemic viewpoint, this is important "because all knowledge is situated in the experiences and context of the researcher" (Willis, 2007, p. 10). From a critical theory epistemic perspective, understanding the "value-determined nature of inquiry" (Guba & Lincoln, p. 109) and how this affects the sociopolitical treatment of oppressed populations is equally important (Chinn & Kramer, 2015; Creswell, 2013: DePoy & Gitlin, 2005).

Limiting the age range to 21 to 69 years for study participants was somewhat arbitrary. The lower limit was intended to foreclose participation by most undergraduate college students because a substantial number of the retrospective and quasi-experimental quantitative studies of crying used college students as their subjects (e.g., Bindra, 1972; Borquist, 1906; Labott & Martin, 1987, 1988; Vingerhoets & Becht, 1997). The upper limit of 69 years was selected to mirror the upper limit of Hunt's (1992) study of crying in women with cancer and because crying frequency in both men and women decreases with age (Bekker & Vingerhoets, 2001; Hastrup et al., 2001, Vingerhoets et al., 2009).

The specification that the crying event(s) have occurred within the previous 90 days was intended to ensure participants would be able to recall information relevant to that event (Frey, 1985). Bradburn, Rips, and Shevell (1987), in addressing the impact of memory and inference on surveys, noted that survey respondents are unable to recall 20% of the critical details of a personal event one year removed. By using a recall period less than one year, I expected to get a more accurate picture of study participants' crying experience pertaining to frequency, duration, and type(s) of crying.

Sample and Sampling Procedure

Participants were recruited using flyers and direct meetings. (See Appendix A for the flyer used to advertise this study.) Flyers were provided to a local women's service organization and to a health fitness center for distribution to their membership. Additionally, flyers were posted on the bulletin boards at the fitness center and at a local university. Informational meetings to solicit study volunteers were held with the university's female faculty and staff and with various all-female fitness and exercise groups at the health fitness center. Word of mouth also proved useful in recruiting potential participants. Measures to advertise the study in local

newspapers and web postings, although planned, were not needed due to data saturation and identification of the core category.

Of the 24 women who volunteered for the study, 14 met the requirements for study inclusion. Of these 14, ten were interviewed. The four women who were not selected for participation were thanked for their interest and asked if they would like to be contacted for follow-on studies. All four women indicated interest in participating in follow-on research and provided their names and telephone numbers for later contact.

The ten women who did not meet inclusion requirements were members of a fitness center exercise group. All these women were older than the 69 years of age established as the upper age limit for study participation. These women expressed disappointment when informed they were not eligible for study participation with one observing, "We cry, too." They suggested that older women who experienced crying while dealing with the emotional stress of personal crisis also be studied.

Limitations

Per Glaser (1998), GT studies are often biased by researchers' attempts to achieve demographic diversity in the study sample. He refers to these demographics as "face sheet variables such as age, sexual preference, class structure, religion, ethnicity, gender, and so forth" (p. 84). Glaser goes on to say:

> These biases are a subtle influence in research. The typical example is to give a face sheet data description of the population being studied, as if, all were relevant to know. In grounded theory this is a distortion and waste. Only those face sheet items are relevant when they earn their way into the theory by fit, relevance, and work. The grounded theorist first studies people; later their face sheet properties will emerge when relevant.

> Other face sheet variables are moot, even if of human interest. To ask what is the influence of gender or social class on a phenomenon is forcing. If either were important it would emerge in the analysis by theoretical sampling and the constant comparative method. One can ask these questions, but the relevance is one of professional interest or a human curiosity, not an emergent relevant one. It is based on issues not analysis. Forcing then seeps in and seems plausible. (Glaser, 1998, p. 84)

Although diversity is not specifically required in GT sampling (Glaser, 1998), it was hoped that a broadly representative cross-section of women would result in the early identification and saturation of categories foundational to theory discovery in this study. Participant racial diversity was expected to mirror that of West Tennessee. Expectations were that many of the women volunteering for the study would be more prone to crying than those who did not volunteer. Given that people tend to cry less frequently as they age (Hastrup, Kraemer, Bornstein, & Trezza, 2001; Hunt, 1992), it seemed likely that a plot of participants' age would be representative of skewed right distribution. Other assumptions were that participants would most likely: (1) consider themselves members of the middle class, (2) be a career woman or full time homemaker, and (3) be high school graduates or have some college education.

The intention that study sample racial and socioeconomic profiles mirror that of West Tennessee was not realized. This can be attributed, in part, to the sample being one of convenience that satisfied GT requirements for data saturation and core category isolation sooner than expected. The participants in this study all self-identified as Caucasian and were college-educated, professional women working full-time jobs. Their ages ranged from 31 to 60 years with an average age of 51.8 years and a median age of 55.5 years. This age distribution was

skewed left rather than right as predicted. Nine of the ten participants had children. Two had small children, seven had grown children. All participants clearly remembered the crisis event that caused their emotional stress. They described their emotions and the idiosyncrasies of their crying in detail rich with metaphors (sometimes mixed), analogies, and similes. These descriptions were evocative of the depth of their feelings and emotional distress while exemplifying their remarkable resilience in putting the crisis behind them and getting back to life.

Interview Procedures

Conduct of the Interview

The initial question asked study participants in GT inquiry is necessarily general because the researcher does not know—and cannot predict—where the data provided by the interviewee might lead (Artinian, Giske, & Cone, 2009; Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967). Because definitive explanatory information regarding the phenomenon of crying as an emotional response to stress is either highly notional, incomplete, subject to limitations, and/or contradictory (e.g., Becht, Poortinga, & Vingerhoets, 2001; Cornelius, 2001; Cornelius & Labott, 2001; Vingerhoets, Boelhouwer, et al., 2001; Vingerhoets & Scheirs, 2001; Vingerhoets, Van Tilburg, Boelhouwer, & Van Heck, 2001), the interviewer's goal is to elicit responses that provide relevant emic data (Creswell, 2013; DePoy & Gitlin, 2005; Kvale & Brinkmann, 2009; Paterson, 2003). These responses are used by the interviewer to generate follow-on questions or information requests intended to further develop the breadth and depth of implicit or explicit data (Corbin & Strauss, 2008, 2015).

In this study, I began by saying to each participant: "Tell me about your crying experience and the personal crisis that preceded it." This invitation was followed by a series of requests that were essentially the same for each participant. These requests were:

Tell me why you cried and how you felt after crying.

Tell me more about the personal crisis that caused you emotional stress.

Tell me about what was going on in your life at the time you experienced this crisis.

Tell me what your experience in that situation was like. Was anyone with you?

Because participant perceptions regarding their crying were retrospective (and because this was a qualitative study), no quantitative data (e.g., heart rate, respiratory rate, skin conductivity) was or could be collected. Therefore, "how they felt" information was necessarily subjective. Even so, the accuracy of qualitative data pertaining to physiological or psychological status as perceived by the individual should not be discounted. I think it is safe to say that most people can tell if their heart is beating faster or slower, if their breathing is labored or normal, and whether or not they are perspiring And, many people can metaphorically describe psychosomatic symptoms of stress-related tension such as "knot" in pit of stomach, "pounding" heart, "splitting" headache, head "in a vise," "gasping for air," and tensed or "knotted up" muscles that are alleviated by "taking a weight off my shoulders," "feeling myself relax," "getting some relief," and "feeling like a new person." Study participants actually used some of these figures of speech to describe how they felt after crying. Additional information regarding how participants felt before, during, and after crying is addressed in detail in chapter 4.

After screening and acceptance into the study, each participant was interviewed at a time and place of her choosing. Two participants were interviewed at the home where one of them lived, two participants were interviewed in their office at their places of work, and six

participants were interviewed in my office at my place of work. All participants completed a demographic informational form, signed informed consent forms, and agreed to have their interviews digitally recorded. (See Appendix B for copies of the Primary Researcher's Telephone Interview Screening Script and the Individual Consent to Participate in Research, the Additional Consent for Re-Contact, and Participant Demographics forms.) These recordings were subsequently transcribed to enhance the data analysis process. (See Appendix C for an interview transcription.) The interviews took less time than expected, ranging from 15.60 minutes to 44.65 minutes in duration. Interview duration, however, was not an indication of its value as a source of information and data. The information and data derived from each of these interviews provided elucidation relevant to the theory's core category and each of the main categories.

Ethical Considerations

Risks associated with this research were that in recalling a painful memory and talking about it, participants would experience psychological or emotional distress and require intervention from a trained professional such as a psychologist, psychiatrist, or counselor. In anticipation of this possibility, I identified appropriately trained professionals who were available on site or for referral. At the university where I work, the on-campus counselor and the nursing department's faculty member who is a certified psychiatric nurse and a nurse practitioner were available to assist as needed. If it had been necessary, I was prepared to refer participants to one of several counseling centers throughout the West Tennessee area that are accepting patients. A list of these centers was provided to participants before beginning the interviews. (A copy of this list is included in Appendix B.) Should a participant have so desired, I would have made an

appointment for her at a counseling center of her choosing. Fortunately, none of the participants required intervention or referral.

An additional ethical consideration was maintaining participant confidentiality. Steps taken to protect participant confidentiality included using an identifier code for each interview event. (Identifier codes used the letter "P" to denote "participant" and were sequentially numbered in the order in which interviews were done. For example, P1 stands for the first participant to be interviewed, P2 for the second participant interviewed, and so forth.) Except for the informed consent and re-contact forms, no names were used on any collected information. The only persons who had access to the audio recordings of the interview or interview transcriptions and were aware of the interviewee's participation in this study were the primary researcher and the data transcriptionist, both of whom signed confidentiality agreements to protect all interviewee personal information. No personal data shared by the interviewee was or will be shared with anyone else without her written permission. Both the audio recordings and transcribed interviews are and have been kept in my locked office in a locked file cabinet or other secure location when not being studied and analyzed. Electronic copies of interview sound and transcribed word files are only stored on password-protected computers. Only aggregate data and identified themes or variables will be shared with external individuals. Costs associated with participation in this study included a commitment of time and possible emotional discomfort due to recalling and relating the experience of crying because of the emotional stress of a personal crisis.

Location and Informed Consent

Per Paterson (2003), "researchers have a responsibility to be sensitive to the needs of the participant" (p. 992). Accordingly, steps were taken to ensure the comfort and privacy of those

interviewed. Among other things, these steps included: (1) conducting the interview at a time and location of the participant's choosing, (2) provision of a comfortable, private setting free of distractions and interruptions, (3) allowances for breaks as needed, and (4) manifesting and adopting a non-judgmental, shared empathetic mindset to let participants know they were genuinely appreciated and accepted without qualification (Rogers, 1946, 1951). Prior to beginning the interview, I carefully explained the Individual Consent to Participate in Research and Consent to be Re-Contacted forms and answered any questions before obtaining the interviewee's signature. (Copies of both forms are in Appendix B. Form content was reviewed and approved by the BU and UT-K Institutional Review Boards for compliance with 21CFR50.27, Documentation of Informed Consent, per USFDA [2016] guidelines. See also Protection of Human Subjects [1980].) Once permission was given to record the interview, I positioned and turned on two (in case one malfunctioned) digital micro-recorders as unobtrusively as possible so as not to distract the interviewee. Because I obtained duplicate high quality audio recordings of every interview, detailed interview (field) notes were not necessary. During the study, I wrote five brief notes related to the interviews. None of the miscellany recorded in these notes figured in study findings or conclusions.

Data Collection and Analysis

Data collected from participant interviews were analyzed using open, axial, and theoretical coding techniques (Corbin & Strauss, 2008, 2015; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Memos documenting coding progress, concept and category identification and organization, core category emergence, theoretical reflections, thoughts about future research possibilities, significance of findings, and correlations to symbolic interactionism were chronicled. (See Appendix D for example coding and theoretical memos.)

Memos were also employed to chronicle the use of model outlines and data tabulations as analysis aids. (See Appendix E for examples.) Several models (examples in Appendix F) were created and tested against the data before a final model of the theory was determined to be representative of how participants had interpreted their experiences. Diagrams were constructed to illustrate the relationships between concepts, subcategories, and main categories. Tables were employed to assist with the sorting of raw data relevant to the classification of concept and category properties and dimensions. A diagram of the main category The Old Present Reality showing the relationships of its subcategories and their properties and dimensions is shown in chapter 4, as is a raw data tabulation listing of the occurrences of certain words, phrases, and themes in participant interviews.

The primary GT analysis technique is constant comparative analysis (Glaser & Strauss, 1967). As qualitative analysis techniques, GT and constant comparative analysis are generally considered synonymous (Corbin & Strauss, 2008, 2015). Constant comparative analysis simply refers to the ongoing inductive-deductive iterative process of comparing, contrasting, and evaluating newly acquired data with that already collected and evaluated. This starts with the open coding of the initial interviews to initiate concept identification (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). These early concepts are considered provisional and may or may not survive the analysis that continues as additional data are gathered, sorted, and compared to existing data. Open coding is followed by axial coding. Axial coding is intended to develop and amplify concepts (Corbin & Strauss, 2008, 2015; Strauss & Corbin, 1990, 1998). This is accomplished through the identification of properties and dimensions explicatory of the concepts. Theoretical coding, often accomplished simultaneously with open coding, serves two purposes (Corbin & Strauss, 2008, 2015). First, it is the method

whereby concepts are grouped into categories that are eventually subsumed by the main categories nascent in the data. The main categories give meaning to the GT process—context, action-interaction-emotions, and consequences—explanatory of the main theme, the core category, constructed from the data. The core category is arrived at as the researcher integrates and interprets data, refining the meaning the participants themselves imbue in the phenomenon under investigation (Corbin & Strauss, 2008, 2015; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Second, theoretical coding is used to target the collection of any additional data needed for enhancing main category conceptual depth and breadth (Corbin & Strauss, 2008, 2015; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The additional data sought is often the result of dimensional analysis (Schatzman & Strauss, 1973) that has identified gaps, both quantitative and qualitative, in the compass of certain properties.

Open Coding

Open coding of study data began with the first interview **(**Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). By means of line-by-line disassembling and reassembling of the information in that interview, several possible concepts and categories were ascertained. All concepts and categories identified in this first analysis were considered provisional, as are all concepts and categories until a theory grounded in the data is finalized (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Revision of the these first provisional concepts and categories began with the open coding of the second interview.

Axial Coding

Axial coding involves the revelation of contextual nuance within the data (Corbin & Strauss, 2008, 2015; Strauss & Corbin, 1990, 1998). It is intended to identify the properties and dimensions associated with the concepts explanatory of the theory. In this study, axial coding began with the analysis of data from the first interview. Most of the properties and related dimensional scales explanatory of the finalized foundational concepts came from analysis of that interview. The early identification of these properties and their dimensions was elemental to the ongoing evaluation of data saturation.

Data saturation is an important objective in GT. Schatzman's (Schatzman & Strauss, 1973) approach to achieving this objective was through dimensional analysis. Dimensional analysis of the properties intrinsic in the data provides a means of determining the degree to which individual properties are adequately described over the range of participant experiences. To some degree, filling in the gaps in property dimensions is an overlapping of axial and theoretical coding. Axial coding surfaces properties and their dimensions while theoretical coding seeks, among other things, to ensure those properties are fully explicated through theoretical sampling (Corbin & Strauss, 2008, 2015; Coyne, 1997; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998).

In GT research, saturation represents the point in the collection and analysis of data at which no new information is forthcoming (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). It may be that all properties relevant to concept and category development have been identified and all possible dimensions within those properties have been accounted for. More likely, however, is that additional sampling intended to fill in minor gaps in the theory's conceptualization or to uncover contrary information is not feasible

because of sampling constraints and resource limitations (Corbin & Strauss, 1990, 1998; Glaser & Strauss, 1967; Strauss & Corbin, 2008, 2015). In the former case, the population available for sampling may not be of sufficient diversity for the discovery of recondite dimensional features or data that contradicts that already obtained. In the latter case, time and money are quite probably of the greatest concern.

Theoretical Coding

Theoretical coding is primarily concerned with data saturation. The purpose of theoretical coding is to identify dimensional gaps in concept properties (Corbin & Strauss, 2008, 2015; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Once a gap (or gaps) is observed in a property's data coverage, theoretical sampling is employed to increase the number of different events or quantifications occurring within the range of dimensions possible for that property. This is accomplished by sampling for participants whose experiences include incidents of the missing data. Ideally, every possible value or specification with a dimension's range will appear in the data. Unfortunately, given the constraints of time, resources, and sampling parameters that bound most research undertakings, this is unlikely (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). For GT purposes, theoretical sampling is considered complete when no new themes or dimensional specifications or values occur within the designated sample population (Corbin & Strauss, 2008, 2015; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998).

Heeding Coyne's (1997) caution that following a fixed procedure in theoretical sampling might "encourage researchers to look *for* data rather that [*sic*] *at* data (p. 627)," I used theoretical coding techniques to look at the data collected from participant interviews to determine if theoretical sampling would be required. In this study, theoretical coding was employed to

identify the differences in each participant's personal crisis, that is, the event that triggered uncontrollable crying; emotional state before, during, and after the spontaneous onset of uncontrollable crying; variations in crying experiences; personal elements of crying; stress and/or tension relief experienced; evaluation of the crying experience; how cognitive clarity was restored; how emotional control was regained; efforts to control emotions and crying; and how biopsychosocial equilibrium and normality were reestablished. And while the women who participated in this study went through essentially the same process of losing and regaining emotional control, their experiences and how they interpreted those experiences at each point in that process were qualitatively and quantitatively different. My interpretation of their interpreted experiences lead to the construction of a theory grounded in data explanatory of the meaning the participants gave to their experiences and how they went about dealing with their problematic situations. Fortuitously, the data provided by the ten women who participated in this study was sufficiently comprehensive that it obviated the necessity of additional sampling.

Main Categories and Subcategories

The identification and classification of concepts is fundamental to GT analysis. Grounded theories are dependent upon the interpreted construction of a hierarchy of concepts and categories that, when integrated into a common schema, offer a hypothesized explanation of how individuals or groups resolve problematic issues (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Basic concepts represent associations among raw data. In the GT hierarchy, basic concepts may be combined to form lower level concepts or become lower level concepts in their own right. Lower level concepts that share linkages and commonalities are grouped together to form higher level concepts called subcategories.

Likewise, subcategories that share linkages and commonalities are grouped together to form even higher level categories called main categories.

Main categories that share linkages and commonalities can be integrated into an overarching category called the core category, a category synonymous with the theory grounded in the data from which the theory was constructed. The higher the concept level, the higher the plane of abstraction (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The highest level of abstraction in GT is the core category (Corbin & Strauss, 2015).

The Core Category

The core category is a conflation of participant past and present actuality in a newly perceived reality animated by the consequences of action-interaction (Corbin, 2015). It conveys meaning to the interplay of participant experiences, situational conditions, social confines, emotional responses to stress, compensatory action-interaction strategies, and intended or anticipated outcomes. In this study, the core category is representative of this past-present-future continuum in that it has simultaneous agency in past, present, and projected reality. The new present reality, integral to the core category, encompasses and subsumes the old present reality; that is, the new reality signifies participants' progression to a revised, expanded, and restored existential status quo reflective of a new level of biopsychosocial equilibrium. Explaining this idea in symbolic interactionism terms, Corbin (Corbin & Strauss, 2015) quotes from Mead's (1959) *Philosophy of the Present*:

> This relation of the event to its preceding conditions at once sets up a history, and the uniqueness of the event makes that history relative to that event… All of the past is in the

> present as the conditioning nature of passage, and all the future arises out of the present as unique events that transpire. (p. 62)

Adding human beings to Mead's observation, Blumer (1969) gives meaning to the whole of GT, not just the core category:

> We must recognize that the activity of human beings consists of meeting a flow of situations in which they have to act and that their action is built on the basis of what they note, how they assess and interpret what they note, and what kind of projected lines of action they map out. (p. 16)

In this passage, Blumer summarizes the interpretative and processual nature of a grounded theory and how it seeks to explain the action-interaction of persons confronted with situational variability, including the contemplation of appropriate action-interaction in response to that variability, the anticipated consequences of the contemplated action-interaction, the implementation of that action-interaction, and the ongoing evaluation of the efficacy of that action-interaction in achieving the desired outcomes.

The Theory

An important point Corbin (Corbin & Strauss, 2015) makes is that "theory is different from description in that it not only tells what happens but offers explanations" (p. 153). As are all GTs, the theory emblematic of this study is anchored in the data from which the core category, main categories, subcategories, and concepts were derived, conjoined, and integrated (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Grounded theories deal with the actions-interactions people undertake when confronted with problematic situations (Glaser & Strauss, 1967). That action-interaction changes the situation

and, in doing so, changes the individual's perception of both the situation and herself (Dewey, 1973).

This updated perception of self must, of necessity, be congruent with the transformed reality (Blumer, 1969). Underlying the dynamics of this theory (and most GTs) is the idea of process, change, and kinesis (Corbin & Strauss, 2008, 2015; Strauss & Corbin, 1990, 1998). That is, reality is not static: It is a function of temporality, as is one's perception of her locus within that reality (Dewey, 1973; Mead, 1932).

The Story Line

The story line gives an active vitality to the researcher's interpretation of the data analysis foundational to the theory grounded in that data. Preparatory to finalizing the designation and scope of a core category elucidatory of the linkages between concepts, subcategories, and categories, it is helpful to develop a story line (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The story line provides the researcher with an opportunity to verify the transactional process fundamental to the theory (Birks, Mills, Francis, & Chapman, 2009). Included in this verification is the review and reassessment of the validity of that theory. That is, does the theory adequately describe the meaning participants gave to the actions-interactions they took to resolve problematic situations and did those actions-interactions achieve the intended outcomes (Corbin & Strauss, 2008, 2015; Birks et al., 2009)? If the story line does not substantiate the theory, then one or the other requires modification. For example, in writing the story line for this study (see chapter 4), it was discovered that, as originally contemplated, the theory did not satisfactorily account for certain nuances in the data. Consequently, the theory was revised to more accurately describe the transactional process inherent in the information provided by participants.

Validity, Bias, and Rigor

Validity and Bias

As with any research that relies upon self-report data, GT studies that rely on interviews to gather data can be compromised by bias stemming from the researcher as well as study participants. The researcher must be aware of his or her own preconceptions and strive to keep them from slanting the data. And it is essential that the researcher ask open-ended questions and encourage the interviewee to speak freely, being careful not to lead the interviewee or interrupt her train of thought. Bias originating with participants may stem from several sources. They may not be able to accurately recall incidents from the past. They may try to anticipate responses they think the interviewer is seeking and attempt to answer questions accordingly. They may not be truthful because of what they consider as socially acceptable or desirable behavior. Lastly, they may not have the verbal communication skills necessary to accurately describe what they have experienced and the situational variables that influenced that experience.

In addition to the sources of bias noted in the preceding paragraph, it must be noted that bias in a GT study can also occur if the researcher omits any of the analytic procedures specified by Corbin (Corbin & Strauss, 2015). Of particular importance is the need to write memos that reflect the coding process and capture the researcher's impressions, decision-making rationale, identification of provisional concepts and categories, and theoretical integration. As Corbin points out, GT is a scientific method: It meets the requirements for good science if done properly.

What constitutes good science in qualitative research has been much debated (e.g., Corbin & Strauss, 2008, 2015; Creswell, 2009, 2013; DePoy & Gitlin, 2005; Lincoln & Guba, 1985; Polit & Beck, 2007), but, in general, good science is epitomized by research results that

reflect accuracy and rigor. According to DePoy & Gitlin (2005), accuracy and rigor in qualitative analysis is "the comprehensive and truthful representation of a particular context" (p. 249). Truthfulness or trustworthiness is a recurrent theme in how one goes about evaluating the validity of GT research (Corbin & Strauss, 2015; DePoy & Gitlin, 2005; Glaser & Strauss, 1967; Lincoln & Guba, 1985). Corbin (Corbin & Strauss, 2015) stresses the creditability and applicability evaluative criteria put forward by Glaser and Strauss (1967). She equates creditability to the truthfulness to be found in how accurately the researcher has captured the meanings conveyed by study participants, taking into account that these meanings are a construction (by the researcher) of a construction (by the participant). As Corbin states it:

> If the research findings are creditable… then all this philosophic debate about truth, validity, and reliability is superfluous. In other words, the proof is in the pudding… If it fits and it is useful because it explains or describes things, then rigor and vigor and truth and everything else must have been built into the research process or the findings would not hold up to scrutiny, would not explain situations, and would be invalidated in practice. (pp. 345-346)

A well-constructed GT can be judged by the "applicability of theory to a phenomenon" (Strauss & Corbin, 1990, p. 23). For Corbin (2015), applicability refers to the criteria Glaser and Strauss use to define a well-constructed GT. These are the criteria I considered in reflecting upon the validity of the theory constructed in the course of this study.

Per Glaser and Strauss (1967), four criteria constitute the applicability of a well-constructed GT: fit, understanding, generality, and control. Fit is an indication of how well the theory describes the reality of the substantive area. Understanding means that the theory should be comprehensible to study participants as well as practitioners. Generality means that the

theory should explain many, if not most, of the contexts relevant to the explicated phenomenon. Control simply means that theory conditions are situational, and specifically so. The grounded theory constructed from the data collected during this study meets all these criteria. (The theory is stated in chapter 4 in the Findings section.) It comprehensively describes the meaning participants gave to the reality of their experiences of crying when dealing with the emotional stress of personal crisis. It also offers testable hypotheses explanatory of the core category, confirming its generality. Of the nine participants who responded to my request to review and comment on the story line, theory, and theory model, all agreed the essence of their experiences was accurately captured. Control was achieved simply by not varying study parameters and the consistency with which interviews were conducted and data analyzed.

Rigor

In the GT process, rigor is obtained by questioning, the constant comparative analysis of data, writing memos to ensure full consideration is given to the data and its implications, inductive and deductive thinking, reflecting upon and revisiting problematic assessments, preparing diagrams to visually represent provisional category linkages, and sampling for category saturation (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Until the core category and its related main category are identified and fully saturated, all hypothesized concepts, categories, and conceptual linkages are conditional and subject to additional verification (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). GT rigor is also influenced by the expertise of the researcher. First time researchers must take extra precautions in coding and conceptualizing data to ensure they are not overwhelmed by a proliferation of unconnected, irrelevant concepts (Corbin & Strauss, 2008, 2015). I took special care to follow Corbin's (Corbin & Strauss, 2015) GT method and to heed

her cautions about coding and conceptualizing. Although I had planned to purchase qualitative analysis software to aid in sorting and classifying data, I decided against that. I wanted to be "hands on" in every facet of this study so that I could develop a fuller, more comprehensive understanding of GT and how to do it. In the process, I think I became a much better qualitative researcher. I certainly have a better understanding of GT than I did prior to beginning this study.

I had planned to consult with my dissertation committee members if I became bogged down in the coding and conceptualization of interview data. I regularly consulted with my dissertation chairperson, who was most helpful in keeping me focused and suggesting ways to improve the clarity of my exposition. Significantly, Dr. Juliet Corbin, co-author of the GT method I used, agreed to be available for consultation via Skype™ during the initial stages of this study.

Resources

The resources required to complete this research included time, training, and funds to purchase the necessary equipment, reference books, and printer ink and paper for printing source materials other than books. The equipment needed included a laptop computer and two digital audio recorders with computer interconnectivity. Training in GT methods was acquired through applicable graduate course work, the study of completed and example GT research to be found in subject matter books (e.g., Artinian et al., 2009; Corbin & Strauss, 2008, 2015; Glaser, 2007; Morse et al., 2009) and professional nursing journals (e.g., Bemker, 1996; Breckinridge, 1997; Salmon, Bruick-Sorge, Beckman, & Boxley-Harges, 2010), advice from the chairperson and other members of my dissertation committee, and consultation with Dr. Juliet Corbin, co-author of the GT method (Corbin & Strauss, 2015) I used in my research.

Summary

National health objectives listed in the U.S. Department of Health and Human Services' Healthy People 2020 agenda (n.d.) include Health-Related Quality of Life and well-being, with the former defined as "a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning" and the latter described as an assessment of "the positive aspects of a person's life, such as positive emotions and life satisfaction." Because crying is generally believed to contribute to a health-related quality of life and well-being so defined and described, research into the phenomenon of crying appears to be justified and essential, if not obligatory. If crying can relieve the anguish and suffering associated with physical, emotional, and spiritual pain, then how and/or why it does so should be determined so that the maximum benefit for population health may be obtained from this knowledge. Nursing is a holistic discipline concerned with the well-being of body, mind, and spirit, and anything with the potential to contribute to this well-being must be fully investigated. This GT inquiry into crying in women dealing with the emotional stress of personal crisis is therefore consistent with the Healthy People 2020 agenda. And, in keeping with Corbin's (Corbin & Strauss, 2015) research aims from the perspective of a nurse, I want to "… develop knowledge that will guide practice…. [and] bring about social change and make persons' lives better" (p. 27). The grounded theory constructed from the data collected and analyzed in this research has the potential to further those aims.

CHAPTER FOUR

FINDINGS AND DISCUSSION

Findings

Introduction

Because patients and family members are highly susceptible to intense emotions that often lead to crying, the phenomenon of crying is of clear interest to the healthcare profession and especially so to nursing. Given the apparent complexity of crying as an emotional response and how little is known about the physiology and psychology of emotional crying, I concluded a fresh consideration of this subject using the qualitative methods and methodology of GT might prove useful in providing another perspective of a phenomenon often encountered in healthcare settings. Accordingly, I selected and interviewed ten female participants from a pool of 14 volunteers who met study inclusion requirements. All participants had experienced crying while dealing with the emotional stress of personal crisis. This convenience sample was demographically homogeneous in that all participants were Caucasian, from West Tennessee, college-educated, and self-described professional women employed full-time. This was not a limitation in that the crises experienced provided the diversity necessary for constant comparative analysis. The only demographic relevant to the theory (Glaser, 1998) was participant sex since this was a study of women only. The empirical data from these interviews provided the information necessary for the construction of a theory grounded in the interpreted meaning these women gave their crying experiences. Those experiences and the related GT presented in this section encompass: (1) disclosure of the core category, main categories, and related subcategories; (2) scholarly and lay statements of the theory; (3) a story line narrative of

the theory; (4) a diagram that models the theory; (5) definition of the relationships between theory categories and subcategories; (6) a discussion of theory subcategory properties and dimensions; (7) commentary regarding theory data saturation; (8) action-interaction strategies employed by participants; (9) participant experiences demonstrating examples of variations within the theory; and (10) examples of how participants accepted and adapted to their new reality following the crisis event.

Main Categories and Subcategories

Not counting the core category, five main categories or themes were found to be explanatory of the process and structure fundamental to the theory resulting from this study. In process sequence, these five categories were The Old Present Reality, Heaping More on the Already Full Plate, Tipping Over the Full Cup, Feeling Emotionally Stronger, and Getting a Handle on Things. (The use of mixed metaphors in naming these categories was intentional.) Each of the main categories was comprised of two or three subcategories that added specificity and detail to the action-interaction-emotion implicit at that stage of the theory's progression. (See Table 1, Core Category, Main Categories and Subcategories.)

The Core Category

The core category generated from study data is Getting Back to Life, an *in vivo* code. An excellent example of this theory's *in vivo* core category is P9's observation regarding the challenge of her (and her husband's) new reality after his diagnosis and treatment for colon cancer: "I think now I just try to appreciate the time that we do have and the time that we've had and try to look at the positive… It could be a whole lot worse, you know…" P3, in discussing a contentious relationship of longstanding with her son and his wife, noted:

Table 1. Core Category, Main Categories, and Subcategories.

Main Category	Subcategories
Getting Back to Life (Core Category)	Resetting Anticipating Consequences Self Preservation
The Old Present Reality	Personal Elements of Crying Filling the Cup
Heaping More on the Already Full Plate	Ongoing Personal Crisis Unexpected Personal Crisis
Tipping Over the Full Cup	Triggering Event Uncontrollable Onset of Crying
Feeling Emotionally Stronger	Attenuating Crying and Emotion Relieving Stress Restoring Cognitive Clarity
Getting a Handle on Things	Accepting and Adapting Letting Go

> I feel better after I cry…. Emotionally, I feel stronger after I've cried…. It's like the crying, I've done it. Now, I can deal with the problem in a more positive way…. I can take a step back and look at what's going on and realize I'm not the person who has caused this. I can't fix it… I can listen, I can give advice, but I can't make that person take that advice. Does it always mean I can step back and say don't bring your problems to me? No. But I think it helps me to be able to look at it more as I'm not the person who caused this.

These statements indicate an acceptance of a new status quo, or modified reality, in the lives of P3 and P9. Inclusive of past reality, this new status quo incorporates adaptations to life changes and the realization of an expanded perspective that embraces both the present and the anticipated future. In essence, the crying precipitated by the stress of personal crisis was empowering: It triggered a process that enabled P3 and P9 (and all the other participants) to reestablish personal control in their respective environments.

The Theory

The theory constructed from the data collected and analyzed throughout this study tells what happens and why it happens when women cry in response to the emotional stress of personal crisis. The theory can be stated in two ways. One version of the theory can be stated in layman's terms so that it is easier to comprehend. This version is intended to aid study participants in understanding and evaluating the theory, model, and story line derived from the data they provided. A second version of the theory is more scholarly in its exposition. It is intended for consumption within the scientific community. In either case, the emphasis is on explaining the process whereby the crisis – crying – recovery – acceptance and adaptation

progression leads to a newly perceived reality that incorporates the old reality within an expanded, more enriched perception of self.

Naming a new theory can be as daunting a challenge as stating it cogently. In my opinion, the theory's name should provide enough information for the identification of the relevant field of study, discernment of its primary emphasis, and be descriptive of the involved conceptualization. The name should also have, as Glaser (2005) would say, "grab" (p. 107). The name should provide an indication of the theory's bounds as well as some indication of its testable hypotheses. With these thoughts in mind, I propose calling this theory *The Tipping Point Theory of Crying in Women Dealing with the Emotional Stress of Personal Crisis* (short title: *The Tipping Point Theory of Crying*).

Scholarly Version

It is hypothesized that crying in women dealing with the emotional stress of personal crisis is an involuntarily initiated adaptive response intended to counter the potentially harmful effects of stress overload. In women who have reached the point of stress overload, crying appears to serve at least two purposes: (1) acting as a stress relief mechanism to inhibit compromises to physical and psychological well-being, and (2) enabling the individual's body and psyche to make the adjustments and adaptations necessary to restore and maintain a dynamic existential equilibrium in a newly perceived reality inclusive of the crisis event that resulted in the stress overload.

Layman's Version

It appears that crying in women dealing with the emotional stress of personal crisis is an involuntarily initiated response that acts to shield them from the potentially harmful effects of

stress overload. In women who have reached the point of stress overload, crying seems to serve at least two purposes: (1) acting as a stress relief valve to hinder or prevent unhealthy mental and physical developments in the individual, and (2) enabling the individual's body and brain to make the adjustments and adaptations necessary for successful continuation within that environment and get on with her life.

Taken individually, the notions expressed in the preceding theory are not new. This is explicitly acknowledged in chapter 5, where how this theory compares with other research into crying and theories of crying are examined. Nonetheless, the *Tipping Point Theory* (TPT) is original in that it is grounded in and logically constructed from a carefully considered interpretation of the data collected and analyzed in the conduct of this study. Although the TPT itself is limited by the specific experiences of study participants, it offers testable hypotheses. Moreover, it provides useful insights relevant to nursing education and practice and has important implications for future research into the phenomenon of crying. These insights and implications are also considered in chapter 5.

Story Line

The underlying theme in the data is one of emotional control. It is safe to assume (where it was not specified) that each of the women confronted with the stress of a personal crisis was already dealing with some level of stress. This stress can be called background stress, that is, the normal stress of daily existence. For a woman, this might include the responsibilities and expectations inherent in being a homemaker, mother, daughter, sibling, wife, and working woman. For example, P4 described her background stress by observing:

> We have two kids, small children, and we have three animals, and we have a house, and I'm working on [a graduate degree]. So, life is very busy. It's also softball season, and

> that is something we're very active in for our daughter, and so for him [her husband] to be gone just heaps more on my plate, on my already full plate.

Supplementing background stress levels might be one or more additional stressors not routinely part of daily existence. These stressors could include having to deal with an unexpected financial demand (car repair, home repair, medical expense), medical exigency, and/or problems at home, work, or within the family. In some cases, the crisis event itself may have been evolving over a prolonged period. This would act to gradually increase supplemental stress levels until a defining moment in one's ability to maintain emotional control was reached. This was true for P2, P3, P7, P9, and P10. When P2 was asked if grief was one of the components of the crisis involving her son and his family, she related the following about the factors contributing to the buildup of her stress level over a "couple of months" before "it all came tumbling out":

> I don't think it was grief. It was more anxiety about what was going to happen, you know, is my son's family going to blow up? I mean, how is it going to affect my granddaughters? Uh, what if they get a divorce? Who will the girls live with…. [Their dad] doesn't know how to do girl stuff. I've never raised girls; I don't know how to raise girls. What is that going to do to us? What do we need to do? How are we going to do that? You know, is it going to scar them for life? Uh, who's going to, who's going to keep the house? Who's going to make payments on the house…. How's that going to work? There's this, this thousand inconsequential details that just bombard.

Study participants were in a state of emotional control maintenance prior to experiencing their personal crisis. This state changed suddenly in the face of a personal crisis event or in its culmination. The crisis transmuted emotional control to emotional overload. Emotional

overload resulted in the loss of emotional control. This emotional progression can be seen in P5's response to her crisis experience.

When P5 returned home after a long day at work, her husband confronted her by demanding to know, "Where have you been?" His surprising implied accusation and the brief exchange that followed it had an immediate effect on P5: "I take so much and then, maybe my, my cup's too full… but when I feel beat up on or, you know, then you might, you tip my cup over." This corresponded with the onset of spontaneous, uncontrollable crying. For all but one of the study participants (P7), the crying process thus initiated had a predictable course that involved steadily decreasing frequency and severity of episodic crying interspersed with interludes of quiet and rest.

The quiet, restful non-crying periods were mostly described as time spent reflecting, problem-solving, and trying to control any further crying. The duration of these episodic crying and reflection events lasted for a few weeks or, in some cases, a few minutes. These intervals of episodic crying and reflection can be termed as periods spent struggling to reestablish emotional control. During this time, the individual, who was striving to regain her composure, began to progressively regain control of her emotions. The reestablishment of emotional control, symbolized by the cessation of crying and a readiness to move on, was marked by a process of accepting and adapting to a newly perceived reality inclusive of the crisis event. Once the newly perceived reality was accepted and adapted to, then emotional control could be said to be both renewed and reorganized. This new reality was emblematic of a life reset necessary for self-preservation in an existentially more complex, nuanced, and challenging social environment.

Theory Model

The model presented in Figure 1 reflects the mix of *in vivo* metaphors, idiom, and standard language used to identify categories and subcategories already listed in Table 1. This was intentional. *In vivo* codes were employed to take advantage of the various ways in which participants described their crying experiences when responding to the emotional stress of personal crisis. Moreover, individual participants were inconsistent in the use of figures of speech, most especially, metaphors. For example, P7 used four different metaphors to describe the point at which she experienced the onset of uncontrollable crying. Taken as a whole, study participants used several different metaphors and idioms in describing aspects of their crying and the associated emotional progression. As an illustration, the instant at which spontaneous, uncontrollable crying occurred due to overwhelming stress was variously described as: "the dam burst"; "the straw that broke the camel's back"; "the event was the trigger"; "burst into tears"; "all came tumbling out"; "tears just sprang"; "tip my cup over"; "put one more pebble up there and tip over"; and "broke completely down." P2 added the simile "like a meltdown" to describe her onset of uncontrollable crying and followed that with a vocal approximation of an explosion.

If *in vivo* codes had not been used in the model, several options for describing the process underlying how women experience crying when dealing with the emotional stress of personal crisis could have been used. These include a straight forward description of emotional transition (see the preceding story line section) or use of the bursting dam, full plate, and tipping cup metaphors. If the tipping cup metaphor had been used, then the main categories in Figure 1 could have been renamed as shown in Table 2, GT Model *In Vivo* Categories Related to Tipping Cup Categories.

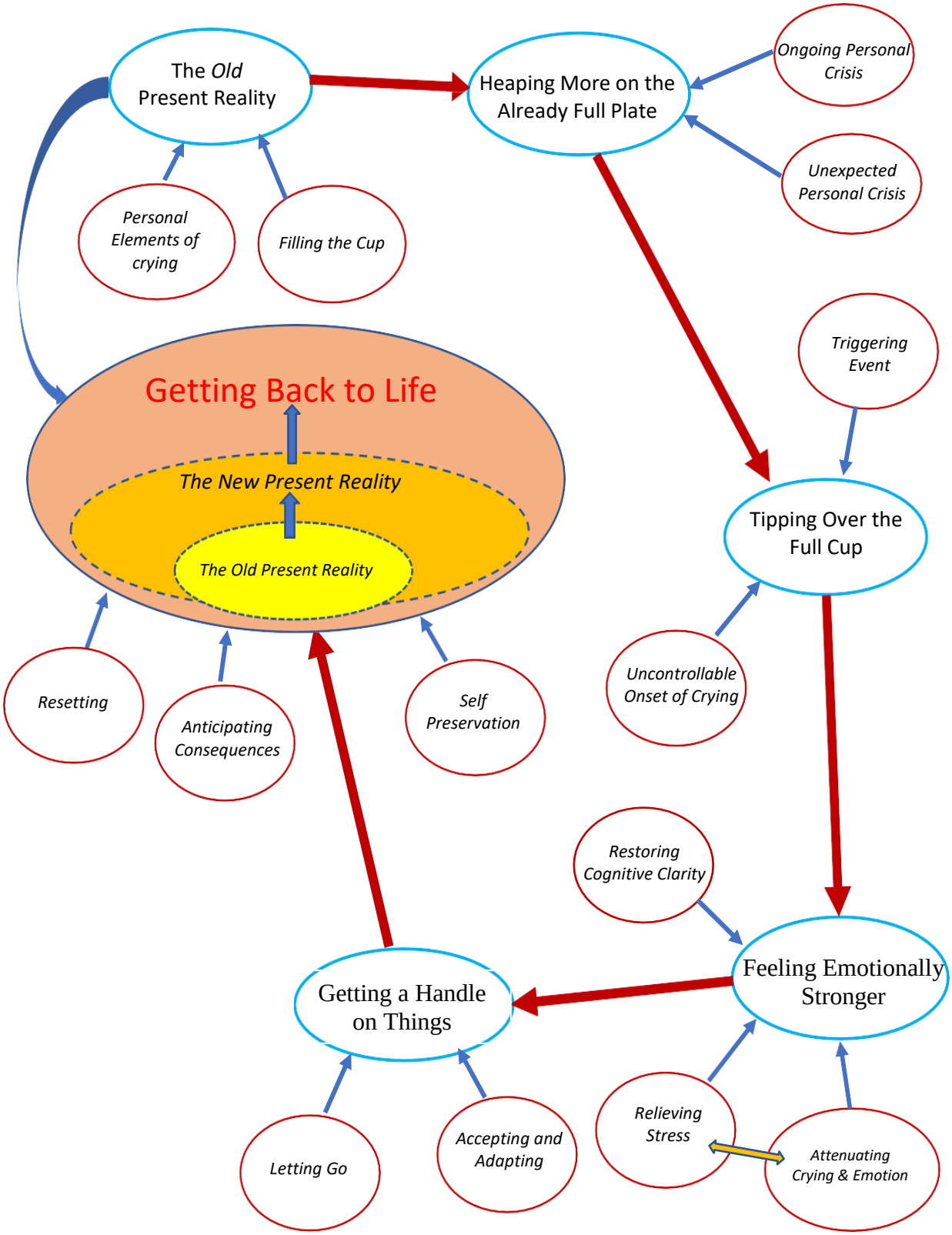

Figure 1. Model of Tipping Point Theory of Crying in Women Dealing with the Emotional Stress of Personal Crisis.

Table 2. GT Model *In Vivo* Categories Related to Tipping Cup Categories.

***In Vivo* Category**	**Related Tipping Cup Category**
The Old Present Reality	Drinking from the Cup
Heaping More on the Already Full Plate	Filling an Already Brimming Cup
Tipping Over the Full Cup	Tipping Over the Full Cup
Feeling Emotionally Stronger	Emptying the Cup
Getting a Handle on Things	Righting the Cup, Cleaning up the Spill
The Old Present Reality	Replacing the Old Cup
The New Present Reality	Selecting a New Cup
Getting Back to Life	Extending the New Cup to be Refilled

Although mixing figures of speech and standard language to identify the model's main and core categories may seem incongruent and inelegant, *in vivo* codes give the TPT authenticity and richness. The actual words used by study participants offer a compelling, evocative picture of how they perceived the progression of events that led to the acceptance of and adaptation to a transformed reality symbolic of the necessity for reestablishing biopsychosocial equilibrium in the face of personal crisis.

The words participants used to paint a picture of their experiences dealing with the emotional stress of personal crisis were not random or indiscriminate, nor was the theory grounded in the data they provided haphazardly conceived. The model presented in Figure 1—and the theory it represents—underwent at least five formulations and was still being revised even as this chapter was being written. Each revision was the result of a modification to how study data had been previously interpreted. The modified interpretations reflected an increasingly greater appreciation and understanding of the subtle shades of meaning participants attached to how they responded to the crisis event. This appreciation and understanding applied to emotions experienced, actions-interactions taken to bring the crisis to resolution, and the outcomes, both actual and anticipated, of that action-interaction.

Figure 1 illustrates the final rendering of the TPT in diagrammatic form. It is a representation of the transactional interplay of context, emotional response, action-interaction, and outcomes that define the process integral to the TPT. It also depicts the interdependent relationships between the TPT's core category, main category, and subcategories.

Relationships between Categories and Subcategories

In this section, the TPT's core, main, and subcategories are defined and their relationships examined in sequential occurrence. Because the main categories Feeling

Emotionally Stronger and Getting a Handle on Things are more closely linked than are the other main categories, they are discussed together.

The Old Present Reality

As mentioned earlier, the first event or stage in the chain of events explained and described by the TPT is a state of emotional control maintenance. This state is symbolized by the main category The Old Present Reality, a label that provides an indication that the participant's reality is going to change or has changed. The before-the-crisis condition is a period of biopsychosocial equilibrium for the participant. This equilibrium is stable within a range determined primarily by the participant's Personal Elements of Crying and minor fluctuations in levels of everyday, or background, stress. When unexpected stressors add to the background stress, then the process of Filling the Cup is activated.

Personal Elements of Crying can include a variety of traits; for example, propensity for crying, feelings about crying in front of others in social and workplace environs, personal feelings about crying, tolerance for stress, and experience dealing with stressful situations. P8, whose background was in law enforcement, stated: "… I've learned to really block, thinking about anything in that [juvenile court] emotional type setting." Something had to be "traumatic" to make her cry. And one of the events that contributed to filling her cup, perhaps decreasing her ability to block out emotions, was the loss of her son's young dog a week prior to the death of her own. Coincidentally, she had an unsettling revelation regarding her father's health.

> … we almost had a funeral wake for her when she was still alive because when she hurt her back, um, we tried treatment and it didn't work. And everybody came over to say goodbye to her and my father, who is 83 years old, was walking out the door and he said, 'Goodbye, [dog's name]' and it kind of hit me as maybe that was preparation for my

father's death, you know…. he's so feeble. He was barely walking. He was just, you know, had a cane and, like, just barely moving out the door.

Heaping More on the Already Full Plate

The second main category in the TPT processual advancement is Heaping More on the Already Full Plate. Its subcategories are Ongoing Personal Crisis and Unexpected Personal Crisis. I think it is reasonable to assume that P8's cup was nearly full when her dog of 15 years died unexpectedly. Mixing metaphors, her already full plate was piled high. It was close to spilling over its sides and creating an emotional mess even before the occurrence of her crisis event.

The temporal separation between Heaping More on the Already Full Plate and Tipping Over the Full Cup may be extremely brief. Of the two subcategories that contribute to Heaping More on the Already Full Plate, that is, Ongoing Personal Crisis and Unexpected Personal Crisis, the latter results in the quickest transition to the main category Tipping Over the Full Cup. This is because the crisis often occurs suddenly and without warning. P1, in describing the suddenness of her father's death, stated:

> … when he passed away, it was very shocking. It was pretty quick when it happened, and it was very difficult…. he had cancer… a blood cancer, but they thought he was in remission, and he went in to get a heart catherization, and, uh, uh, he clotted afterwards and that's what killed him. So, we didn't expect it. We thought he was coming home the next day and, uh, it was pretty shocking.

In P1's case, the Unexpected Personal Crisis (her father's sudden demise) heaped too much on her already full plate (her father's cancer). The stark reality of her father's death became the Triggering Event that caused her full cup (already full plate) to tip over.

Tipping Over the Full Cup

The main category Tipping Over the Full Cup embodies the integration of two subcategories, the Triggering Event and the Uncontrollable Onset of Crying. As already noted, the transition from Heaping More on the Already Full Plate to Tipping Over the Full Cup happens very quickly because the Unexpected Personal Crisis that destabilizes the Already Full Plate is sudden and, in P1's situation, "shocking." Reaction to the Unexpected Personal Crisis is the Triggering Event that causes the full cup to tip over. In actuality, the distinction between the two personal crisis subcategories of the main category Heaping More on the Already Full Plate and the Triggering Event subcategory of Tipping Over the Full Cup is not as clear as it appears in Figure 1. The personal crisis, whether ongoing or unexpected, and the reaction to that crisis were what triggered the Uncontrollable Onset of Crying adjunct to the main category Tipping Over the Full Cup. Study participants, for the most part, tended to view the crisis and their reaction to it as sequential (e.g., P2, P3, P4, P5, P6, and P9), although in some cases the crisis and the reaction seemed to have occurred simultaneously (e.g., P1, P7, P8, and P10) and might, therefore, be considered one and the same.

Feeling Emotionally Stronger and Getting a Handle on Things

Feeling Emotionally Stronger has three subcategories: Attenuating Crying and Emotion, Relieving Stress, and Restoring Cognitive Clarity. Getting a Handle on Things has two subcategories: Accepting and Adapting and Letting Go. Differentiating between Feeling Emotionally Stronger and Getting a Handle on Things was difficult because the boundary between these two closely related categories was not apparent in the early stages of theory development. At first, it appeared that the construction of this theory would result in a GT first, that is, the compound main category. However, further evaluation of and sensitivity to the data

gleaned during this study allowed for the separation of these two closely linked main categories. This was accomplished by recognizing that Restoring Cognitive Clarity was a concept unto itself. As such, it was dependent upon the stress relief that accompanies the attenuation of crying and emotion. P6's response when asked what crying did for her is revealing in this regard:

> I think, I think a lot of times it's very healing. It's, uh, I think for me personally, it's a coping mechanism, and it's how I know when I'm no longer upset and crying about something, then I know it's resolved in my brain…. once I've cried about it, and I've kind of, then, I can kind of come to a resolve about that event.

The realization that Restoring Cognitive Clarity was a distinct subcategory of Feeling Emotionally Stronger rather than a concept that overlapped and interconnected that category and Getting a Handle on Things established an unambiguous separation between these two main categories. This realization occurred when I grasped clarity of thought was a necessary prerequisite for Letting Go and Accepting and Adapting, the subcategories of Getting a Handle on Things. That clarity could only happen after the stress relief that occurred concomitant with the attenuation of crying and emotion, but it inevitably preceded the adoption of a fresh perspective inclusive of the crisis event.

The category-subcategory and main category-main category relationships relevant to the main categories Feeling Emotionally Stronger and Getting a Handle on Things are further accentuated by information provided by P6 and P9. Consider first P9, whose husband had a close call with stage 4 cancer but was now cancer free:

> Short term, I think it sometimes makes me feel better…. Once I cry, like I physically can think clearer and I move on… it's like I get so bogged down with it that it's like I have all these negative thoughts, and everything's negative and bad and, you know, once that

> happens then it kind of clears for me, and I can be more positive… I can feel myself relax more. I can feel, like I carry everything in my shoulders, so I can… relax a little better once I get that out of me.

In this brief reflection, P9 explains how the crying that followed the initial crisis-triggered "really hysterical crying" made her feel better by allowing her to relax. Relaxing was accompanied by being able to think more clearly. Having a clearer mind permitted her to purge herself of negative thoughts and adopt a more positive attitude. Implicit in the adoption of a positive attitude was that she had accepted the reality of her changed situation and was adapting to it so that she could move on with her life.

P6, who had suffered a miscarriage, summarized how she became emotionally stronger and was then able to come to grips with her situation:

> When I was at home, you know, I could cry for 20 or 30 minutes and it may be just while I'm doing, you know, sitting in the bathtub or taking a shower or, you know, cooking dinner or whatever… it's usually not a big sobbing cry but, you know, I mean just to be kind of thinking about things and would just have a good, steady cry…. Usually, I feel, I feel better about the event… sometimes I think, you know, I just needed to cry about it, and cry about it, and then I'm over it…. That just kind of helps me cope with, with whatever is going on. And I think at that time it was a grief response and a frustration response because there was a lot of frustration with, you know, why is this happening?

P6, like P9, experienced episodic crying after the first trauma-induced, uncontrollable outburst of "heavy sobbing." She acknowledged crying sometimes made her feel better, that it was necessary for her cope with what happened and the grief and frustration that followed. The

crying she did after the crisis event allowed her to get over her grief and frustration, and that signaled her readiness to accept and adapt, to let go, to get a handle on her life.

Moving to Feeling Emotionally Stronger and then on to Getting a Handle on Things is evident in P4's interview responses involving the unplanned and badly timed trip her husband was taking:

> You got to get up and go on with life… I couldn't just sit and cry, so I had to get up and go on…. The more I thought about it, while it was still overwhelming, I knew that I would have support from other people during that time and that even though I was still hurting that he was leaving, and I was going to have to get help from other people, I knew that was just what I was going to have to do. As some of the pieces fell into place, it wasn't as overwhelming as before. Oh, it's so better after I cry!

All study participants had experiences similar to those of P9, P6, and P4 in how they recovered from the emotional trauma associated with their crisis events. The precipitation of uncontrollable crying and ensuing adjustment process were instrumental in restoring psychological and physiological stability to the degree necessary for letting go, for accepting and adapting. The emerging extension and expansion of each participant's perceived reality achieved coherence in the conceptualization of the main category Getting a Handle on Things.

Getting Back to Life

Getting Back to Life, the theme central to the TPT, is more complex than the other main categories for two reasons. The first and most obvious reason is that it is the core category. As such, all the other categories and subcategories fall within its domain. The second reason is that it is a composite exemplification of The Old Present Reality and The New Present Reality, with the former having been subsumed by the latter. The New Present Reality is representative of a

renewed lease on life based solidly in a freshly envisioned reality. With this freshly envisioned reality comes the desire to move on, to get back to living. The crisis-instigated stress release has allowed the realization of a revitalized perspective apropos of the efficacy of the actions-interactions-emotions requisite to maintaining biopsychosocial equilibrium within an expanded and more complex social setting. Per P7:

> Like stress relief, you know. It's just like I, I've released the stress, and then, it's just kind of a feeling of: OK, I, I've got it together, now. You know, so it's just like you, I, I feel the tears are like the stress and so, now, the stress is released.

The three subcategories of Getting Back to Life—Self Preservation, Anticipating Consequences, and Resetting—symbolize the life changes required to "get it together"; that is, the life changes basic to reestablishing and maintaining the biopsychosocial equilibrium indispensable to continuation in a social environment newly conceived from the ashes of a superseded reality.

Properties and Dimensions

Properties are attributes that can be used to differentiate among the variations in a concept's occurrence. Dimensions of those properties permit either a direct quantification of the property over a specific range or the recognition of a unique exhibition of that property. In this study, properties and indications of their possible dimensions emerged with the analysis of the first interview. These were identified even though no determinations had been made about the concepts relevant to the study. This was possible because the appearance of an attribute that is measurable or takes on different forms signifies the existence of a property, and the existence of a property implies the existence of a concept or category. Giving that concept or category a descriptive title can be postponed until such time as the breadth and depth of its scope, determined by dimensional saturation of its constituent properties, are determined.

In analyzing the first interview, six categories were identified, as were eleven subsidiary concepts, or subcategories. Related to the eleven subsidiary concepts were 17 properties that were suitable for dimensional analysis. These initial categories, subcategories, and properties with their dimensional ranges are shown in Table 3. (Memo 4 in Appendix E refers.)

Of the initial concepts and categories developed in coding the first interview, only one survived the coding and constant comparative analysis of follow-on interviews. Somewhat surprisingly, the lone category to persist after months of rigorous data analysis and comparison turned out to be the *in vivo* core category, Getting Back to Life. Nonetheless, it was apparent from open coding the first interview that provisional concepts such as the Effects of Crying and the Stress of Crying, in some form or another, would figure in the constructed theory. Given that, I determined it might be useful to identify the properties and dimensions of crying. Per Plas and Hoover-Dempsey (1988), properties of crying include variations, propensity for crying, crying patterns, social constraints on crying, and personal attitude about crying. In the context of this study, dimensions for the property of variations required specification rather than numerical quantification; for instance, streaming tears to heaving and sobbing. Propensity for crying might range in dimension from seldom cries to cries easily. Crying patterns might range in dimension from a single, brief period of intense tear flow to intermittent bouts of bawling and quiet periods with crying decreasing in intensity and frequency over a period of several days. In the latter case, it might also be useful to consider intensity and frequency as crying properties where intensity would range from low to high and frequency would range from approximately once an hour to once a day.

The diagram in Figure 2 is illustrative of how properties and their dimensions underpin the conceptual abstraction integral to the creation of one of the TPT's main categories.

Table 3. Categories, Subcategories, Properties, and Dimensions from First Interview.

Category	Subcategory	Property	Dimensional Range
Getting Back to Life			
Personal Crisis that Preceded Crying	Loss of Family Member	Relationship	Mother, father, spouse, child, etc
		Closeness of Relationship	Not Close – Very Close
		Timing of Event	Expected, Sudden, Unexpected, etc.
Reaction to Loss	Grieving Process	Guilt	None - Extreme
		Feeling Sorry for Self	Not at all – Very Much
		Interference with ADL	None - Extreme
		Physical Manifestations other than Crying	Specify
The Stress/Crying Process	Progress of Crying and Attenuation of Emotion	Mental Triggers	Memory, start feeling emotional
		Physical Precursors	Specify
		Physical Aspects of Crying	Duration of Specific Events
			Time Period Over which Crying Occurred
			Type
			Vocalization
			Frequency
		Social Context	Alone – with Someone
		Influences of Age	Younger - Older
		Familial Propensity	No - Yes
	Effects of Crying	Relieve Anxiety	Not at All - Completely
		Response to Anxiety	Specify
	Stress of Crying	Social/Cultural/Familial Prohibitions	Specify
		Personal Feelings About	Specify
Controlling Crying	Using Medications		
	Desire to Control	Fear of Losing Control	Specify
Understanding the Reasons for Crying	Crying as Part of Self	Forgiving Self	Specify
	Crying as Reality		
	Self Perception		

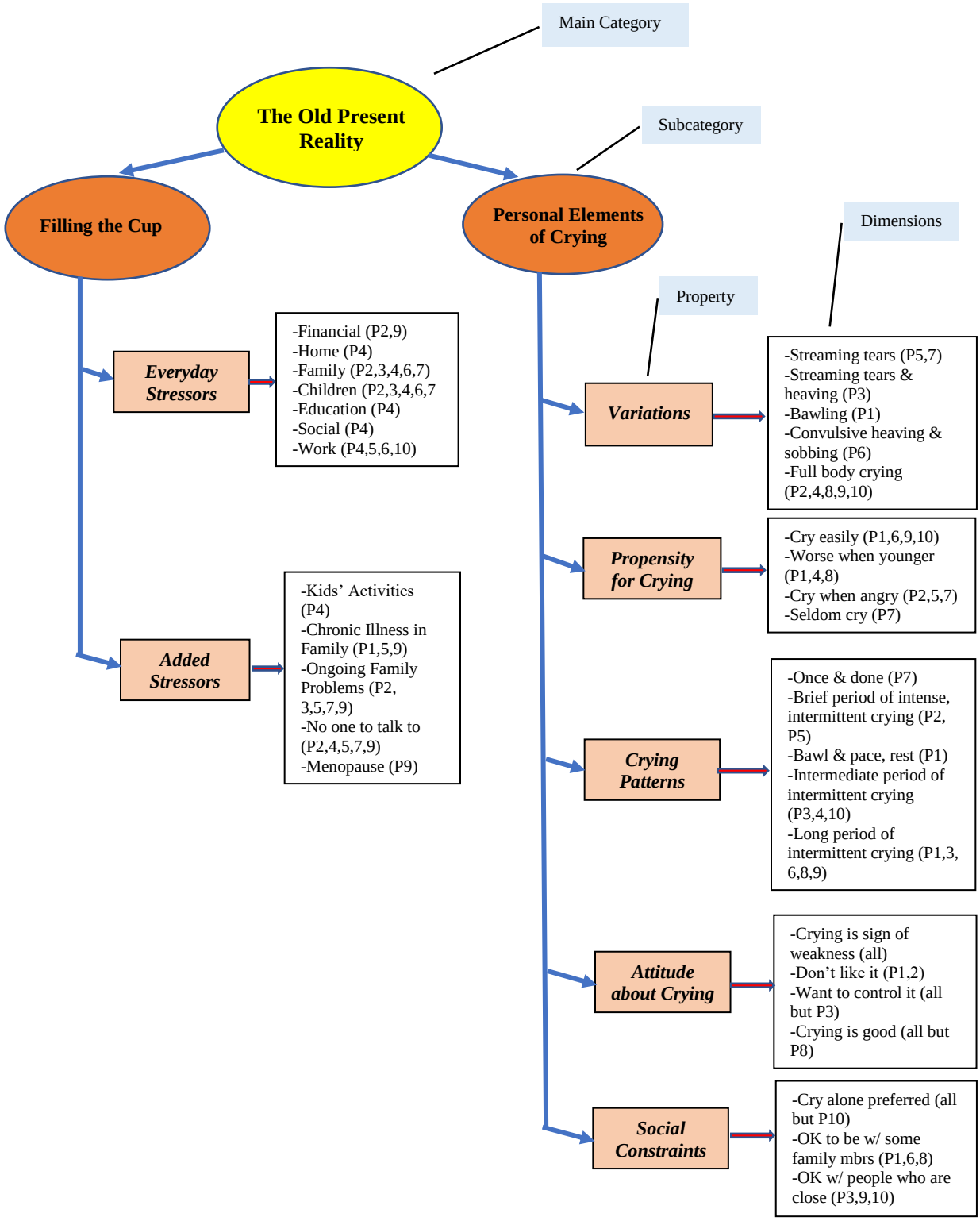

Figure 2. Main Category *The Old Present Reality* and Its Subcategories with Properties and Dimensions Shown.

Specifically, Figure 2 shows the extent to which the concepts Filling the Cup and Personal Elements of Crying, subcategories of the main category The Old Present Reality, are saturated.

Saturation

As stated earlier, relevant concept properties and their respective dimensional ranges can be determined with some degree of certainty beginning with the data analysis of the first interview. This determination precedes the final conceptualization of aggregate data that affirms a theory emblematic of the interpreted meaning study participants give their contextual actions-interactions and resultant consequences. The power and richness of this final conceptualization—the GT—is governed by the extent to which data saturation has been achieved. This is where tabulating the raw data extracted during open and axial coding can be helpful.

Table 4 shows the occurrences of certain words, phrases, and themes—concepts in their own right—in the ten interviews supporting this study. These words, phrases, and themes constitute a pre-conceptual level of data analysis and were either stated directly or clearly and unequivocally implied. Most of the words, phrases, and themes listed in Table 4 were selected as being of possible significance after coding the first two interviews. The basic concepts exhibited in this table, most of which are *in vivo*, provided a foundation for imagining theory concepts, subcategories, and main categories. A cursory inspection of the data in Table 4 indicates saturation in several raw data categories. Participants whose interviews contained a specific or clearly implied reference to the words, phrases, and themes in Table 4 are indicated with the letter "X." Of interest is that theoretical data saturation can be confirmed by assigning

Table 4. Common Words, Phrases, and Themes Stated or Clearly Implied by Participants.

Line #	Common Words, Phrases, & Themes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
1	Bawling, burst into tears, tears just sprang, uncontrollable sobbing	X	X	X	X	X	X	X	X	X	X
2	Brings me back to reality	X	X	X	X	X	X	X	X	X	
3	Can't fix it		X	X		X	X	X	X		X
4	Cathartic, healing, therapeutic	X				X	X				
5	Cleansed, clean, refreshed	X				X				X	
6	Concerned about social ramifications of crying in front of others	X	X	X	X	X	X	X	X	X	X
7	Cry easily	X					X			X	X
8	Crisis situation not solved		X	X		X	X	X			
9	Crisis situation resolved	X	X		X	X	X		X	X	X
10	Crying alone preferred	X	X	X	X	X	X	X	X	X	
11	Cry and think, reflect, or process	X	X	X	X	X	X		X	X	X
12	Crying gradually got less and less	X		X	X		X		X	X	X
13	Crying is a sign of weakness, vulnerability, being a Softie, unprofessional	X	X	X	X	X	X	X	X	X	X
14	Cry less now that I'm older	X			X				X		
15	Dam burst, I couldn't stop it; I couldn't help it; came crashing down; cup has tipped over	X	X		X	X		X	X	X	
16	Exhausted, tired, drained during or immediately after crying	X	X	X	X	X					
17	Feel better afterwards, emotional and/or physical stress relieved, tension relieved	X	X	X	X	X	X	X	X	X	X
18	Feelings of Guilt, questioning self	X		X	X	X	X	X			X
19	Feel peaceful, quiet after		X				X				
20	Frustrated and angry about situation		X		X	X	X	X			X
21	Get on with your life, move on	X	X	X	X	X	X	X	X	X	
22	Getting the anxiety out	X	X	X	X	X	X			X	
23	Gotta be a big girl, pull yourself together, get control of yourself	X	X		X			X	X	X	
24	Interference with ADL	X	X						X		
25	Like a meltdown		X		X					X	
26	Needed to cry, to let some of this out		X	X	X	X	X	X	X	X	X
27	Not averse to crying with those who are close to them	X	X	X		X	X		X	X	X
28	Not a pretty crier		X		X	X					X
29	Shocking and/or sudden unexpected crisis event	X			X	X		X	X	X	
30	Spontaneous, unexpected crying onset	X	X	X	X	X	X	X	X	X	X
31	Stressed, overwhelmed, high anxiety level	X	X	X	X	X	X	X		X	
32	Think crying is good	X	X	X	X	X	X	X		X	X
33	Think of something and cry	X		X	X		X		X	X	X
34	Very stressful, traumatic	X	X		X	X	X	X	X	X	X
35	Want to control crying, emotions	X	X	X	X	X	X	X	X	X	X

the meaning conveyed in Table 4 line numbers to the TPT's core and main categories. This is shown in Table 5.

An inspection of the common words, phrases, and themes in Table 4 will reveal that the meanings conveyed in some of the lines overlap with that of others. For example, lines 1, 15, and 25 are similar in meaning, as are lines 6, 10, 13, and 27; lines 4 and 5; lines 3 and 8; lines 17 and 22; lines 21 and 23; and lines 31 and 34. Combining lines with similar meanings reduces the number of common words, phrases, and themes groupings in Table 4 from 35 to 25 and provides a more compelling image of the degree to which data saturation was achieved in the study.

Action-Interaction Strategies

The action-interaction strategies employed by participants to regain emotional equilibrium consisted mostly of self-interaction or interactions with family members who were very close to them. Self-interaction focused largely on attempts to control crying, both to keep it from happening and to stop it once it had started. With some participants, self-interaction involved dealing with feelings of guilt (P3, P6), trying to comprehend why they were crying (P1, P2), and attempts to rationalize away any responsibility for the crisis situation in which they found themselves (P3, P7). Interaction with family members was generally limited and entailed seeking support, comfort, empathy, and nonjudgmental understanding (P1, P6, P8, P9, P10). In the main, action taken by study participants was limited primarily to purposeful attempts to isolate themselves while crying. This was sometimes due to a desire not to burden others or to conceal feelings, but it was always intended to protect against being perceived as weak.

In most cases, study participants were limited in the influence they were able to exert in regaining control of their emotions once, as P2 phrased it, "the dam burst." The spontaneous onset of uncontrollable crying, a psychogenic parasympathetic reaction (Frey, 1985; van

Table 5. Core and Main Category Connections to Raw Data in Table 4 by Line Number.

Core and Main Categories	**Table 4 Raw Data by Line Number**
The Old Present Reality	6, 7, 10, 13, 14, 27, 28, 32, 35
Heaping More on the Already Full Plate	20, 26, 31
Tipping Over the Full Cup	1, 15, 24, 25, 29, 30, 31, 34
Feeling Emotionally Stronger	4, 5, 11, 12, 16, 17, 22, 33
Getting a Handle on Things	3, 8, 18, 19
Getting Back to Life	2, 8, 9, 19, 21, 23

Haeringen, 2001) to overwhelming stress, was an unexpected prelude to a series of actions and interactions that eventually resulted in the restoration of emotional control and, subsequently, a return to a state of emotional equilibrium. With one notable exception (P7), the events occurring after the initial outburst of uncontrollable crying and its cessation followed a similar trajectory. Broadly speaking, that trajectory consisted of alternate periods of crying and not crying. Importantly, participants seemed incapable of managing or directly controlling the occurrence, frequency, duration, or intensity of episodic crying within that trajectory. Nonetheless, they did benefit from the time it took for the crying-not crying cycle to run its course. It was during this period that most participants developed a more discerning mindset vis-á-vis the problematic situation with which they were confronted. This allowed envisioning the precipitating emotional crisis from a different perspective, a perspective that facilitated the eventual acceptance of and adaption to a new reality borne of and inclusive of the crisis event.

The alternating periods of crying and not crying experienced by study participants were similar in that most participants desperately wanted to control their crying after experiencing the initial uncontrolled outburst. Only one participant, P3, made no apparent effort to control her crying, even though she felt that crying in front of those not close to her might be perceived as weakness. Over time, the periods of crying gradually became more intermittent, less intense, and of shorter duration until they effectively ceased.

There were exceptions to the total cessation of crying once the emotional impact of the crisis was past. P3 and P7, both of whom were dealing with continuing family dysfunction that involved their grown children, acknowledged the eventuality of more emotional heartbreak in the future. P1, whose father unexpectedly passed away, and P6, who had a miscarriage, both said memories of what they had lost would sometimes cause them to cry. Each of them identified the

emotion associated with this post-crisis crying as sadness. This sad crying persisted for weeks after the crisis event. P1 poignantly revealed, "I forgive myself for still crying, you know, when I think about it." P6, talking about crying as a response to thinking about her miscarriage now that it was in the past, stated:

> No, it doesn't solve anything, but I usually do feel a little better because, I think, of the emotional relief. 'Does make it better, because, I think, you can't keep that bottled up all the time. And, so sometimes it is helpful to think about things and cry. And then, most of the time… I'm fine…. It's still there. And I think it always will; I don't think it'll ever go away.

Almost all participants exhibited the ability to constrain one aspect of their episodic crying-not crying. Several said they experienced physical or emotional precursors to the crying incidents that followed the initial bout of crying. P1's signal that crying was imminent was that she got a lump in her throat; P5 said her throat would start to close up and this was sometimes accompanied by becoming flushed; P2, P4, and P7 said that building anger often forewarned them they were about to cry. These precursors gave them time to isolate themselves so they could cry alone. Tellingly, none of these precursors provided participants forewarning of the sudden and unexpected onset of crisis-stimulated crying.

The two main reasons given for the desire to cry alone were not wanting to be perceived as weak and to keep from upsetting others, especially family members. Rather surprisingly, the collective "family members" sometimes included the family member who was the source of the precipitating crisis. As an example of the former reason, P4 stated:

> I don't like to cry in front of people…. It's not pretty, first of all…. I'm supposed to be in control. If I'm crying, I'm not in control…. It would be a weakness, because they can

use it against you. Like, I have to protect myself… because you don't know when somebody is going to use something against you.

As an example of the latter reason, P9 reflected about crying in front of her husband: "I usually go off by myself. I don't know… sometimes it's because I don't want him to see he's hurt me enough that I'm crying over it." P5 contributed the following thoughts regarding purposively crying alone so as not to burden others:

> I just don't want to add more fuel, you know, to a situation. I don't want that person to feel bad because they hurt my feelings. You know, they may not even be aware they've done it… I know crying is, of course, with men, crying upsets them even more…. Even with my daughter… I don't want her to see me crying…. I don't want to upset her because she's very reactive to the emotions of other people and so I don't want to put that added burden on her.

For whatever reason, crying alone, whether in the face of overwhelming emotion or time spent recovering from being overwhelmed, appears to facilitate the restoration of cognitive clarity. This happens coincidentally with or because of the diminishment of stress and the gradual attenuation of emotion. Basically, most participants used the in-between of crying spells to rest, think, and process. A notable exception to this interaction strategy involved P4. She claimed that because she was left alone while crying, she used the time spent crying to process and problem-solve. And because she was physically tired and mentally foggy after crying, P4 said she was careful to not make any decisions until she had gotten over her crisis-induced crying episodes. As a contrary example, P5 employed a purposeful action-interaction strategy to moderate her stress-impaired cognition. During and between crying stints, she carried on a conversation—talking out loud and to herself—with an imaginary counterpart to her husband,

who had wrongly accused her of infidelity. This hurtful accusation apparently stemmed from a minor mental impairment possibly attributable to chronic health issues. Describing the experience, P5 related:

> I remember I was talking to myself…. I was giving him my defense, my reply if he were of the right mind, I would have been able to, to defend myself, but instead of defending, I went into the bathroom. It was easier that way for him…. After I talked it out with imaginary (husband's name), who was not ever going to be able to reply in the way that my imaginary (husband's name) did, I got myself under control.

Interaction strategies other participants employed to regain emotional equilibrium included equating tears to stress so that crying translated to a perception of stress relief (P7) and accepting there are situations that "cannot be fixed" (P3 and P7). Acknowledging that unfortunate reality can be a requisite first step toward the reestablishment of emotional equilibrium.

Study participant action strategies not previously mentioned include pacing and thinking while crying (P1) and adopting another dog to replace the one that had died (P8). Prior to adopting another dog, P8 admitted that the week after her old dog's death, she "worked a lot that week where I didn't have to come home… 'cause I didn't want to open the door and not have anybody… nobody greeting, that the dogs not greeting me." (P8 said "dogs" because she had kept her son's dog, a 6 months old puppy, that had died because of an injury a week prior to the passing of her dog.) Two factors in the adoption are pertinent to P8's action strategy. First, P8 adopted her new dog less than two weeks after her old dog's death. Second, she intentionally adopted a dog that needed a lot of care and attention: "She's a Heeler-Boston mix, so she likes to

heel people. And she's been known to bite somebody, 'probably why she was a rescue dog. But she's like an abused child, so we take care of her. There you go."

Variations within the Theory

Very simply stated, the TPT's premise is that a woman who cries when confronted by the overwhelming emotional stress of personal crisis will experience a series of events that track in a comparatively predictable pattern. First, there is the sudden and unexpected outburst of uncontrollable crying. Second, this outburst of crying and the episodic crying-not crying that follow function to relieve both psychological and physiological stress attributable to the emotional overload instigated by the personal crisis. The stress relief concomitant with the initial outburst of crying and the progressive attenuation of crying and emotional upset enables the gradual reinstatement of mind and body well-being. That, in turn, permits the reestablishment of biopsychosocial equilibrium at a new level of cognition. However, the actuality of this experience was not the same for study participants. Although the overall series of events was similar for all but one participant (P7), there were notable differences in how two of the events in the series were experienced. Variations within the theory consequent to this study were related primarily to: (1) the onset of uncontrollable crying in response to the emotional stress of personal crisis, and (2) the crying-not crying period subsequent to the uncontrollable crying event.

Onset of Uncontrollable Crying

The unexpected onset of uncontrollable crying in response to a personal stressor happened in a multiplicity of ways. For some participants, this emotional tipping point was exceeded as a direct and immediate response to the crisis occurrence. This, however, was not

always the case for study participants. In some instances, there was a very slight delay between the crisis occurrence and the onset of uncontrollable crying. Some participants were also involved in an ongoing crisis that finally came to a head. Lastly, and perhaps most interesting, was the one participant whose onset of uncontrollable crying appeared to have been held in check by her unconscious psyche until a suitable, safe time and place was found for her to "meltdown."

Those participants whose initial crying was directly and immediately triggered by the crisis event included P1, P8, and P10. P1's personal crisis event was the "shocking" death of her father. She described her experience as, "At first… I couldn't stop crying." P8 took the death of her dog very hard. After her son called to tell her that her dog had suddenly died, she said, "So I called a friend at work, and she had to bring me home because I couldn't drive…. I mean, you know, tears just rolling down my eyes. Just uncontrollable." P10's crisis event also involved death, but it was the death of a close friend, who had lost a long struggle with cancer. P10 said: "I remember I got the phone call, and I just, I fell to the floor, and just leaned on the bed and sobbed my eyes out over that."

The relation of the crisis event and the onset of uncontrollable crying experienced by P4 and P5 was very much like that of P1 and P10. The only difference was that P4 and P5 took a few minutes after the crisis happened to begin crying. In P4's case, she left the room as soon as her husband informed her he was leaving on an unannounced trip. Since he had just returned from an extended trip, this really upset P4. In her words:

> I was so mad that I didn't say anything to him. I just left and went to another room by myself and sat there and the more I thought about what was going on, the worse that I got, and so then I started crying…. Then I kept crying, and I probably cried for about 45

minutes to an hour ‘cause any time I thought I felt better, or thought I could get up and face it, I just got upset all over again.

P5, smarting from her husband’s implication that she had been unfaithful, also got angry.

I left the room because it, it shocked me, and, and I went into the bathroom, and I replayed our conversation again, and it hurt. I felt like I was wounded. And then, and then the tears just sprang, and, and I just cried, you know. I didn’t sob, but I, you know, I had a lot of tears and just… I’m a quiet crier. I don’t wail words or anything.

Other participants (P3, P6, P7, P9) whose unexpected crying was tied to a personal crisis were already involved in a stressful situation that eventually reached crisis proportions. With P3 and P7, the dilemma they faced involved family dysfunction involving their grown children. That dysfunction culminated in a triggering event, an event that tipped over the metaphorical cup already filled with stress and anxiety. With P6 and P9, the crisis event was even closer to home. P6 suffered a miscarriage and underwent a DNC; P9’s husband was diagnosed with stage 4 colon cancer, a diagnosis that set into motion a whirlwind series of treatments including a colonoscopy, chemotherapy, colon surgery, more chemotherapy, and finally, liver surgery.

P3 attributed her onset of uncontrollable crying to discord between her son and his wife. The discord involved finances, moral values, and religious beliefs. Further complicating the situation was a grandchild with ADHD who had a talent for manipulating his parents. Although it was unclear from the interview data when the discord reached a crisis level, P3 described her crying in reaction to it, saying: “I’m not a person that always like sobs, boo hoos… mine would be, I guess what you might call sometimes a violent cry… Does that, I mean, I still shed tears, but it’s not like this sobbing thing.” P6, however, described her crisis-instigated crying as sobbing: “When I cry like that, that’s usually very, very rare. I’m usually… very upset about

something for me to do really heavy sobbing." It is important to note that P6 cried on several occasions while she waited for a determination to be made regarding the viability of her pregnancy, but the crisis-induced emotional overflow did not occur until she had returned home following the DNC.

P7's crisis came during a phone conversation with her son, who was angry about something that had happened between him, his father, and sister. He began screaming at her and said, "Look what you've done to my life, look what you've done to my life! You've ruined my life, you bitch…" In actuality, P7 had nothing to do with the circumstances of the argument her son had with his father and sister, but he blamed his mother because his father was "her husband." P7, already in a high state of anxiety because of the ongoing dissension, said of her reaction to her son's flare-up:

> It was just more than I could take, so it made me start crying…. So, I'm angry, and so, like, the tears, like, just pour down my face…. I'm not a sobber… I don't, like, curl up in a ball. It's just I'm so angry and tears just pour down my face.

P9's uncontrollable outburst of crying followed a few weeks of trying to suppress the feelings and emotions—and tears—that had arisen after her husband's cancer diagnosis and treatment began with a trip to the local emergency room because he was experiencing unbearable abdominal pain. No longer able to suppress her emotions, P9 related her reaction to being told by the doctor who performed colon surgery on her husband that he had removed all the cancer in the colon, but that it had metastasized to the liver.

> I remember holding it together while he was standing there telling me, but I don't even know if he was out the door when I broke completely down…. I just remember leaning over in the chair and my sister… just came over and jumped in the chair with me and just

wrapped herself around me, and I just buried my head in her and cried and cried and cried.

The most interesting crisis-related crying experience occurred with P2. She had gone to her doctor's office for her annual physical. In recalling the experience, P2 said a problem resulting from her son's "bad decisions" had been bothering her for about two months prior to her "falling apart." This happened so unexpectedly, that P2 was at a loss to explain what happened to make "it all [come] crashing down." After being shown to an examination room, P2 recollected: "It didn't seem like anything different than any other day. I wasn't particularly sad… I was just sitting there thinking about things, everyday things… I wasn't thinking about me or anything in my life." But then the doctor walked into the room and asked, "So how are you today?" P2 described her response as follows:

> And I burst into tears…. I don't even know why, what triggered it other than just, I don't know…. I had no idea I was just going to all at once fall apart like that, and I couldn't… I was there for an hour and a half, and I cried the whole time.

Reflecting on her uncontrollable and embarrassing outburst of crying, P2 wondered if her unconscious self was waiting for the right moment to let her react to heightened emotional stress levels caused by the problems her son was having.

> I've tried to think, to think it through myself, and that's, that's the only thing I could come up with was that, somehow, I felt like that was a safe place to show my vulnerability…. I don't know other than there's no judgment there… I think, in some way, without even consciously realizing it, somehow, being in a healthcare office with a doctor I knew and that I trusted, that I felt safe…. I probably desperately needed to cry, to talk it out, to whatever, to let some of this stuff out that I had been holding in and, for

whatever reason, it just all came tumbling out. And once, like the dam burst and once it did, I couldn't get it to stop.

The onset of uncontrollable crying experienced by P2 was qualitatively different than that of other study participants, but its contribution to the alleviation of her stress and tension was similar in effect. That effect reached its peak during participants' crying-not crying periods.

Crying-Not Crying Period

The differences in the crying-not crying periods experienced by study participants fall into three groups. The period groupings can be loosely categorized as those (1) lasting longer than a day, (2) lasting less than two hours, and (3) not lasting beyond the initial crying experience. Most episodic crying and not crying periods lasted at least two days for the majority of participants, including P1, P3, P4, P6, P8, P9, and P10. P2, P6, and P9 also experienced instances of crying before the climax of the crisis events in which they were involved. P2, remembering her frustration with her son, admitted, "There were a couple of times I literally just went walking in the woods crying, scream at the sky kind of thing…" In P6's case, she talked about "happy crying" when those people who had some knowledge of her dilemma showed they cared about her and assured her of their support. In P9's case, she spent about two weeks anticipating the worst for her husband and his battle with cancer. During this time, she felt she had to "hold it together" for the sake of her husband but still cried at times when her anxiety broke through that control.

The experiences of P1 and P4 are representative of those whose episodic crying-not crying lasted at least two days. Of the study's participants, P1 took the most time to adjust to her crisis event, the death of her father. Thinking back about her father's death, P1 observed:

> I found myself pacing. Just pacing, pacing. And I, I mean, I didn't even take a shower. It was just like I was awake, I couldn't sleep…. But, you know, it just, it just was a very difficult time. Probably even through the funeral and probably for a week or so afterwards…. I just really didn't get a lot of sleep or anything…. It would go in short splurges…. I would be OK, then, I don't know, maybe 10 minutes, I would just start bawling again, and then, then I'd be OK for a while…. It's better now. [I cried for] weeks. It gradually got less and less…. at first, it was every, you know, day would be, you know, for the day, you know, there would be minutes, or hours between them. It just progressively got better.

In a similar vein, P4 acknowledged how her crying-not crying episodes spanning 3 or 4 days helped her deal with her husband's unexpected trip:

> And then when I'd calm down, I'd say, 'OK, we've got time to deal with it.' [But then] I'd start thinking about everything I would have to deal with and it was just that overwhelming feeling that you've got to take care of all of this made me start crying again.

Later in the interview, P4 added:

> But there's distractions everywhere, you know, there's always distractions, and if I'm crying, usually everybody's leaving me alone, so I have time to process things while I'm crying, and I can think things through, and usually pray, and it's just almost like a quiet… it's not quiet, but it's no distractions. I can process…. But it got better. It got better as I went on. I wasn't as foggy like Saturday night as I was, you know, Tuesday morning…. That foggy time is resting time, 'cause I can't deal with it anymore. I need a break from

it, I need to file it away, kind of put it where it belongs so that it's not out in something I'm dealing with.

Not all participants went through a lengthy crying-not crying period. P2 spent an hour and a half violently sobbing as she tried to talk to her doctor. P5 spent 15 minutes in the bathroom crying copious tears and conducting a conversation with an imaginary husband.

P2, describing her response to her doctor after he asked her to tell him about why she was crying:

> I just told him I was real worried about our son, and that he was making some, some bad choices, and, you know, and that… I remember, I remember I said… I got, I got frustrated and a little, a little angry because I was, like, I just can't fix it, I just want to fix it. And then, I started crying again. Intermittent, but I'd say about 90 percent of the time I was crying…. That's the way the whole blessed hour and a half went.

From what she said, it did not appear that P2's crying and emotions were attenuated during her time in the doctor's office. She did, however, stop crying before she left the doctor's office and realized significant emotional relief later that day.

In a rather unusual instance of crisis-related crying, P5 actively sought to relieve her stress and tension with a strategy that involved role playing. She estimated her total time crying, from onset to crying-not crying to cessation, was only 15 minutes. She went on to say after she first began crying, she began talking to herself, playing both the roles of her and her husband, during brief interruptions of tear flow. Her crisis-triggered crying onset fed directly into a truncated period of crying and not crying and, though the experience was much compressed, it still had the desirable effects of attenuating emotion, relieving stress, and enabling her to accept, adapt, and let go.

Of all the participants, P7 had the most abbreviated crisis-triggered crying event. Her triggering event—her son screaming and blaspheming at her during a phone call—was previously noted. P7, who classified herself as someone who seldom cries and admitted to not crying about her father's death until 2 months after he had been buried, stated her son's outburst made her angry. She said anger was almost always her trigger for the sudden onset of crying which she could not control. In this instance, P7 said she cried for about 5 minutes, then accepted the situation for what is was and likely to always be and moved on. Her situation was not unlike that of P3's. Both were confronted with circumstances to which they had become resigned because it seemed unlikely the dysfunction in their families would ever be satisfactorily resolved.

Accepting and Adapting

All but one of the study participants (P10) indicated that the alleviation of stress and tension was crucial to their return to reality, a psychological passage from what was to what is. An analysis of the data provided by participants made it apparent that overcoming the stress and tension originating with the crisis situation was a necessary and essential prerequisite for accepting and adapting to the existential implications of what had transpired.

With P10, who admitted to crying easily and frequently, her response to personal crisis was tempered by her unaffected acceptance of crying as an innate, healthy emotional outlet. Hence, she seemed acclimated to and understanding of the relationships existing between the diminishment of crying and emotion and the affiliated psychological adjustments needed to accept and adapt to a reality encompassing the crisis event. Although P10's adaptive strategy appeared to be inherent, the adaptive strategies evidenced by P1, P3, P4, P5, P6, P8, and P9 were

not. Their adaptive strategies involved reflection on and consideration of the circumstances of their crisis involvement. For instance, P1 noted that crying during this time:

> Seems to cleanse and to, to bring me back to reality…. I usually feel better afterwards because it's almost like it's cleansing, you know, it's cathartic… so just getting through that.... I feel OK afterward…. But as time has progressed it's like I've thought about it, and it's OK, you know.

P3 commented similarly: "I feel better after I cry…. even with the crying, but I think, emotionally, I feel stronger after I've cried…. It's like the crying, I've, I've done it. Now, I can deal with the problem in a more positive way." P8 also chose to emphasize the positive when asked what made her stop crying. She said:

> Well, I guess just regaining your composure and, you know, thinking I have to put myself back in the train of thought that it's a dog, you know. It's not a human that, I really almost think from a catastrophic point of view that I have two healthy children, and I need to be thankful for that. 'Just put myself back to where I'm blessed as opposed to a loss…. I mean, you know, still just get it out and then go on.

In looking back at her crisis-initiated crying experience, P5 reflected on the new reality she had to prepare for: "It changed the dynamics of our life…. I had recovery, but it was self-recovery. It was like my body reset." Neither P5 nor P2 went through an extended, distinct period of crying-not crying. For both, however, their abbreviated emotional attenuation sessions were instrumental in enabling them to accept and adapt to their respective crisis conditions. P5's experience forced her to acknowledge that her husband's mental acuity was likely to continue deteriorating; P2's volatile emotional release left her emotionally drained, but at peace:

> It was like I wasn't agitated. You know, I had been agitated for days, and just kind of hyper, and I didn't feel happy, I didn't feel sad, I just, I just didn't feel like I was being pushed from the outside. I think, I think overall I was in general more content or more peaceful after the doctor's visit than the days, weeks preceding it. I don't know that the crying necessarily did it, or whether it was just getting it out there and talking about it or, or what. It didn't solve it, but there was peace.

Although she was specifically referring to crying in response to memories of her miscarriage, P6's thinking regarding the efficacy of crying reinforced that of other study participants, especially P8. Explaining this, P6 said:

> I think it's a release of tension. I think it's very therapeutic for me because it reminds me of, you know, what I've lost, but it also reminds me that I've got a lot, you know, to be thankful for and that I'm not the only person who suffered it…. I think that it is part of me coping and processing and emotionally handling and dealing with, with, you know, what happened.

From this observation, it is apparent that P6 incorporated her crisis event into what she referred to as "the present reality." This new present reality is a reality that has been reshaped and expanded by the crisis event and P6's reaction and adaptation to that event. As such, it is reflective of how P6 experienced the crisis and how that experience altered her view of her social being. Although P6 thought of her crying and thinking when remembering (and when she was still in the crisis stage) as a coping process, she recognized there was a process involved in the progression and gradual diminishment of her emotional stress. Lastly for P6, crying stemming from crisis-related emotional stress led to or was conducive to reflection. That reflection enabled an expanded perspective that was accepting of and adaptive to the new present reality.

Based on the meaning study participants gave to crying in the face of the overwhelming emotional stress resulting from personal crisis, it can be seen crying undoubtedly plays a role in the individual's reestablishment of harmony within her environment. For all study participants, achieving this harmony involved acceptance of and adaptation to a newly perceived reality. This reality was shaped by an altered social environment that required a fresh appraisal of the action-interaction necessary for successful continuation in that environment.

Discussion

Introduction

One of the criteria for evaluating a GT study is to provide a summary of how research procedures were employed in conducting that study (Corbin & Strauss, 2015). Summarizing the research procedures serves two purposes. First, it allows consumers of the research to judge whether the stated research methodology was consistently applied. If it was not, then the research will not have achieved its purpose. Second, reviewing the procedural process utilized during the research will permit the consumer to form an opinion relative to the value of that research. With those thoughts in mind, the GT procedures I followed in the conduct of this study are presented later in this section.

As indicated by the findings presented in the preceding section, this GT study was successful in generating a theory explanatory of what happens when women cry in response to the emotional stress of personal crisis. Because this research employed the GT methodology and methods of Corbin & Strauss (2015), I did not begin with a specific question or any hypotheses to be tested. From a one-dimensional perspective, the theory constructed from data provided by the ten participants shares similarities with the two-factor and overflow/hydraulic (also a two-factor theory) theories of emotional crying, but its differences are of major

consequence for those seeking to understand the role crying plays as a mitigating factor in crisis-instigated emotional overload.

Sample Size and Data Saturation

The conclusions drawn from this study—discussed in the next chapter—came from a sample of ten women who volunteered for and met the requirements for study inclusion. I mention this again only because some might think this too small a sample for GT research. But, as previously noted, sample size is not specified for GT studies (Glaser, 1998; Glaser & Strauss, 1967). What is specified is the sample be of sufficient size and, in some cases, diversity to achieve data saturation (Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). As can be determined from the raw data displayed in Table 4 and the crisis-tipping point information in Table 6 on the next page, data saturation was realized with the sample studied. The information in Table 6 shows the diversity in participant crisis experiences in addition to the instant at which the onset of uncontrollable crying occurred, that is, the tipping point.

Conducting the Research

Because there are several different approaches to conducting GT research, I would like to elaborate on how I used Dr. Juliet Corbin's (Corbin & Strauss, 2015) methods in this study. As can be inferred from the information provided in chapter 3, doing GT research entails the conscientious execution of a comprehensive and proven analytic process. In the remainder of this section, I discuss how I went about: (1) interviewing participants; (2) analyzing and coding the interviews; (3) using the constant comparative analysis method for analyzing data; (4) determining properties and dimensions; (5) sorting and organizing data; (6) identifying recurrent

Table 6. Crisis and Tipping Point Table.

Participant	Personal Crisis	Tipping Point
P1	Father's sudden and unexpected death	When informed of Father's passing
P2	Major family crisis involving her son, his past indiscretions, and how to deal with uncertain outcomes	During visit to doctor for annual physical, P2 broke down when Dr. asked, "How have you been?"
P3	Discord between son and his wife that carries over to P3's life and has resulted in the limiting of access to her grandchildren.	Feeling that she and her husband are being punished for not seeing the right side of the argument and the limited access to grandchildren.
P4	Husband unexpectedly announcing he would be leaving on a trip shortly after returning from one	P4 left the room because she was too mad to talk, thought about the impact her husband's continued absence would have on her, got even more angry, and this triggered her crying.
P5	Husband, who may be suffering from the early stages of dementia, indicated he didn't trust her after she came home late from work	Went into bathroom to be alone, replayed conversation with her husband, felt wounded, hurt, betrayed, and the tears just sprang.
P6	Miscarriage and DNC. P6 suspected pregnancy at risk about 9 days prior to DNC.	After returning home from DNC, P6 was soaking in tub and thinking about the miscarriage and DNC and broke into sobbing.
P7	Family discord involving husband, son, and eldest daughter that resulted in what may be a permanent family schism.	In phone conversation with son, he railed furiously at P7, blaming her for the discord and calling her a bitch. This made her angry, and her anger triggered her crying.
P8	Unexpected death of her 15-year old dog. This came within a week of losing a 6-month old dog to a back injury.	Call from her son informing her that her dog had died.
P9	Husband's stomach pain diagnosed as colon cancer	After surgery, colon surgeon informed P9 that cancer had metastasized to liver.
P10	P10 had established a close personal relationship with someone who had terminal cancer her community organization was assisting.	Receiving phone call informing her that her friend had died.

themes in the data; (7) conceptualizing concepts and categories; (8) determining the core category, main category, and subcategories; and (9) putting it all together, i.e., integrating concepts and categories, preparing a story line to describe the process inherent in the theory, and developing a statement and model of the theory itself.

Interviews and Transcriptions

The first interview and all those that followed proceeded without incident. A few interviews were briefly interrupted, but to no ill effect. All interview audio recordings were of high quality. Interview transcripts were complete and verbatim. I listened repeatedly to each recording while studying the accompanying interview transcript. Each interview added to the data essential to capturing the meaning participants gave their experiences of crisis, stress, crying, and recovery.

Coding

As soon as I had an interview transcript, I read through it while listening to the interview audio recording. This was done to ensure the transcript was accurate. If it was not, I pointed this out to my transcriptionist who then corrected the transcript to make sure it matched the recording. Once I had an accurate transcript, I began coding by marking and annotating the concepts appearing in the transcript. Then, I read through the transcript again to revisit each marked concept and to write down my thoughts and commentary on the transcript. I was not overly concerned with delineating between open, axial, or theoretical coding in annotating the first few transcriptions, but I did focus on identifying properties and dimensions that would be relevant to the designation of concepts as the study progressed. After coding each interview and noting the provisional concepts I had identified, I prepared a summary of the interview in memo

form (see Memos 1 and 18 in Appendix D for examples) and usually recorded the results of my coding as a part of that summary. In the summary of the first interview, I highlighted and bracketed provisional concepts within the body of the summary (see Memo 1). In later summaries, I listed the results of my coding under tentatively designated main categories and subcategories (see Memo 18).

Data Analysis and Constant Comparative Analysis

Data analysis began immediately following the first interview. In addition to the memos I used to record study progress and the generation of substantive ideas, I also kept hand-written remarks to supplement my written annotations and commentary on interview transcripts. Much of what was in these remarks ended up in the memos, either in condensed or expanded form. I also drafted numerous rough diagrams and outlines by hand. These were based on my current thinking regarding where I was in the data analysis process. When I was away from my computer, I sometimes just jotted down things I wanted to be sure to include in my memos or in the written exposition of research progress and product.

As I analyzed the data collected during this study, I found myself wondering about the seeming veneration with which constant comparative analysis is viewed in the world of GT. I am not sure how one would go about analyzing the empirical data collected during a GT study using another method other than perhaps qualitative analysis software. Had I not heard of or read anything at all about constant comparative analysis, that is still how I would have analyzed the interview data I collected. The process of analyzing an interview naturally leads, for me at least, to comparing the data in it with the data from previous interviews. That comparison is very likely to lead to new intuitive insights about the meaning representative of the aggregate data. Those insights logically lead to deductive testing against newly gathered data from sources

often purposely selected to enable just such testing. That, in turn, leads the researcher back to the older data to make more informed comparisons. Unless one has an eidetic memory, the iterative process of going back and forth from interview to interview to reconsider earlier thoughts, conclusions, and interpretations would seem to be intrinsic to the qualitative methods of GT.

In analyzing the interview data collected, I found myself rereading the interviews time and time again. Usually, I did this to compare data in the interviews to see if there were similarities or dissimilarities in meaning, expression, and context. With each new interview, I went back to the transcripts of previous interviews, the summaries I had done of those interviews, my coding and theoretical memos, and my hand-written remarks and diagrams to locate interpretations of the new data in the old data.

Determining Properties and Dimensions

The process of determining properties and dimensions has already been discussed at some length. Still, I think it is important for first time GT researchers to understand that properties and dimensions focal to concept and category development can be identified prior to data conceptualization. This is because dimensions, whether measurements or specifications, are easily extracted from data without the necessity of assigning them to a specific concept other than the property they quantify or describe. Finding dimensions leads to identifying their associated properties, and properties give meaning to conceptualizations explanatory of the data under analysis. During the early stages of this study, I focused on discovering dimensions and their related properties. I think this aided me in keeping abreast of data saturation, and that helped me understand when it was time to begin constructing the core and main categories.

Sorting and Organizing Data

A key to establishing data saturation is having a system for sorting and organizing data. To some extent, this is initiated by writing detailed coding, summary, and theoretical memos. These can be organized sequentially or by subject. I chose to organize my memos sequentially. I kept hard copies of my memos in a 3-ring binder, and I maintained a memo file folder on my computer, which I backed up on a flash drive every so often. The hand-written remarks and diagrams I kept in a pile by my desk in case I needed to refer to them, which I occasionally did. In hindsight, it would have been helpful had I dated my hand-written material. However, a great deal of the information in the hand-written material found its way into my typed, formal memos.

The most efficient way for data sorting and organization, at least for this study, was using tables. Of the seven tables included in this study, Table 4, Common Words, Phrases, and Themes Stated or Clearly Implied by Participants, proved the most useful. It provided a clear visual representation of data saturation at the raw data level. Transferring the data from Table 4 to Table 5 permitted the connection of raw data with main categories and the core category.

Conceptualizing Concepts and Categories

While the GT explicating this study started to take form in my mind around the time of the fifth interview, I was still focused on the themes of control, resilience, and survival. And I still had questions about the role crying played in the experiences being described by participants (see Memos 5 and 7 in Appendix D). At first, efforts to control crying seemed focal but, as I became more in tune with the meaning being conveyed in participant interviews, I realized efforts or the desire to control crying were ancillary to the theme central to participant experiences. For one thing, participants reported being unable to control their crying in response to the emotional stress of personal crisis. This applied to both the unexpected onset of

uncontrollable crying when the stress associated with the crisis reached its zenith and the intermittent episodic crying that followed. For another, the crying seemed to be more of a distraction than a conscious action/interaction intended to directly enable crisis resolution or acceptance. Still, the stress relief that accompanied the sudden outburst of crying and the gradual diminishment of crying afterwards was indispensable to participants obtaining a new lease on life.

I was also distracted by participant revelations regarding different types of crying, that is, sad, happy, or angry; as a controlled or uncontrolled stress response; or while watching movies or TV shows. I had to sort out the different types of crying to distinguish between those that were related to the crisis event and those that were not. And, there was the problem of both controlled and uncontrolled crying and how each type of crying figured in the stress response to the impending crisis or its culmination. After the sixth interview, I began tabulating raw data from the interviews. After completing all the interviews, I also prepared a table showing the instigating crisis and the tipping point (Table 6). This helped me distinguish between differences in crises and tipping points and provided me with information needed for determining variations in participant experiences.

Core Category, Main Category, Subcategories

When it came to making a final determination of the core and main categories and related subcategories, *in vivo* codes saved the day. My progress in describing concepts and separating main categories from subcategories (and from each other) was more difficult than I imagined. At one point, I was even considering the possibility that such a thing as a compound main category might exist. (See Memo 17 in Appendix D.) After stumbling through several attempts at main category conceptualization (see Memos 5 and 7 in Appendix D; Memos 4, 15A, and 29 in

Appendix E; and Memos 27 and 28 in Appendix F), it dawned on me that the participants might have already solved this problem for me. I was right. It was the recognition that the participants themselves had accurately annotated each step in a spiraling progression that started with one perception of reality and concluded with another that allowed me to visualize the process underlying the theory.

By carefully reviewing and reconsidering the *in vivo* codes various participants had used to characterize the stages in their crisis – emotional overload – uncontrollable crying – stress relief – adapting and accepting – moving on with life progression, I discovered an *in vivo* core category surrounded by a cluster of *in vivo* main categories. The process underlying the theory could have been described with a consistent metaphorical correlation or straightforward description in terms of emotional variations, but it was the mixed metaphors and figures of speech used by the participants that shined a light on what was happening and why most brightly.

Putting Everything Together

Once the core category and main categories were labelled and integrated into a process exemplifying theory dynamics, it was necessary to clarify relationships between the main categories and their subcategories. While it may seem sequentially corrupt, I identified the main categories before defining the subcategories foundational to them. At this point in the research analysis, I had already isolated most of the subcategories as well as their properties and dimensions. What I had not done was determine which subcategory fit with which main category. Because I had muddled through an earlier attempt at identifying main categories and linking them with a story line (see Memo 17 in Appendix D), I was still undecided about labelling and defining theory subcategories. I had a general idea of what should go where in

conceptualizing the subcategories, but my foray into a blind alley involving compound main categories had left me confused about what to call and where to put several of the subcategories. I finally concluded that the subcategories Relieving Stress and Attenuating Crying and Emotion, although separate, were dynamically interconnected and foundational to the main category Feeling Emotionally Stronger. The real breakthrough in my thinking came when I realized the subcategory Restoring Cognitive Clarity belonged to Feeling Emotionally Stronger and not the main category Getting a Handle on Things. From that point, things progressed rapidly. I prepared Table 3 to show how the *in vivo* core and main categories might be restated using the tipping cup metaphor. I then wrote a finished version of the story line that explained the theory in narrative form and diagrammed what I hoped would be the final model of the theory. That took several attempts. Lastly, I composed the two versions of the TPT, one for scholarly consumption, one for the layman (see p. 103).

Participant Feedback

To further validate the TPT, I asked study participants to evaluate my interpretation of what they had shared with me by reviewing and commenting on the story line, theory, and model I had constructed. I wanted them to tell me if I had accurately represented the meaning they gave to their crying in response to the emotional stress of personal crisis. Their responses are shown in Table 7. P9's initial feedback resulted in a change to the original rendering of the last sentence of the layman's version of the theory from "enabling the individual's body and mind to make the adjustments and adaptations necessary to move beyond the personal crisis and get on with her life" to "enabling the individual's body and brain to make the adjustments and adaptations necessary for successful continuation within that environment and get on with her life." Because this was a minor semantic change to the layman's version, I did not submit

Table 7. Participant Evaluation of Story Line, Theory, and Theory Model

Each participant was provided with a copy of the story line, both versions of the grounded theory, and the theory model and asked: Would you read my theory and review the model to give me feedback as to whether I captured and correctly reflected what you conveyed to me in the interview with you. If you see any place where you think I missed the mark, please let me know. Thanks, Mary Bess	
Participant	**Evaluation**
1	This is so good, I wanted to keep reading. You are really a talented writer. Yes, I definitely think you captured and correctly reflected what I conveyed to you in the interview. I really like the diagram. It is very easy to understand and personally relate my own experience. Thank you for sharing and good luck in your final work.
2	Yes, I think your theory and model do represent the phenomena. I think you hit the mark very accurately.
3	Just read over this and I think you are on target.
4	Wow! This is amazing.
5	I believe you have captured what you wanted to from this. Your model further explains the physiological basis when compared to the model described by the McEwen's Stress Response Theory. Adaptation is the key thought here, in that when frequently assaulted by stressors (which in my case the fallout from the original trigger that caused ALL the mess now present) our bodies change and create new set points of normal. I am evolving with protective "armor" to deal with the next wave that increases my allostatic load or as your model illustrates; I am accepting/adapting and resetting for self-preservation. Very nice work!
6	I absolutely agree with what you have developed. This perfectly describes my experiences and I think you've really done a great job.
7	
8	I don't see anything I disagree with. In addition, you have a nice graphic. Do you need anything else from me?
9	Very impressive! I can tell you have put a lot of time and thought into this. Okay, of what I could understand :) you hit the nail on the head. The only thing I kind of disagree with but think I understand where you're coming from is under "laymen's version" on the first page. The last sentence of the first paragraph (number 2). Although I agree with that statement to a point, I don't believe "to move beyond the personal crisis and get on with her life" is an accurate reflection of my experience. It may be true of the group as a whole but I feel like it did not help me "move beyond" but helped me to continue through the personal crisis. Thank you for letting me be a part of this. I look forward to reading the final version. P9 (2) – Yes, I agree with that. (Response to theory revision per her suggestion.)
10	I read over the materials that you gave me and, yes, I think it reflects an accurate assessment of the things that we discussed. I totally agree that crying for women revolves around the need to release/reduce stress and maintain/regain emotional control. Reading all of this "research jargon" made me relive those stressful times when I was writing my thesis!.....it made me CRY a little bit!!!! JUST KIDDING!!!

it to the other participants for comment.

The positive feedback from participants lends validity to the TPT and gives credence to the conclusions I have drawn from this study. Based largely on those conclusions, I feel warranted in making several recommendations for nursing teaching and practice and future research.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Summary

This study was undertaken to investigate crying in women dealing with the emotional stress of personal crisis. According to Vingerhoets et al. (2009), "the field of crying research can best be described as scattered, incoherent, and lacking a systematic approach" (p. 469). It is apparent that Vingerhoets and his colleagues were addressing quantitative research into crying; qualitative research investigating this phenomenon has been minimal. Given the limited number of qualitative studies dealing with emotional crying—I found six studies, including one mixed methods, in the literature—a GT inquiry into the phenomenon of stress-related emotional crying offered the potential for surfacing a theory that would make a positive contribution to the state of the science while beginning a systematic, coherent approach to the study of emotional crying. This GT study accomplished that. I constructed a theory explanatory and descriptive of crying in women dealing with the emotional stress of personal crisis based on my interpretation of the data collected from interviewing ten participants. The study itself can serve as a first step in the systematic GT exploration of crisis-related emotional crying. Conclusions and discoveries related to the TPT and its place in the literature, relationships to other research and theories, significance for nursing teaching and practice, and recommendations for future research are discussed in the following paragraphs.

Conclusions and Discoveries

The conclusions and discoveries stemming from this study are based upon my analysis of the data provided by ten women from Western Tennessee. I believe it is reasonable to hypothesize most of these conclusions have general applicability for women raised in the United States whose demographic profile is similar to that of study participants.

This study is unique in that it is the first GT investigation of a topic whose understanding has perplexed philosophers, scientists, and laymen for centuries (Frey, 1985; Frijda, 2001; Kottler & Montgomery, 2001; Lutz, 1999). It offers an empirically grounded theory that describes an emotional process and explains how psychogenic crying in women is essential to and necessary for countering stress in the face of personal crisis. This process exhibits a predictable trajectory. It begins with the spontaneous onset of uncontrollable crying triggered by the overwhelming stress of adversity and distress. It ends with a newly established biopsychosocial equilibrium based in acceptance, adaptation, and a renewed desire to move on, to getting back to life. In addition to giving intimate meaning to a little understood, distinctly human phenomenon (Kottler, 1996; Montagu, 1959; Vingerhoets et al., 2009) via the TPT, my analysis of participant study data lent further clarity to several other crying-related issues. These included the qualitative differences between the emotional crying displayed during sad movies or TV shows and the emotional crying associated with stressors personally endured; the reasons why women in our culture try hard to control crying; why women cry alone; how women define different types of crying; how emotional crying at non-crisis levels may be amenable to self-regulation; and how crying in response to overwhelming emotional upset can be empowering. Most importantly, analysis of the data provided by study participants revealed numerous investigative opportunities that are likely to lead to the advancement of holistic nursing teaching

and practice. Key among these opportunities is developing an understanding of how emotional crying functions as an adaptive process leading to the restoration of psychophysiological equilibrium.

An Adaptive Process

The onset of uncontrollable crying in the face of stress-induced emotional overload appears to be part of an adaptive or evolutionary response or process inculcated within human genetic makeup to enhance the likelihood of survival when heightened stress levels are threatening physiological and psychological constancy. This onset of uncontrollable crying seems to be signaling stress overload and/or levels of stress dangerous to the individual's biopsychosocial well-being. As predicted by the TPT, the subsequent reduction in stress and accompanying attenuation of emotion permits an envisioning of the stress overload source via an updated perspective that either minimizes or obviates its psychical prominence.

For the healthcare or counseling professional, two things about the onset of uncontrollable crying in the face of a personal crisis stand out: the before and after of the crisis event. If the healthcare or counseling professional—doctor, nurse, psychotherapist, counselor, minister—can anticipate the crisis event, then actions can be taken to prepare the patient for it with the intent of mitigating the severity and duration of the crisis response predicted by the TPT. After the crisis-instigated onset of the emotional crying process described by the TPT, the ability to determine where the patient is in that process may prove useful in identifying intervention junctures. That should permit the planning of interventions appropriate for those junctures to best aid the patient in her progression toward the reestablishment of biopsychosocial equilibrium, that is, getting back to life.

Cause and Effect

Each of the study participants specifically identified her personal crisis as the antecedent for the emotional overload that triggered the onset of uncontrollable crying. Participants exhibited the ability to distinguish between the uncontrollable crying associated with overwhelming stress and the semi-controllable stress-relieving crying that P2 alluded to when she commented: "… crying was almost always something I could control. I, I mean I might at some point need to cry and go off by myself to cry, but this particular time, I had no control over it, and that frustrated me." P1, P3, P5, P6, P9, and P10 also implied a degree of prescience in knowing when they needed to cry (or were about to cry) because of heightened stress ascribed to above-normal levels of anxiety, frustration, grief, and/or disappointment.

Understanding the differences in the two types of emotional crying described here can be useful to the healthcare or counseling professional in determining the type of support, if any, appropriate to the situation. The purposes of that support differ in that the person whose crying is a personal crisis response depicted by the TPT can benefit from help in restoring mind-body-spirit equilibrium in the most timely and efficacious manner; the person whose crying is signaling the need for temporary relief from heightened but non-crisis levels of stress may require interventions to address the sources of that stress and how to best deal with them. For example, a person who is crying because she does not have the money to buy food for her children requires a series of interventions that might include determining the source of stress (no money for food), actions to temporarily alleviate that stress (providing food for her family in the near term), determining why she cannot afford to feed her family (no job, no child support, victim of robbery, etc.), and finding ways to eliminate her money problems in the future (finding

her employment, helping her get child support, providing her with enough funds, either as a gift or a loan, to tide her over, etc.).

Types of Crying

Study participants exhibited the ability to differentiate among types of crying. This included the two types of stress-related crying described in the preceding paragraph and the sad, socially acceptable crying at funerals, happy crying with children and when people were caring and supportive, and angry crying caused mainly by frustration.

The significance of this conclusion is that sometimes the best method of determining why someone is crying and, therefore, what intervention is required or appropriate may be just to ask the person who is crying. From my experience, the risk in this is people tend to apologize for crying as if, by crying, they have done something wrong or improper. In any event, it is always appropriate to assure the crying person that expressing emotions by crying is healthy, normal, and perhaps even healing (Cornelius & Labott, 2001; Vingerhoets et al., 2009). Then, that person may be willing to share the reason or reasons for her crying. Based on the reason(s) given, the healthcare or counseling professional can determine whether (and which) intervention activities are necessary and appropriate.

Self-Regulating Crying

Several participants casually mentioned crying when they felt the need to cry. This need was generally attributable to anxiety or stress levels that were high but had not reached crisis proportions. In these instances, participants insinuated their crying was a stress-relief emotional response they could delay, disguise, or otherwise manage. Because this contradicts the generally

accepted convention that emotional crying is an involuntary parasympathetic response (Frey, 1985; van Haeringen, 2001), this is a subject that warrants further investigation.

A GT study to explore how (or if) individuals can delay or manage their crying in certain situations but not in others has the potential to provide additional insight into understanding emotions, crying, and stress. Of interest are the stress levels associated with variations in the emotional crying response (Vingerhoets et al., 2000; Vingerhoets et al., 2009). Information about how (or if) the self-regulation of emotional crying functions as a stress-relieving therapeutic might create an entirely new approach to psychotherapy. This approach could be used by the therapist to assist the patient in employing crying as a stress-relieving therapeutic during therapy sessions. It could also be used to teach patients how to consciously manage emotional crying for stress relief on a pro re nata (PRN) basis.

Precursors

When asked whether they had any warning of an impending crying event, most participants described precursors to crying not associated with crisis events. These precursors included tearing up, lump in the throat, tightness in the chest, pit in the stomach, and getting angry and loud. Significantly, the crisis-related onset of uncontrollable crying occurred without warning: it was sudden, unexpected, and unavoidable. In some instances, healthcare or counseling professionals may witness the onset of crisis-related emotional crying or perceive the precursors to the less volatile types of stress-related crying previously discussed (Kottler, 1996; Wagner et al., 1997; Zengerle-Levy, 2006). Knowledge of the TPT can assist the therapist in recognizing this type of crying for what it is. Recognizing the onset or progression of crisis-instigated emotional crying predicted by the TPT gives the therapist several interventional options. These include monitoring the processual flow of the crying individual's return to or

progress toward a new state of biopsychosocial equilibrium, intervening at TPT-identified junctures as necessary to best benefit the patient, seeking to determine the crisis that led to the onset of uncontrollable crying so that it might be dealt with, or just providing a safe, supportive, nonjudgmental environment for the patient to outwardly express her inner emotional turmoil.

Sudden, Unexpected, Unavoidable

The sudden and unexpected crisis-related onset of uncontrollable crying was unavoidable because it appears that it was initiated in and by the crying person's unconscious psyche as an instinctual, parasympathetic (Frey, 1985; van Haeringen, 2001) compensatory action concerned primarily (or even solely) with maintaining and/or restoring equilibrium in that person's physiological and psychological functioning. This knowledge is important because (1) its onset is a positive indication that the person is involved in a personal crisis of significant proportions, and (2) it prepares the healthcare or counseling professional for what may transpire when the patient (and her loved ones) is informed of a potential crisis-instigating event such as the diagnosis of a life-threatening illness. Per the Roman proverb, *praemonitus, praemunitus,* forewarned is forearmed. The healthcare or counseling professional who is forewarned of a possible crisis-instigating event can take measures to prepare the patient (and her loved ones) for what she is about to learn. This preparation may diminish the emotional impact of the distressing information to the exclusion of a TPT-type event or it may moderate the severity of psychophysiological trauma experienced during the successive stages in the TPT.

Cognitive Clarity

For whatever reason, crying, whether in the face of overwhelming emotion or time spent recovering from being overwhelmed, appears to facilitate the restoration of cognitive clarity.

This happens coincidentally with or because of the gradual diminishment of stress and attenuation of emotion. In general, most participants used the in-between of crying spells to rest, think, and process. This leads to the conclusion that crying in response to the emotional stress of personal crisis is a normal, healthy response to high stress situations. The converse may also be true; that is, not crying in response to the emotional stress of personal crisis may lead to unhealthy and undesirable psychological and physiological outcomes. Therefore, intervention efforts in crisis situations should be focused on managing the crying response to emotional crisis rather than inhibiting it. For the practitioner, knowledge of the TPT can help in determining (1) if the crying – emotion diminishment – return to normality process is proceeding predictably, (2) junctures where intervention may be best implemented, and (3) planned interventions in advance of juncture arrival.

One of the more important TPT junctures for the healthcare or counseling professional to be aware of is the restoration of cognitive clarity. This is the stage in the TPT process where the crying person has regained control of her mental acuity and is no longer subject to episodic uncontrollable crying. In short, this is the ideal time for the professional to intervene to aid the crying person in understanding, accepting, and adapting to her new reality so that she can get a handle on things and get on with her life.

Empowerment

All participants found the restoration of cognitive clarity empowering. This was the essential and necessary condition that enabled them to regain emotional control. Regaining emotional control was an obligatory first step in beginning the reestablishment of biopsychosocial equilibrium within the recently evolved, freshly perceived environment. Clarity of cognition prompted an enhanced understanding of what was, what is, and what may be. This

clarity allowed participants to visualize their situational contexts in a sharper, more brightly shaded, and expansive diorama of perceptual actuality. In turn, the actions-interactions necessary to adapt to and accept that actuality were implemented by letting go of what had been because that was no longer focal.

While the restoration of cognitive clarity was empowering for the participants in this study, that begs the questions of how empowering was that restoration and do women in marginalized populations experience similar empowerment when going through the stages of the TPT? The answers to these questions are of interest to healthcare and counseling professionals. Both deal with the individual's perception of self and the span of control she is able to exercise in her life (Vingerhoets et al., 2000; Vingerhoets et al, 2009). Knowledge of these variables can affect the choice and administration of interventions, if called for.

Control

Most of the participants in this study expressed a strong desire to control their crying. Because crying in response to the emotional stress of personal crisis defied control efforts, these women purposely isolated themselves to prevent their crying from being observed. The primary reason given for wanting to be alone while crying was that it could be perceived as a weakness, as an inability to handle the exigencies of day-to-day living in both the social and workplace environments. Although study participants could not recall any truly determined parental efforts to change their childhood and adolescent crying behavior, it was apparent that all were clearly aware of social and cultural proscriptions on the public display of emotional tears. The negative consequences, perceived and actual, of crying in front of others not emotionally close likely prolongs the trying process of restoring biopsychosocial equilibrium once that equilibrium has been destabilized by the emotional stress of personal crisis. Unfortunately, attempting to control

the uncontrollable may be detrimental to one's physiological and psychological well-being while counterproductively extending the period required for accepting, adapting, and getting back to life. Healthcare and counseling professionals can use the TPT as a guide for helping patients who are experiencing the uncontrollable crying of a personal crisis understand what and why they are crying. This may aid them in relinquishing efforts to control what is an otherwise healthy emotional process.

Crying in Workplace

The women who participated in this study were acutely aware of how negatively crying in the workplace was viewed by their male (and many of their female) coworkers. They were also aware of how crying in the workplace was likely to compromise their credibility as serious professionals who were competent and could be relied upon to make the tough decisions. As P2 tersely phrased it, "Big boys don't cry, and I live in a big boy world." Per Plas & Hoover-Dempsey (1988), the artificial constraints on emotional expression in the workplace result in a variety of negative consequences, including lost productivity, suppression of creativity, decreased quality of output, strained personal relationships, job dissatisfaction, higher employee turnover, and higher levels of job-related stress.

The implication in the preceding paragraph is that restricting or punishing crying in the workplace is bad for business. It seems likely that the underlying reasons for the artificial prohibition against crying at work, for both men and women, are cultural and social conventions that reject public displays of emotion as distasteful and inappropriate (Plas & Hoover-Dempsey, 1988). Because these social and cultural conventions have endured for as long as women have left home and hearth to venture into the world of work outside the home, it is well past the time to begin rolling back antiquated ideas about emotional expression that is healthy, normal, and

productive. There is little doubt in my mind that the perpetuation of the negative stereotyping of women who cry in the workplace has been a contributing factor in the discrimination and marginalization of women in business and industry. Using the TPT as part of an educational program beginning as early as elementary school may offer opportunities for revising longstanding social and cultural conventions against emotional expression through crying. In a like sense, the TPT can be used as a point of origin for research into other ways for obviating negative perceptions of crying, and not just in the workplace.

Crying During Movies

Several participants off-handedly mentioned their propensity for crying during sad movies or TV shows. It was apparent this type of crying was compartmentalized from the other types of crying they discussed. There was agreement that crying when watching sad movies was external to their reality, that it had nothing to do with them personally. Accordingly, it could be discounted as a temporary emotional aberration. Interestingly, some participants avoided watching sad movies because that made them cry, and they did not like that. P7, who characterized herself as someone who seldom cried, stated emphatically that she did not watch "those" movies because they always made her cry. As earlier stated, study participant observations about watching sad movies and the effects that had on their emotions and crying clearly implied that using sad movies to stimulate crying in laboratory settings (Frey, 1985; Gross et al., 1994; Kraemer & Hastrup, 1988; Labott & Martin, 1988; Labott & Teleha, 1996) is an unsatisfactory experimental methodology for evaluating emotional arousal. This is because the emotional responses stimulated by watching sad movies are qualitatively different than those experienced because of stress overload or heightened stress not at crisis levels.

The Dichotomy

A dichotomy that bedeviled the women in this study was evidenced in their feelings about the efficacy of emotional crying. On the one hand, they all thought that emotional crying, especially when that crying was due to overwhelming emotional stress, was beneficial, that it was cathartic, cleansing, refreshing, and made them feel better once it was over. On the other hand, all but P3 expressed some level of frustration at not being able to control their crying in the workplace and/or in social situations. P1 put the control issue in personal perspective: "I don't want to feel sorry for myself. I gotta be a big girl…. That's probably why I want to control it."

The participants in this study wanted to control crying because they understood that crying is disparaged in work and social settings. Until this changes, it is unlikely that women will stop trying to control crying, especially in front of others. With the TPT to model the benefits of crying, perhaps cultural and societal objections to this normal and healthy physical display can be modified so that women can let their tears flow and their minds, bodies, and spirits heal.

Limitations

Study limitations were discussed at length in chapters 3 and 4. Although information was collected from a relatively small sample of ten women, both diversity in types of crises experienced and data saturation were sufficient for theory construction. The theory constructed from the meaning participants gave their experiences of crying in response to the emotional stress of personal crisis resulted in the discovery of new knowledge concerning crying, stress, and emotions in women. It also confirmed or reinforced some results from previous research while leading to several conclusions that merit thoughtful consideration and further investigation. The theory itself meets the requirements for good science detailed in chapter 3: it satisfies the

definition of a well-constructed GT. It fulfils the criteria of fit, generality, understanding, and control (also detailed in chapter 3), and its hypotheses point the way to future research endeavors and scientific explorations that have the potential to expand and enhance the SOS of crying in general and its relationships with stress and emotion in particular.

Place in the Literature

The theory and conclusions resulting from the analysis of the empirical data provided by study participants adds to and expands the body of qualitative and quantitative research into the phenomenon of crying. To my knowledge, there are no GT studies in the limited number of qualitative studies undertaken to investigate linkages between and among crying, emotions, and stress. In consequence, no theories concerning these topics have been proposed in qualitative research, although Hunt's (1992) mixed methods study surfaced some interesting phenomenological data that was in alignment with and reinforced by the results of this study. Importantly, the theory and conclusions resulting from this study suggest several topics that might benefit from qualitative inquiry. Many of these topics are ripe for inquiry using GT methods. In the realm of quantitative research into crying, emotions, and stress, this theory adds new dimensions to previously investigated hypotheses. The hypotheses integral to the TPT are all testable using quantitative investigative techniques and have the potential to add to the quantitative side of the SOS for emotional crying.

Connections to Other Research and Theories

The findings from this study exhibited some connections with the results of other qualitative and quantitative research. These connections are true for specific research findings addressing general characteristics of crying as well as research designed to test many of the

theories and hypotheses concerned with emotional crying. Connections with some of the specific quantitative findings discussed in the Vingerhoets et al. (2009) chapter on Crying in *Tears in the Graeco-Roman World* (Fogen, 2009) include: (1) crying behavior is influenced by individual and situational factors; (2) there are different types of crying with different meanings; (3) parents discourage crying in children; (4) crying is a complex biopsychosocial phenomenon; (5) crying when angry is associated with perceived injustice, crying when sad is associated with loss; (6) crying, by means unknown, may aid in restoring physiological and psychological well-being; (7) the onset of crying may be related to one's inability to show emotional distress in other ways; (8) loss and conflict are the most prevalent reasons for crying among adults; (9) women cry more often when angry than do men; (10) crying happens most often at home or in the car; (11) most crying occurs when alone; (12) crying at work is generally considered inappropriate; and (13) improvements in mood after crying are related to crisis resolution and accepting and adapting to the situation that triggered the crying event.

One research result reported by Vingerhoets et al. (2009) with which the findings from this study seemed to be at odds was the conclusion that antecedents to emotional crying are "… rather trivial and fatuous" (p.457). Admittedly, the premise of this study specified that the participants have experienced a personal crisis, and the personal crises described were neither trivial nor fatuous.

Qualitative research of significance to this study is Hunt's (1992) mixed methods study of the lived experience of women with cancer. Repeating information already stated in chapter 2, Hunt was interested in discovering how the emotional expression of crying imparted meaning "to the cancer patient's surrounding life-world" (p. 8). She posited crying signaled a disturbance in the body's biological, psychological, and social equilibrium that required

realignment of biopsychosocial relationships to reestablish homeostatic balance. In the phenomenological phase of her research, Hunt identified the theme Being in Unity With and the attendant subthemes of Connecting and Letting Go. Women who connected purposely viewed the world in positive terms, engaged others in social interaction, and appreciated things for what they are, have been, and may yet be. Letting Go involved the tolerance of things in life which could not be controlled, accepting and moving beyond problematic situations, and being open to new experiences and opportunities. Hunt also observed that Letting Go might involve self-transformation and the embracement of a revitalized perspective of life and living.

The similarities between Hunt's phenomenological themes and the categories and subcategories explanatory of the TPT are readily apparent. Letting Go, for example, is a Hunt subtheme and a TPT *in vivo* subcategory. However, the phenomenological theme Letting Go encompasses elements of several TPT categories and subcategories. The similarities between Hunt's themes and the TPT categories and subcategories are not surprising. The qualitative analysis methodologies of phenomenology and GT are based on a common theoretical framework, symbolic interactionism. As such, they share the same sociological perspectives and mutual epistemological, ontological, and axiological positions.

Plas and Hoover-Dempsey's (1988) research into emotions in the workplace gave specific emphasis to crying at work. In many cases, they found evidence that supported the concerns the women in this study expressed about crying in front of others where they worked. Of the ten women who contributed to this study, all but one (P3) spoke of the desire to control their crying, and not just in the workplace. This desire to control crying was attributed to the perception that crying made them appear weak, less competent, and unprofessional. Thus, expressing emotions by crying provided co-workers and superordinates with ammunition that

could be used against them in one way or another. Interestingly, P3 and P4 were most concerned about the social ramifications of crying in front of those in their immediate social circle or certain family members or people they were not close to.

The concerns all study participants elaborated regarding crying in front of others seem to belie Nelson's (2005, 2008) views on crying and attachment theory (Bowlby, 1980). Attachment theory is based on the premise that crying is a means of signaling others for help and support (Kottler, 1996; Kottler & Montgomery, 2001; Nelson, 2005, 2008). Most of the participants in this study purposely avoided other people when they cried. However, P9's breakdown in front of family members did result in her sister coming to her aid, and P9 obviously took comfort from her sister's physical embrace as she sobbed while being held. And, P6 reported "happy crying" after friends and colleagues who had some awareness of her situation offered her comfort and support. P10 reported crying in front of her husband while telling him about her friend's passing, but she indicated that was normal for her because she cried easily and frequently.

Although I found little to support attachment theory, my analysis of study data did offer some support for the catharsis theory of crying. In the act of catharsis, emotions are purged from one's system through an "energetic reaction" that leads to "cry[ing] oneself out" (p.8, Breuer & Freud, 1895/1955). Three study participants actually used the word catharsis to describe the stress relief that followed crying; two others described the cathartic effects of their crying in terms such as "cleansed" or "refreshed." However, the process underlying the TPT differs from the hydraulic/overflow presumption that cathartic emotional release is achieved through an outburst of crying (Breuer & Freud, 1895/1955). Per Breuer & Freud (1895/1955), the onset of crying occurs at the zenith of the emotional crisis. Crisis averted, emotional healing can begin. The TPT findings support the hypothesis that the onset of emotional crying occurs at the peak of

the emotional crisis. TPT findings do not, however, support the physiological notion in the hydraulic/overflow theory that tears build up in the lacrimal glands as emotions build and then overflow at the peak of the emotional crisis. Needless to say, this study did not physically evaluate tear buildup in participant lacrimal glands. Still, for study participants who experienced crying onset the moment they were informed of an unexpected crisis, it seems obvious that there was no time during which tears could have been building up in their lacrimal glands. And even though the combined catharsis-hydraulic/overflow theories posit that emotional healing can begin upon cessation of crying and the concurrent return to psychophysiological equilibrium thus enabled, the process by which this is purportedly accomplished is not specified. Further, it is difficult to agree with Labott and Martin's (1988) version of the hydraulic/overflow theory that claims tears and the overflowing emotions are one and the same. This presumption fails to take into account the episodic crying-not crying periods that follow the initial crisis-triggered outburst of crying and seems to assume a direct linear relationship between tear flow and emotion attenuation.

Efran and Spangler's (1979) two-factor or two-stage theory (Efran & Greene, 2012) of crying is similar to Labott and Martin's (1988) two-factor version of the hydraulic/overflow theory. Both theories have their basis in the creation of emotional arousal (factor one) and the subsequent reduction of that arousal (factor two). For Efran and Spangler, the onset of tears signals the transition from increasing emotional arousal to decreasing emotional arousal. This theory suffers from many of the same deficiencies as its sister two-factor theory. Laboratory testing of the two-factor theories was attempted by having undergraduate students view a sad movie or a portion thereof. Analyzing the results from this study, Labott and Martin found that emotional arousal antedated crying. They did not find that the onset of crying precipitated a

reduction in emotional intensity. They did find, however, that subjects who watched the entire sad movie reported feeling better after crying. Labott and Martin concluded that neither of the two-factor theories was likely to provide definitive insights into weeping. Given the observations participants in the TPT study volunteered about watching sad movies or TV shows, it may be that Labott and Martin used an inappropriate experimental method of testing to evaluate these theories. From what TPT study participants said, it was clear that they defined crying while watching sad movies or TV programs as a type of crying that was qualitatively different than the crying associated with the emotional stress of personal crisis and emotional responses to stressors in general.

Recommendations

In consequence of what I discovered during this research, I have a number of recommendations to offer. These recommendations deal with the profession of nursing specifically and the phenomenon of crying in general. Concerning the former, the theory and conclusions from this study have implications for nursing education and practice. Concerning the latter, the results from this study suggest that future research, both qualitative and quantitative, into the function of crying as a parasympathetic response to the emotional stress of personal crisis (Frey, 1985; van Haeringen, 2001) have the potential to unlock information of value to several disciplines, and not just those associated with healthcare delivery.

Significance for Nursing

Crying as an emotional response to stress, crisis instigated or otherwise, is a subject of importance to the nursing profession. Regardless of the setting, nurses are the healthcare professionals most likely to see patients and their family members and friends expressing

emotions through crying, or not crying. Nurses witness a wide variety of personal crises and their consequences and recognize that anxiety is often expressed through crying. Knowledge, understanding, and appreciation of this uniquely human emotional response is integral to nursing's raison d'être, and that is to provide patients and their families with quality healthcare accentuated by support, empathy, and compassion. For that reason, crying should be explored in the curricula of all schools of nursing and knowledge of crying applied in nursing practice in every healthcare and prevention field.

Practice

Given the ubiquitous nature of crying as an emotional response, especially in healthcare settings, it seems reasonable and prudent that knowledge of this uniquely human trait be integrated into nursing teaching and practice. While the function and purpose of emotional crying is still largely unknown, what is known about its causes and effects should be available to nurse educators and practicing nurses. For example, answers to the following questions would prove useful to nurse educators and practicing nurses alike: What is the best way to respond to a crying patient or family member? Is there a best way? What works, what does not? What is the likely trajectory of emotional crying triggered by stress? What is the difference between crying because of emotional overload and crying as a temporary outlet for situational stress? When do persons perceive that it is helpful and appropriate to cry alone? When is it appropriate to offer comfort and support to a crying patient or family member? Should that support be physical, verbal, or a combination of both? What kinds of verbal support are counter-productive? Knowing the answers to these questions is important to the practice of holistic nursing. Additionally, the information discovered in this study is, in itself, of value to the nursing profession, and it should be disseminated to nursing students and nurses in general.

Understanding what is known about the phenomenon of emotional crying has the potential to enhance the practice of holistic nursing, regardless of the practice setting.

Information gleaned during this study is suggestive of ways in which knowledge of crying can augment nursing practice. Looking to the questions posed in preceding paragraph, it might prove helpful to develop an intake assessment specifically targeting patient crying history and characteristics. This information could be used to guide interventions for crying patients or to anticipate situations that might result in crisis-instigated crying. For patients who are discovered crying, information from the assessment might prove useful in determining what precipitated the crying and the appropriate interventions. In this regard, it could also prove useful to develop communication techniques for assuaging or supporting the crying patient (Frey, 1985) and ensuring all nurses are trained in those techniques. It was obvious from the information provided by study participants that they did not like to be presented with platitudes when they were crying. P6 seemed to be most understanding in these instances because she acknowledged that people really do not know what to say when someone is crying. Still, other participants were clearly dismissive of being told things like, "Don't cry, it'll be all right."

Practicing nurses should also be aware of their own feelings about crying as well as that of others. In Western cultures, there is a clear bias against emotional displays in public, especially crying (Plas & Hoover-Dempsey, 1988; Vingerhoets et al., 2009). Nurses cannot let any negative predispositions they may have about crying prejudice their interactions with crying patients or their loved ones.

Patients and those close to them are not the only ones who cry. Nurses cry, too. This includes nurses of both genders. And, like the participants in this study, nurses cry for personal reasons. But they may also cry because of bad things that happen to their patients and the effect

this has on the patient's family and friends (Zengerle-Levy, 2006). Nurses, because of close and frequent contact with patients when they are vulnerable, often establish empathetic, supportive relationships with those patients. They may also establish the same types of relationships with members of the patient's family. When patients suffer, so do those close to them, and this oft times includes their nurse or nurses. For these nurses, the empathy and caring that are hallmarks of the nursing profession may find outward expression in crying, sometimes alone, sometimes with the patient, sometimes with his or her family and friends. And sometimes, nurses may not know what to do when patients and their family members cry (Wagner et al., 1997) For that matter, nurses may not know what to do or how to respond when they cry.

Teaching

I have found no information to indicate crying is a subject covered in nursing curricula or in nursing texts. The topic of emotional crying should be added to nursing textbooks and incorporated in nursing curricula at all levels. Nursing students need to understand that emotional crying as a reaction to stress is a natural, healthy response. It is not a sign of weakness, nor is it to be condemned as socially inappropriate. Students should be taught to deal with this type of crying based on the best available information. A good place to start might be with the TPT. Using the TPT as a heuristic could help students gain familiarity with the types of emotional crying they are most likely to encounter. Understanding the processual nature of emotional crying is rudimentary to the identification of junctures where intervention can be accomplished most effectively.

Additional recommendations for including crying in nursing education include:

1. Integrate information relevant to what is known about the emotional crying process into foundations of nursing courses. This information should address, among other

things, how crying factors into and is encountered in various healthcare events, especially crisis events.

2. Have students engage in self-reflective exercises to consider their own beliefs about crying and how those beliefs might negatively or positively affect patient care if that patient is crying or might cry because of a pending crisis event such as a terminal diagnosis.
3. Have students discuss possible nursing interventions to support patients (and possibly their loved ones) during emotionally upsetting circumstances.
4. Have students develop an intake assessment to evaluate a patient's crying characteristics (e.g., propensity for crying, type of crying, desire for comfort or not, etc.).
5. Have students plan support interventions for patients in situations that would be likely to invoke crying.
6. Explore crying by nurses and how to deal with crying in front of and with patients and/or their loved ones.
7. Have students develop and practice communication techniques supportive of the crying patient.
8. Integrate the preceding learning experiences into a simulation exercise involving a crying patient and her loved ones. Incorporate a variety of patient responses to the interventions attempted.

Some of the foregoing nursing education recommendations are also worthy of consideration for future research.

Future Research

The homogeneity of this study's sample, while unimportant in and of itself (Glaser, 1998), suggests opportunities for follow-on substantive GT studies specifically targeting African American, Native American, or Hispanic/Latina women in Tennessee and elsewhere since minority stress is prioritized by the Institute of Medicine (2011) report *The Future of Nursing*. Minority women are often victims of bias, and the stress associated with that bias can reach crisis levels. Conducting similar studies focusing on women over the age of 69 and participants from diverse socioeconomic strata, educational levels, and cultural and ethnic identification will extend and validate this theory for further transferability. And, this study can be used as a template for studying crying in men experiencing the emotional stress of personal crisis. Follow-on studies of the aforesaid groups may lead to a more detailed explanation and deeper understanding of the processual nuances involved when people cry in response to the emotional stress of personal crisis. While these studies would still fall within the realm of substantive grounded theory, formal grounded theory (Glaser, 2007; Glaser & Strauss, 1967) based on the core category Getting Back to Life could be developed by investigating the various ways—not just crying—in which people who have experienced the emotional stress of personal crisis respond to that crisis. The development of a formal GT, as conceived by Glaser's (2007), might also be realized by abstracting Getting Back to Life to people in different occupations and cultures who have experienced personal crisis.

Comments made by some participants indicated attempts others made to comfort them when they were crying did not help and occasionally made things worse. For instance, several study participants observed that having your husband respond to crying by saying things such as: "What did I do to make you cry?"; "There, there. Don't cry. Everything will be all right. You'll

see."; and "Please don't cry." will do nothing to provide emotional relief. According to P2, offering meaningless platitudes does not help. However, the same participant did say that it helped when her doctor asked her to "Tell me what's wrong." And P6 said having people ask "How can I help?" or "What can I do to help?" gave her comfort and made her feel cared for. This suggests research into what to say or do when someone is crying might discover simple ways in which to alleviate stress and let people know they are not alone (unless they want to be, which most of the participants in this study did).

Continuing in this same vein, research to examine the effects of not receiving support when it would benefit the person crying could prove useful in uncovering "tells" that nurses could be alert for. For example, how does it affect the crier when a loved one they would like to talk to about the crisis walks away and refuses to talk about it (P6), or becomes so unnerved they cannot focus (P5), or will not talk about it in the depth and to the extent that might lead to resolution or acceptance (P2)?

Other areas worthy of additional research that emerged from this study include asking if crying affects people differently based on the type of crisis. Put another way, what role does the type of crisis—loss of pet, loss of family member, loss of friend, family dysfunction, family medical problems, financial woes—play in the severity of the onset of emotional crying and its trajectory? Is the crying trajectory different because of the situational context? Does the onset of uncontrollable crying signal that the crying person's physiological and/or psychological well-being is under imminent threat? If so, what potential compromises to that person's mental and physical health should nurses be watchful for? How should they be prepared to intervene?

Interventions on behalf of patients and those close to them when they are crying is of concern to nursing, but knowing what is happening and what to do when it is the nurse who is

crying is just as important. GT research into nurses crying in the workplace might very possibly provide information that would benefit the health and well-being of practicing nurses. These studies could investigate female nurses, male nurses, or both in various healthcare delivery settings and under a variety of crisis conditions. The crises studied could include those that are patient-centered or work-related (leadership, management, organizational dysfunction, work schedule, work load, counter-productive cost savings initiatives, etc.). The results of these studies might disclose or suggest strategies for helping nurses cope with and/or adjust to the occupational stress that comes with the profession.

The data from this study could prove useful in developing and testing the crying intake assessment previously discussed. Similarly, it might possibly contribute to developing and testing a survey instrument for quasi-experimental analysis of statistical correlations and relationships between and among many of the concepts derived during this study's data analysis. This might uncover some information of value that I did not have as findings in my study. And, administrators and providers in certain healthcare settings might be amenable to the collection and chemical analysis of the three tear types to further elaborate Frey's (1985) findings about the physiological properties of tears.

Several participants casually mentioned crying when they felt the need to cry. This need was generally attributable to anxiety or stress levels that were high but had not reached crisis proportions. In these instances, participants insinuated their crying was a stress-relief emotional response they could delay, disguise, or turn on or off, depending upon the circumstances. Because this contradicts the generally accepted convention that emotional crying is an involuntary parasympathetic response (Frey, 1985; van Haeringen, 2001), this too is a subject that warrants further investigation.

The last subject I think might benefit from future research is the cultural and social practice of discouraging crying in this and other Western countries. This begins with children, and the prohibitions against crying grow as children grow (Vingerhoets et al., 2009). In my opinion, condemning crying as an emotional response is depriving humankind of an instinctual survival mechanism that is part of human genetic makeup. I think Darwin (1872/1998) got it wrong: crying does serve an evolutionary purpose. Just because science has not been able to definitively determine what that purpose is and how it works does not mean it does not exist.

Final Thoughts

I believe the TPT will prove useful in expanding the body of knowledge addressing the relationships between crying, emotions, and stress. The findings from this research warrant and underscore the need for further research, both qualitative and quantitative, into crying in those whose psyche has been overwhelmed by stress and the attendant emotions. The apparent role that emotional crying plays in response to a situation involving unbearable stress requires further clarification, exposition, and understanding. That is, how does the onset of uncontrollable crying and the follow-on interludes of crying – not crying, signaling both the deterioration and reestablishment of mind-body-spirit equilibrium, function as a biopsychosocial healing modality? How can that knowledge be incorporated into holistic nursing practice? If crying is or can be a holistic therapeutic, how can nurses oversee and manage its incidence and trajectory to the patient's best advantage?

Crying, a phenomenon that continues to evade understanding of its biopsychosocial function and purpose, is an insufficiently understood parasympathetic secretomotor response that, in my opinion, is of significant importance to healthcare, most especially the practice of holistic nursing. Holistic nursing practice is based in the art and science of ministering to mind-

body-spirit wellness, and crying appears to be an adaptive response to stress overload that is essential to maintaining optimum physiological, psychological, and spiritual health and well-being. As such, it is paramount that an understanding of crying be incorporated into holistic nursing's professional domain. To provide quality individualized patient care, nurses should value and be conscious of the healing potential of crying and know how to leverage that potential to maximize benefit to the patient and those close to her.

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APPENDICES

Appendix A

Participant Recruitment Flyer

WOMEN VOLUNTEERS BETWEEN THE AGES OF 21-69 NEEDED FOR RESEARCH STUDY

During the past 90 days, have you cried after an emotionally stressful crisis?

If so, and you are not receiving professional counseling or medical treatment as a result of your emotional crisis, I'd like to interview you.

This study involves the conduct of exploratory research into the crying that follows the emotional stress of personal crisis. This stress might have stemmed from a crisis associated with death or illness, personal relationships, family problems, financial concerns, catastrophic events, or work. The purpose of this research is to make discoveries that may lead to improvements in the quality of healthcare and advance the science and practice of holistic nursing.

Confidentiality and privacy will be carefully maintained.

If interested in participating, please contact:

Mary Bess Griffith, MSN, RN, CS, FNP
Associate Professor and Director, Department of Nursing
Bethel University

Phone: 731-885-0016 (home) 731-514-9180 (cell)
731-352-6472 (work)

E-mails: grif6521@charter.net (home)

griffithmb@bethelu.edu (work)

Appendix B

Primary Researcher's Telephone Screening Interview Script

Thank you for your interest in this research project. Please understand that any information you provide during this screening interview will be kept strictly confidential. With your consent, I have a few questions I'd like to ask before we go any further. (Do not proceed if consent is not granted. If the answer to either of the first two questions is NO or if the answer to any of questions three through eight is YES, thank the prospective participant for her interest in the research project and politely terminate the interview. Also, ask: If you know of any of your friends who might be willing to participate in this study, please have them call me.)

1. **Did your crying event take place within the past 90 days?**

2. **Are you between the ages of 21 and 69 years?**

3. **Are you receiving any counseling or care regarding the stressful event that preceded your crying experience?**

4. **Do you ever cry for no apparent reason? Specifically, have you ever been told by a medical professional that you experience bouts of pathological crying?**

5. **Was your crying in response to the stress-related crisis you wish to share in any way intentional? That is, did you purposely cry hoping to elicit another person's sympathy or support?**

6. **Do you think that talking about your crying event might result in psychological or physiological discomfort greater than that you already experience as part of your normal, everyday life?**

7. **Are you still experiencing any emotional trauma associated with this crisis event?**

8. **Are you hoping this interview will provide any sort of therapeutic benefit in dealing with the effects of this crisis?**

If the answers to the preceding questions are satisfactory, then make arrangements to provide the potential interviewee with an *Individual Consent to Participate in Research* form for her review. (Note: This form will be reviewed, explained, and signed at the interview site prior to beginning the interview.) Set up the interview at a time and place of her choosing. Answer any questions the prospective participant may have. Also, ask: If you know of any of your friends who might be willing to participate in this study, please have them call me.

Individual Consent to Participate in Research

You are being asked to participate in a research study titled: "A Grounded Theory Inquiry into Crying in Women Dealing with the Emotional Stress of Personal Crisis."

The purpose of this consent form is to describe the procedures of the study, explain to you what to expect as a participant, and document your agreement to participate. One of the goals of informed consent is to explain to you that your participation is voluntary; you have the right to withdraw from the study at any time without any negative consequences to you.

1. The purpose of this study is to explore crying in women who have dealt with the emotional stress of personal crisis during the past 90 days. The assumption basic to this study is that emotional stress stemming from personal crisis is experienced under a number of circumstances. For example, an emotionally stressful personal crisis might be precipitated by:
    - Death – of a family member, long-time friend, or beloved pet
    - Relationships – unrequited love, separation from a loved one, problems with significant other, or divorce
    - Family problems – problems with children, abuse, addiction, or caring for elderly parents
    - Work – heavy workload, unrealistic deadlines, abusive boss and/or co-workers and/or customers, sexual harassment, discrimination, failure to get planned promotion or pay raise, or insufficient time off
    - Financial – job loss, home foreclosure, consumer debt, cost of health care, or uninsured loss due to natural disaster
    - Serious injury or illness – the participant's own or that of family member

It must also be noted that some of these stress-inducing crises can span many of the aforementioned circumstances.

2. This study is being conducted by Mary Bess Griffith, MSN, RN, CS, FNP, to meet dissertation requirements for a PhD in Nursing awarded by the College of Nursing at the University of Tennessee, Knoxville.
3. You are being asked to participate in this study because you have reported to the interviewer that you have experienced crying while dealing with the emotional stress of personal crisis during the past 90 days.
4. If you agree to participate in this study, you will be asked to share that experience with the interviewer.
5. The interview is estimated to last about an hour but may last longer if you wish to share additional information about your experience with crying and personal crisis. You may take a break at any time during the interview. You may also stop the interview at any time that you wish without any negative consequences to you. The interview will be conducted in a private location agreed upon by you and the interviewer. With your permission, the interview will be audio recorded to ensure accuracy. If you withdraw from the study before data collection is completed, your data will be destroyed.
6. Risks associated with this research are that in recalling a painful memory and talking about it, you may experience psychological or emotional distress and require intervention from a trained professional such as a psychologist, psychiatrist, or counselor. In anticipation of this possibility, the investigator has identified appropriately trained professionals who will be available on site or for referral. At Bethel University, the on-campus counselor and the nursing department's faculty member who is a certified psychiatric nurse and a nurse

practitioner are available to assist as needed. If necessary, you can be referred to one of several area mental health/counseling centers in Kentucky and West Tennessee. A list of these centers is attached. If you would like, I will make an appointment for you at a mental health/counseling center of your choosing.

7. Steps to protect your confidentiality include using an identifier code for each interview event. No names will be used on any information collected during the interview. The only people who will have access to the audio recordings of the interview or interview transcriptions and be aware of your participation in this study will be the interviewer and her research assistant, both of whom have signed confidentiality agreements to protect all interviewee personal information. No personal data shared by you will be shared with anyone else without your written permission. Both the audio recordings and transcribed interviews will be kept in the interviewer's locked office in a locked file cabinet or other secure location when not being studied and analyzed. Electronic copies of interview sound and transcribed word files will be only stored on password-protected computers and not transmitted by e-mail. Only aggregate data and identified themes or variables will be shared with external individuals. Costs associated with your participation in this study will include a commitment of your time and possible emotional discomfort as a result of recalling and relating your experience of crying because of a personal crisis.
8. You will not directly benefit by taking part in this study, but the knowledge gained from this study may be used to help healthcare professionals deliver higher quality holistic care. No compensation will be offered or provided to you if you agree to participate in this study.
9. A written dissertation reporting the results of this study will be submitted to the

University of Tennessee, Knoxville. Study results may also be shared in journal articles and conference presentations. Only aggregate data as well as themes or variables identified will be published. No personal information will be shared without your explicit written permission.

10. This study has been approved by the Bethel University and the University of Tennessee, Knoxville, Institutional Review Boards (IRBs). The UT-K IRB can be contacted with questions about informed consent, participant rights, or complaints about the way in which you were treated during this study at research@utk.edu or 865-974-3466. If you have specific questions about this study, the researcher can be contacted by phone at 731-352-6472 (work) or 731-514-9180 (cell). Her e-mail addresses, in order of preference, are: grif6521@charter.net, griffithmb@bethelu.edu, and mgriff38@utk.edu. Dr. Joanne M. Hall, the researcher's supervisor, can be contacted at 865-548-4318 or e-mailed at jhall7@utk.edu or joannehall7@gmail.com.

_____

CONSENT

By signing below, you acknowledge that: (1) you have read and understand the information provided about this study, (2) you have been given an opportunity to ask questions and all questions have been answered to your satisfaction , (3) you have not been and will not be compensated for your participation, (4) you have not been coerced in any manner and freely consent to participate in this study, (5) you are not receiving counseling or medical treatment as a result of the crisis that precipitated your crying, and (6) you have been given a copy of this document.

Please initial below to indicate whether or not you agree to the audio recording of this interview.

_____ Permission is granted to audio record this interview.

_____Permission is not granted to audio record this interview.

Participant's Name (please print): _____

Participant's Signature:_____ Date: _____

Additional Consent for Re-contact

I understand that it may be helpful for the researcher, Mary Bess Griffith, to re-contact me to clarify or further develop the information I provided in my original interview. I may be contacted at the address, phone number, and/or e-mail listed below. I consent to be re-contacted for the purposes of clarifying or further developing the information I provided in my original interview.

Name _____

Signature _____ Date _____

Contact Information

Address _____

Phone Number

_____

E-mail _____

Participant Demographics

Participant Identifier Code		
Address		
Phone Number	**Home**	**Cell**
Race/Ethnicity (✓ one)	**□Asian □Hispanic □African-American □Caucasian □ Native American □ Other _____**	
Age in years		
Marital Status (✓)	**□ Single □ Married □ Separated □ Divorced □ Widowed**	
Employment Status (✓ one)	**□ Employed Full Time □ Employed Part Time □ Full Time Homemaker**	**□ Unemployed □ Retired**
Highest Level of Education Completed (✓ one)	**□ High School □ Technical/Professional Certification □ Associate Degree □ Bachelor's Degree □ Graduate Degree □ Other _____**	

CONFIDENTIAL. Destroy upon study completion.

Area Mental Health/Counseling Centers

Pathways Behavioral Health Services
Access: 1-800-587-3854
24-Hour Crisis Line: 1-800-372-0693
Locations: Union City, Lexington, Jackson, Milan, Tiptonville, Dyersburg, Brownsville

Carey Counseling
Access: 1-800-611-7757
Locations: Henry County, Gibson County, Obion County, Carroll County, Benton County

Professional Care Services
Access: 1-800-353-9918
Locations: Tipton County, Lauderdale County, Fayette County, Shelby County, Dyer County, Haywood County

Joseph A. Williams
Williams Christian Counseling
Mayfield, KY
1-270-247-5667

Lavonice Williams
Christian Psychiatric Services
Bartlett, TN
1-901-483-3660

Paul Deschenes & Perry Pratt
Christian Counseling
Jackson, TN
1-731-660-0019

Barry A. Greenlee, M.Div., LMFT
Dyersburg, TN
1-731-233-4606

LifeWorks Resources
Mark Baldwin, Counselor, EdD, (ABD), LPC, MHSP
Jackson, TN
1-731-467-0504

Renew Health & Wellness
Candace R. Eubanks, Clinical Social Work/Therapist, LCS
Union City, TN
1-731-393-4420

The Starting Place
Dee Wright, Clinical Social Work, LCS
Dyersburg, TN
1-731-217-4970

Traci Schott, Clinical Social Work, LCSW, MSSW
Jackson, TN
1-731-400-8022

Coffman & Company
Dr. James R. Coffman, Marriage & Family Therapist, ThM, DMin, LMFT, LPC, (MHSP)
Ripley, TN
1-731-612-8544

Douglas Dayne Wells, Psychologist, MA, LPP
Paducah KY
1-270-681-4617

Delta Behavioral Group
Memphis, TN
1-901-369-8100

McVay Counseling Center
Dr. Dewaine Rice, Counselor, EdD, LPC, MHSP, NBCCH
Germantown, TN
1-901-235-8824

Ashlie Edwards Counseling
Ashlie Edwards Coble, Pre-Licensed Professional, MMFT
Jackson, TN
1-731-271-5568

Patricia Heath, Counselor, LPC-MHS, NCC
Jackson, TN
1-731-624-2346

David Johnson
McKenzie Medical Center
McKenzie, TN
1-731-352-7907

Johnnie M. Welch, MAR, D.Min, LPC, LMFT
Dyersburg, TN
1-731-287-9008
Jennifer Taylor, LCSW, RPT
Cordova, TN

1-800-651-8085

Eric Cassius, LPC, MHSP, CHT
Counseling Psychology, Coaching, Marriage & Family Therapy
Memphis, TN
1-901-685-5491

Appendix C

Transcript of Interview with Participant 4

GT Interview with Participant 4 (March 18, 2016. 28.42 minutes)

(First 3 minutes 29 seconds of tape spent re-visiting pre-screening questions and discussing how the interview will be conducted.)

I Can you tell me about your crying experience and the personal crisis that preceded it? So, if you'll kind of explain what your personal crisis was… to the level that you're comfortable… and then, the crying experience that occurred as a result of it.

P4 OK. My husband, who is gone a lot, for a certain period of time, umm, did not tell me he was going on the trip until right before the trip,

I OK.

P4 and that made me very unhappy (voice trails off)

I OK. It made you unhappy because?

P4 I wanted him home, and I did not know, I didn't want him to go away after being away for work for other reasons.

I OK, so he had been away for a number of days already

P4 Before, yeah. And now he was leaving again.

I And it was unexpected.

P4 Yes.

I OK. And help me understand why that's a stressor to you.

P4 It is a stressor. We have two kids, small children, and we have 3 animals, and we have a house, and I'm working on my PhD. So, life is very busy. It's also softball season, and that is something we're very active in for our

I OK.

P4 daughter, and so for him to be gone just heaps more on my plate… on my already full plate.

I OK, so it was somewhat of a… and, and you didn't know about it.

P4 I did not know about it.

I Ok. Just all of a sudden you found out that he was going to be gone…

P4 Yes.

I So, your response to that was you cried.

P4 Cried, yes.

I OK. Well, can you tell me about, then, that crying experience? Describe the crying experience, uh, just about it.

P4 Like, the physic…

I It, all of it.

P4 I, I was so mad that a I didn't say anything to him… I just left and went to another room by myself and sat there and the more I thought about what was going on the worse that I got and so then I started crying.

I OK.

P4 Uh, and then I kept crying, and I probably cried for about 45 minutes to an hour

I OK.

P4 'cause anytime I thought I felt better, or I thought I could get up and face it, I just got upset all over again.

I OK. So, you probably cried for about 45 minutes.

P4 Yes.

I OK. Describe what crying is like for you, the, the whole experience… and you can describe it from the physical standpoint, the psychological standpoint, the emotional, any standpoint.

P4 I'm not a pretty crier, I just usually, uh, I'm not quiet, and I sob, and once I start, I can't stop. Like, it takes a lot to stop crying.

I Um hmm. OK.

P4 So that was one of the reasons 'cause I even , even into the next day, I still cried. And was on the verge, on the verge of tears and then cried, because it, it's just once that opens, it takes a lot to stop crying again.

I OK. When you say it's not pretty, you sob, can you describe, like do you… is it a body reaction? Just facial, vocal?

P4 No, it's just facial. I don't really say anything. I'm too, I can't talk when I cry.
I Is it a loud? When you sob, is there noise

P4 Yeah, It's loud.

I that comes out?

P4 I'm usually loud. I, I can't hide it. He knew, he knew I was hiding

I OK, so he

P4 He knew I was crying somewhere.

I Ok, so you're making vocal sounds

P4 Um hmm.

I as you sob, and tears are coming out and… Ok, and it went on for 45 minutes and then occurred again

P4 Yeah.

I on… Continuously? Or on and off all throughout the next

P4 No, on and off

I all throughout the next day.

P4 throughout the next day.

I OK. Do you have any kind of body-associated, anything with your crying? Can you describe any sensations anywhere? And not, not that you have any, I'm just asking.

P4 No. Sometimes, I mean, I get short of breath because I'm crying so hard.

I OK.

P4 It's not

I OK, OK.

P4 Nothing else, really.

I OK, short of breath but not really anything else. All right. And you can't stop, you said. That was an interesting thing. Describe that a little bit, about what you, when you say you can't stop.

P4 (Brief pause). I'll, I'll slow down, I guess, and get calm where I can stop, 'cause I try to put myself back together and then usually all of the feelings come back, and I start crying

I OK.

P4 again until

I You said

P4 I can deal

I You said the feelings come back?

P4 Thoughts, emotions, whatever was coming back, uh, whatever I was, like, at the time just the idea of having to take care of. All the things I was going to have to take care of while he was gone and it was almost overwhelming.

I It was overwhelming.

P4 And so, anytime I would calm down, I would think, you can handle this, you've got this, and then I'd calm back down and then all of those feelings of "Oh my gosh, all of this stuff is going to be going on and then having to try to deal with it just, it was just overwhelming to me."

I OK. All right. Well, let me repeat that back to you to make sure I've got it right, then. So, you had the stimulus that initiated the initial crying.

P4 Um hmm.

I And that was the finding out and knowing you had all of it. You used the word "overwhelming." Would you say that was the initial stimulus to begin with

P4 Yeah, yeah.

I or was it more or was it something else?

P4 No, the initial stimulus, well, it (brief pause, then softly as to self, "What was the question"). The initial stimulus was not, that he was leaving again. But, knowing what all that entails when he's gone

I It had a consequence.
P4 is very overwhelming, umm, because of all the things I have to care of.

I So then that started the crying.

P4 Yes. And then when I would calm down, I'd say Ok, we've got time to deal with it… I'd start thinking about everything, I would have to deal with and it just that overwhelming feeling that you've got to take care of all of this made me start crying again.

I All right. That's an interesting statement. So, let me, let me just ask you a question then when you said it went on and off for two days, is that what stimulated each of the following uhhhh

P4 Yeah.

I things? Was

P4 It was.

I still thinking about

P4 was still thinking of what it was going to entail, what all went with the situation… not just the fact that he was leaving, but everything that went with it.

I OK. What happened as you went through this experience, because did it, how did it change? 'Cause you said you thought about it and then you cried and then you stopped crying and then you thought about it and you cried, what changed?

P4 Uhh, circumstance. 'Can't always sit down and cry, you got to get up and go on with life and I had other things to do that day, so I just couldn't sit and cry, so I had to get up and go.

I OK. Umm, what helped you… no, wait a minute, hang on. Let me, let me think what I need to clarify. Hang on just a minute. OK. Each time you thought about, you were overwhelmed by the thinking about that, how did it compare to the initial? Was it, were you like, Oh, explain to me each experience.

P4 Well, I think the more I thought about it, um, while it was still overwhelming, I knew that I would have support from other people during that time and that even though I was still hurting that he was leaving, uh, and I was going to have to get help from other people, I knew that was just what I was going to have to do,

I OK.

P4 as some of the pieces fell into place,

I OK.

P4 it wasn't as overwhelming

I OK.

P4 as it was before.

I OK. How did the crying play into that whole, uh, event, that whole occurrence? 'Cause you said the overwhelming caused you to cry, and then I believe I understood you to say it was less and less overwhelming

P4 Um hm.

I and you came up with you either accepted there were solutions or you accepted… so, and how did the crying play into that?

P4 Oh, it's so better after I cry!

I OK.

P4 It's almost like a, not really a relief, but (thoughtful pause) it almost gives me time to think about it. I don't know if that makes sense or not.

I No, that's

P4 But because there's distractions everywhere, you know, there's always distractions, and if I'm crying, usually everybody's leaving me alone, so I have time to process things while I'm crying, and I can think through things, and uh, usually pray, and uh it's just almost like a quiet… it's not quiet, but it's no distractions

I OK.

P4 during that time.

I OK. So it's a processing time

P4 I can process, yeah.

I for you. OK. So then that crying situation or event stops, and describe after that.
P4 I'm really tired, usually, after that.

I OK.

P4 Uh, (brief pause) I almost feel foggy, after… especially like in the worst it was, the more foggy I am, and I almost feel like I'm kind of in a haze and it should, 'cause it, it's straining, I mean it, to have to like process it all and think through all that by myself. And, uh, (softly) it's just that I'm tired, I'm usually tired…

I How long does it usually…

P4 It just depends on how bad it is. Uh, the first initial took me a couple of days to get over.

I To get out of the fog?

P4 Yeah. To kind of feel like I wasn't in that place where I was going to keep getting upset about it and

I OK.

P4 keep reoccurring. It took a good 24 to 48 hours

I OK.

P4 before I finally started to feel… it maybe even lasted longer than that, it may have been more than like 3 or 4 days.

I OK.

P4 Um, but it got better. It got better as I went on. I wasn't as foggy like Saturday night as I was, you know, Tuesday morning.

I So, it diminishes

P4 Um hm.

I as time goes on. Is that, do you process any during that time or is that just a resting time or… What would you describe that foggy time as?

P4 No. Usually, that foggy time is like a resting time, 'cause I can't deal with it anymore, I need a break from it, I need to file it away, kind of put it where it belongs so that it's not out in something that I'm dealing with all the time.

I OK.

P4 Life goes on. I've got to deal with kids, and work, and school, and household stuff, and so it just, it, I, I kind of file it farther back so that I can deal with what needs to go on.

I OK. All right. So then the foggy time and then you said, but there, and then there's a follow on event and you said that being overwhelmed by it brings on the next event.

P4 Um hm.

I Ehhhh, how does the fogginess overwhelm this and the next event all play into each other? Does, you're saying that the fogginess is kind of a resting time, how does that change?

P4 It's, it's not a good time for me to make decisions. Umm

I The fogginess.

P4 Eh, yeah. During any of that time.

I Oh, OK, OK.

P4 During any of that time, it's not a good time to make decisions.

I OK.

P4 I can't think clearly.

I All right.

P4 And priorities are different. Where that situation may seem like it's a big deal, it's not quite as big of a deal in reality.

I OK.

P4 Yeah, like I mean in the grand scheme of things, that's not a huge deal. It was for me at the time, and so

I And that's what precipitated

P4 Yeah.

I the crying.

P4 And so, I know now I usually don't make decisions

I OK.

P4 when I, because everything seems like it's such a big deal, and I give myself time to get distance from it to process it and not do anything… I just don't make any, I just don't

I OK.

P4 do, nothing drastic.

I OK. That makes sense. So the fogginess is kind of the, you said you filed it away

P4 Right.

I and you're not making decisions… Is that right?

P4 Yeah, yeah.

I Am I understanding that right? OK. So then what happens that then you have the next crying event if you're foggy and you filed it away…

P4 I don't keep it filed away.

I Uh

P4 Laughs. I'm not good at keeping it filed away. And, uh,

I 'Wonder what allows you to bring it back out? If the fogginess keeps it filed away?

P4 Well, I think the fogginess is being tired from the initial

I Crying event?

P4 Yes.

I Ohhh.

P4 And, it's just like my energy is drained.

I OK.

P4 And so I don't make any decisions 'cause I know that… I always feel kind of like I'm after somebody has a migraine, you know, their just kind of groggy

I Yeah.

P4 and don't really do

I OK.

P4 it's kind of like that, and so

I So, you're in a resting phase.

P4 Yes, but

I Or exhausted phase.

P4 More like exhausted, probably.

I OK.

P4 And then I don't… it's just very hard to make, like it's hard to think rationally

I OK.

P4 during that time.

I OK. You're drained, so it's put away, and then what allows it to come back out?

P4 Umm (reflectively).

I It just does.

P4 It just does, yeah.

I OK.

P4 Whether there's something that's due during that time period or having to deal with the person who started it to begin with

I A trigger.

P4 It, yeah, it gets pulled back out.

I A trigger. 'Doesn't matter. I mean 'could be many things is what you're saying.

P4 Yeah.

I And then you cry again.

P4 Yes.

I Ok. And if, and if I understand right, it may or may not be as, you're saying

P4 As the first one.

I The first one is usually the worst, the

P4 Yeah.

I Biggest, I guess.

P4 Yeah.

I Is that the right word?

P4 Yes.

I OK.

P4 ‘Cause it’s the most shocking
.
I OK. So, you’re crying to the shock as well as the overwhelmed, so… OK.

P4 Um hm.

I All right. So, each time you cry, then what happens after that experience? What’s, what’s the… OK, you cry the next time, and so is it the same thing? Uh, is it different? How, how

P4 No, it’s about the same.

I OK.

P4 (Inaudible)

I Well, then what… help me understand why… how do you get to the diminished “OK, I’m handling this”? What brings you through this entire crying experience and the stressor to the

P4 Finding solutions.

I And, OK. And when in this process are you finding solutions? Am I understanding you to say that that’s during the crying?

P4 Actually during the crying. Because I don’t process well after.

I But during.

P4 During. (inaudible)

I So you’re actually solving problems during your crying.

P4 Yes.

I Wow! How neat! Huh. OK, all right. Umm, let me think about anything else I, I want to clarify, because my whole goal is to understand what crying is to you. What experience it is, bad, good, or indifferent. ‘Doesn’t matter. Just what it is. Umm, do you, do you have any sense that you’re going… No, let me rephrase this. The crying occurs.

P4 Um hm.

I What’s before? I, I understand the situation,

P4 Yeah, the situation

I But

P4 Ummm

I you said… Here's what you said to me: "I knew and so I went to another room." What do you mean "I knew"?

P4 Well, that I was upset. I was just mad, and I didn't want to be around that.

I OK.

P4 I think it… I don't know. Uh, (makes noise clacking tongue against top of mouth apparently to fill void while thinking). He told me, and then, he'd been gone, and that, that had been a really hard two weeks, really hard, and I didn't feel like I could do that again, and the idea of doing that again was overwhelming.

I Yeah.

P4 And, I didn't plan on crying because I thought I was more mad than anything, but as I sat there thinking about all of the things I was going to have to do and how overwhelming, like just that thing you're going to have to do this, and this, and this, it was just too much to handle because I was already so tired. And so, I don't, I think, I think it was the overwhelming, overwhelming of emotions, just not even knowing where the place… I didn't know if I was mad, or sad, or hurt… I didn't know, I just knew that I was tired and I was ready for this period of our life to be over with, and

I And it wasn't.

P4 And it wasn't.

I OK. Do you have like any… Are you surprised when you cry, do you know it's coming or where…

P4 I used to know when it was coming, but now I, it surprises me, 'cause I don't cry as easily as I used to.

I OK. So you don't have any kind of physical or mental or emotional warnings or
P4 (inaudible).

I anything like that. OK. Uh, what about socially? Now, let me explain to you what I mean by that. What's the context of your crying? Uh, do you, umm, with, without, around people

P4 Oh, no. Usually by myself. I don't like to cry in front of people.

I Help me understand that.

P4 Well, it's not pretty, first of all.

I Laughs loudly.

P4 Also laughs. They, I, I'm supposed to be in control. If I'm crying, I'm not in control.

I Ohhhh. Why… Help me understand that "supposed to be in control."

P4 I am supposed to have a handle on everything, and if I'm crying I don't have a handle on something. Something is not how it's supposed to be.

I OK. I'm, I'm going to still dig in that a little bit more. Help me understand why you're supposed to have a handle on things.

P4 Oh, I'm supposed to be sensible.

I OK. According to?

P4 I don't know. (Laughs) According to me.

I Oh, OK, OK.

P4 (continues to laugh)

I According to you.

P4 Yes.

I OK. So, you're saying that you have these goals or outcomes that you or expectations

P4 Expectations.

I and crying indicates?

P4 That I am not meeting my expectations.

I OK.

P4 Because if I was meeting my expectations, something wouldn't shock me or I wouldn't have that overwhelming because I would already have a handle on it.

I OK. But, whose expectations are these?

P4 Mine.

I OK.

P4 (Laughs)

I But you're crying in front of yourself?

P4 Yes.

I OK, so then you told me you cry by yourself.

P4 Yes.

I So…

P4 'Cause nobody else can see me.

I But, so what, what… yeah, but you, you understand what I'm asking,

P4 Yeah.

I because I'm confused.

P4 Yeah.

I Uhh, whose expectations are they?

P4 (Pause) Which expectations?

I Wellll…

P4 Of why I'm crying?

I No.

P4 and why I'm

I No, No. OK, you're saying you're supposed to be super mom, you're supposed to be in control,

P4 Yeah.

I you're supposed to handle everything,

P4 Um hmm.

I and so if I cry, that shows I'm not in control and therefore I want to cry by myself.
P4 Yeah, so nobody else sees that I'm not in control.

I Ahhhh! OK, so do the other people have the expectations, are you, just want them to think, are you, ehhh, help me understand that.

P4 (pause) I think, don't know, I think part of it's cultural, socially, just this interest in, everybody always having, you know, huge birthday parties, and gorgeous meals on the table, and is involved in this, and going there, and doing this, and… It's, it's hard to keep up with.

I So, measurement.

P4 Yes. Keep, like, making sure (child's name) has everything he/she needs to do, and making sure I've got all my stuff, and then he's got his stuff, and the baby's not into anything yet, bless him/her… I hate to give him/her stuff.

I OK, so really you're saying you've created expectations based on your interpretation of social

P4 Yes.

I expectations. And if you cry, it shows you're not meeting expectations.

P4 Yes.

I Therefore, if you show somebody else, are they your measurement, or your judgement, or yourrrr…

P4 I guess so.

I or do you just… OK, well I know… don't let me tell you

P4 No, I mean, I don't, I don't know. I just, and then, uh, I mean even at church, she's got the problem of 31 women who did everything, you know, you're a problem with 31, she had a handle on her bills, she had a handle on her food, she had a handle on her house, had a handle on her kids, had a hand… you know, then had, had an awesome relationship with God. (pause) I'm, I'm nowhere near close to being able to keep up with everything and everybody by myself.

I OK. (stopped recording briefly because someone opened door to office)

I OK. So, you're out of control and you're not meeting expectations
P4 Um hm.

I and you don't want anyone else to see it

P4 Yes.

I because if they saw it, they would

P4 It would be a weakness.

I A weakness?

P4 Um hm.

I In you?

P4 Um hm.

I And that would be bad for them to see a weakness

P4 ‘Cause they can use it against you.

I Oh, OK. So, it makes you feel vulnerable or

P4 Um hm. Like I have to protect myself.

I OK. Now, I don’t want to put that word in your mouth.

P4 No. It does feel like,
I (talks over P4) Is that

P4 like I’m having to protect myself because you don’t know when somebody going to use something against you.

I OK. All right, that, that makes sense to me.

P4 OK.

I OK. But now don’t let me create your

P4 I won’t. No, no, no.

I (raises voice to talk over P4) I’m trying to interpret and

P4 (unintelligible, drowned out by I)

I understand

P4 Yes.

I correct me if I’ve missed it at all.

P4 No, no, that's right. (unintelligible)

I OK. All right. Um, I think I understand before, during, after… what precipitated it. (Pause) What does the crying do for you? I know you said it did problem solving or processing. What does it accomplish? If anything?

P4 Well, sometimes it just helps me let go of whatever the feelings are.

I Oh.

P4 Uh,

I OK.

P4 because I don't let people see that I'm overwhelmed or that I have a lot on my plate because I don't want them to think I can't handle what I have

I Um hm.

P4 and so, it's almost like acknowledging this is too much and even though it may not be acknowledged by other people, I acknowledge it myself… Um, and try to come up with a solution to make it manageable whether it's getting help from the family, uh, whatever I need to do to make it, make it work.

I OK. All right. Ok, so that's what it does for you.

P4 Um hm.

I OK. All right. Can you think of anything else you could tell me that would help me understand your crying experience?

P4 I don't think so.

I Just one last question. Crying: good, bad, irrelevant, indifferent, just the process, ehhh, what the (slurred)

P4 I think it's good. I mean, I don't, I don't have

I Do you

P4 I don't

I Do you hate crying?

P4 I

I Do you like crying?

P4 I, I don't, I don't mind crying when I'm by myself. I don't like crying in front of other people.

I OK.

P4 Uh

I Because of what you said.

P4 Yes. But if it's just me, I don't mind, I don't mind crying.

I OK. All right. 'You do it frequently?

P4 No. Not anymore. I used to cry a lot.

I What's changed?

P4 I don't know. As I've gotten older, I don't cry as much. I don't know if it's hormone related, or, uh, but I don't cry as much. I don't know if I'm better at handling things

Unknown hmph

P4 as I was when I was younger.

I OK. All right. Thank you very much for your time.

End of Interview

Appendix D

Example Coding and Theoretical Memos

GT Inquiry into Crying in Women Dealing with the Emotional Stress of Personal Crisis

Memo 1 Summary and Open Coding of P1's Interview

Open Coding
March 14, 2016
Summary and Open Coding of P1's Interview
Codes in [ ]

P1's emotional stress resulted from the sudden, shocking, and unexpected death of her father. [Loss of Family Member]. While she felt no guilt at not being present when her father passed away, she did note that her sister who was present, the youngest of her three sisters, did feel some guilt about not being able to do anything. She wished P1, who is a nurse, had been there because perhaps she would've been able to do something. [Guilt]

As the oldest sister, P1 had assumed responsibility for taking care of her father… taking him to the hospital, being there if he was sick, being there for him at a moment's notice. [Caretaker]

P1, in describing her crying experience following her father's death, noted that at first she couldn't stop crying, she just paced and paced and paced, couldn't sleep, and she didn't even take a shower. [Reaction to Loss] [Crying] [Pacing] [Interference with ADL]. She acknowledged her reaction was not normal, but then questioned what was normal. [Grieving Process] Still, her crying and pacing did help in dealing with her anxiety, even though it was a very difficult time that lasted through the funeral and a week or so afterwards. [Relieve Anxiety] [Duration]

P1's crying lessened as time passed. What began as frequent, intermittent bawling (in vivo) and pacing gradually progressed to crying only when sudden and unexpected crying events occurred, when things would strike her or make her think of something, but the pacing stopped after the first few days. She couldn't help it. [Inability to Control]

P1 noted she was a lot worse when she was younger, implying that as she aged, she was less prone to crying. She also indicated that the proneness to crying might be something in her family. [Age Effects on Crying Triggers] [Family Trait or Familial Propensity for Crying] She said that as young girl, she remembered praying not to cry so much. [Praying not to Cry]

Anything that raised P1's anxiety level made her cry, and she hated that. [Heightened Anxiety] [Personal Feelings about Crying] [Relieve Anxiety] P1 also said her youngest sister, who is the most like her, was the same way when it came to crying. Her younger sister is also on anti-depressant medication, and she's afraid to go off meds because she'll start crying again. [Control Crying Tendencies with Medication]

P1's precursors to crying (she cries easily) were, when she was younger, getting a lump in her throat, eyes welling up (still happens if something is sad), talking to someone and start feeling emotional then tears would well up, but she can kind of pull it back and not cry, now that she's older. [Physical Precursors to Crying] P1 even noted that she often (when she was younger) cried in church during the preaching and wondered why she was crying when no one else was. She speculated that perhaps she was moved more than anyone else, that she was intuitive and able to be empathetic. [Empathy] These traits permitted a deeper understanding and appreciation of what the preacher (?) and even her patients were feeling or expressing. [Mental triggers to crying] Still, P1 noted that she still wanted to be able to control her crying even though she felt that crying might be inseparable from her being. [Crying as part of self] [Controlling crying]

Still, P1 admitted that tears would just start coming out of her eyes at times when she started to feel emotional [Conditions or situations that might result in crying], and she didn't like that, she wanted to be able to control it. She said she hated not being able to control her crying (and external expression of emotions?). Control was a recurring theme in P1's interview. [Desire to control].

Interestingly, P1said she still cried when she went to her father's grave, but that was all right because she forgave herself for still crying. [Forgiving self] She missed her father, and even thinking about him might result in a feeling of sadness that made her cry. [Memory as trigger] She described the precursors to crying and the effects of them upon her whole self as very stressful, just sad. [Stress of crying] [Crying as reality]

Now, tears just come, but she can usually get over it (the sadness) quickly whereas it wasn't so easy for some weeks after her father's passing. She said it helped to take a deep breath to get past the crying, that it seemed to cleanse her (mind) and bring her back to reality. That is, she saw getting through the crying episode as cathartic. [Effects of crying] Still, the stress of crying was not refreshing when it (the stressful event) was still new. [The stress/crying process] But the combined effects of bawling, pacing, and repeat helped anxiety work its way through. As the anxiety worked its way through as evidenced by ever diminishing occurrences of bawling and pacing, P1 reported feeling cleansed and refreshed. [Progression of crying and attenuation of emotion] P1 also noted another positive attribute of crying about her father's death. "The process of going through it," even though her degree of control was tentative, helped her go on with her life. The point to be made here is that, had she lost control, P1 would not have been able to go on with her life.

P1 stated that, mostly, she cried alone, but that it was all right to cry in the presence of her sisters and mother. [Presence of others—social context—when crying] She was used to crying in front of family members even though as a child she had been told not to cry, don't feel sorry for yourself, quit feeling sorry for yourself and get to work, get back to whatever it is. Even now, she said she doesn't want to feel sorry for herself, I gotta be a big girl. [Social/cultural/familial prohibitions] [Self perception] And even though P1 repeatedly expressed a desire to control her crying, she still felt crying was good, but wanted to be able to pick and choose the times she cried.

Memo 5 Theoretical: Thoughts about Crying

Theoretical: Thoughts about Crying
March 18, 2016
P1

It is important to keep in mind that GT is about process, process whereby the individual takes conscious action-interaction to resolve a problematic issue or situation. According to Corbin and Strauss (and most other GT researchers), process is inherent in GT. This is a contention with which Glaser disagrees. He maintains that GT begins without a research question and is not necessarily a transactional system. This study, however, begins with a research question, and the question itself implies process: crying in women dealing with the emotional stress of personal crisis. The question provides context, action-interaction directed toward treating with an issue of importance to the individual, and anticipates outcomes or consequences of that action-interaction.

My initial take on this research was that crying, to some undetermined and heretofore undefined degree, might turn out to be the action-interaction component, albeit unconscious, crucial to the individual's efforts to deal with her stressful situation. Having coded my first interview and having an awareness of the content of the other two interviews I have conducted thus far, I'm reconsidering that presentiment. While it's too early to arrive at any definitive conclusions regarding the themes and categories that may emerge from the additional data to be collected and analyzed, I have some thoughts about crying, survival, and control that need further exploration and consideration.

First, because emotional crying is not conscious (it's a parasympathetic response), it cannot be the specific action-interaction that the individual experiencing the stressful situation employs toward resolving her stress-related crisis or crisis-related stress. Second, is crying the first physical manifestation of the stress associated with the crisis? Does it signal stress overload or levels of stress dangerous to the individual's biopsychosocial (BPS) well-being so that the stress can be consciously acknowledged, dealt with, and accepted? Are the resulting actions-interactions directed at controlling the potentially harmful effects of stress in order to establish a new level of BPS stability (in vivo from P1: Get Back to Life)? In short, is crying part of an instinctual survival mechanism (Code: Preservation of Self) in that it serves a variety of purposes including acting as a type of early warning system that BPS meltdown is imminent? (This is where several theories of crying attempt to partially explain crying as a phenomenon; e.g., catharsis, overflow, two-factor, discharge.) Is the crux of this thinking that crying is incidental to or a natural consequence of dealing with crisis but that the real story is in the actions taken to control it? That is, is crying part of an adaptive, perhaps evolutionary, process or mechanism inculcated within human genetic makeup to enhance the likelihood of survival through the self-control, conscious and subconscious, of threats to BPS constancy?

Memo 7 Theoretical; Resilience

Theoretical: Resilience
March 19, 2016
P1

My husband, who is transcribing interviews for me, remarked that P1's statements "you have to be able to go on with your life," "you have to get back to life," and "get back to whatever it is" reminded him of a quotation from the mathematician Jacques Bernoulli. Jacques was much enamored with the logarithmic spiral curve, and gave it the motto: "*Eadem mutato resurgo*." Translated, "Although changed, I rise again the same." At first, I didn't give his effort to enlighten me with more stuff about mathematics much thought, but it does occur to me that in the context of this study, Bernoulli's motto for the logarithmic spiral curve (whatever that is) might have some relevance to symbolic interactionism.

From a symbolic interactionism perspective, changing and rising again the same call to mind the mythical Phoenix, a bird whose long life ends in a spectacular conflagration but is then reborn from its own ashes. The death and rebirth of the Phoenix are repeated in an endless cycle. Somewhat similarly, an individual's life consists of an ongoing series of adaptive actions-interactions necessitated by the need to adjust to the stresses of altered conditions. If the individual's response(s) to the meaning given to the altered condition(s) is/are appropriate, then that individual's perception of reality is modified accordingly. This modified or new reality establishes a transformed status quo of meaning for the individual that redefines social action-interaction until such time as something in the social environment changes and renders prevailing action-interaction ineffective.

Equating participants in this study to the Phoenix is a bit extreme, but to the extent Bernoulli's motto is applicable, the sense I get from my first three interviews is one of resilience, if not rebirth. Crying seems to be a part of the action-interaction occurring from participants' interpretative perception of an alteration(s) in their social environment, but its role in the adaptive, interpretative process isn't clear at this point. I certainly think that each of the participants I interviewed to date have demonstrated resilience in the ways in which they have adapted their perceptions of social reality to permit existence in and acceptance of an evolved personal reality. So, if resilience is a concept important to this research, how can it be categorized? I could use Self Resilience, Resilience of Self except that Self has specific meaning in symbolic interactionism, that is, understanding how others perceive you. (With that thought in mind, I need to review my concepts and categories from P1's interview to ensure there's no confusion re Self.) How can I put action-interaction or problem resolution into this concept? I'll have to revisit this after I have analyzed additional interviews.

Memo 17 Theoretical: Provisional and Abbreviated Story Line

Theoretical – Provisional and Abbreviated Story Line
March 31, 2016

In order to recast the categories and concepts identified thus far (P1-P4), it might prove helpful to formulate a provisional, albeit abbreviated, story line in outline form to better understand the processes underlying the question of crying in women dealing with the emotional stress of personal crisis.

First, it is safe to assume (where it wasn't specified) that each of the women confronted with the stress of a personal crisis was already dealing with some level of stress. The stress might have been what can be called background stress, that is, the normal stress of daily existence. Being a homemaker, mother, daughter, sibling, wife, working woman, etc. The stress might have already been heightened by one or more additional stressors not routinely part of daily existence. Having to deal with an unexpected financial requirement (car repair, home repair, medical expense), medical exigency, work problem, relationship problem, etc.

Nothing out of the ordinary (Predisposing factors, the gathering storm, cracks in the wall, the optimum load, rising waters, **dammed reservoir level before the storm**, Tentative equilibrium, Treading water, maintaining emotional control in the face of typical and unexpected minor stressors,

Maintaining emotional control

Typical stress

Unexpected minor stressors

Filling the cup

Precipitating personal crisis (**flood waters pouring into the reservoir**, overloading emotional control

Heaping more on my already full plate (Overloading emotional control)

The crisis itself

Family

Illness

Pet

Warning signs (Note: These probably shouldn't be included in the model or theory because these were provided as being more or less typical of crying incidents and were not necessarily mentioned as part of the narrative associated with the emotional crisis under discussion.)

Physical

Emotional

Tipping Over the Full Cup (**The dam breaks and the flood waters come pouring out**, the last straw, the walls came crashing down, system shock, breaching emotional control)

Breaching emotional control

The Tipping Emotion

Crying as emotional release

Feeling Quiet, Finding Peace or Relieving Tension, Feeling Emotionally Stronger (Dampening the Emotional Angst, dampening emotions, drowning out the background noise, **receding flood waters, taking stock of the damage**, struggling to regain emotional control) Note: At present, it appears there's no distinct boundary between these two concepts, so together they form a compound category. The same is true of the following compound categories. These compound categories need to be separated, so I'll need to further analyze and compare the data from the interviews.

Crying as restorative agent

Crying as reconciliation agent

Letting Go, Getting a Handle on Things (Adjusting to the new reality, regaining emotional control, **making plans for reconstructing the dam and flood control system based on recent experience**, shifting priorities, coming to grips). This represents the process, the flux, associated with accepting and adapting to a new status quo.

Resetting, Getting back to life (**regulating reservoir water-levels with the reconstructed dam and flood control system**, reorganizing and renewing emotional control) This represents the changed status quo that has been accepted and adapted to. What's ordinary has been redefined: It's a new ordinary inclusive of the old ordinary and the adaptation to the precipitating crisis situation.

Memo 18 Summary and Axial/Theoretical Coding of P5's Interview

Axial – Theoretical Coding
March 31, 2016 (Recoded December 17, 2016)
Summary and Axial/Theoretical Coding of P5's Interview

Summary

P5's personal crisis arose following a confrontation with her husband. She came home from work after having attended a regularly scheduled meeting that took place every Monday afternoon. Attending the meeting made her later than usual in coming home, and her husband demanded to know why she was late and where she had been? P5 said the distrust he expressed shocked and wounded her. She felt betrayed by someone with whom she had a long, intimate, and loving relationship. Angry because the hurt was personal, P5 left her husband and went into the bathroom to be alone, where she replayed what had transpired between them in her mind. This provoked her crying. She said, "the tears just sprang." She said she didn't sob, she just had a lot of tears. After about 15 minutes, she regained control of herself and went back to where her husband was. He acted as if nothing had happened and, in fact, didn't remember the conversation the next morning.

Unfortunately, there was an underlying explanation for her husband's out of character reaction to her late arrival home. P5 explained that he had had knee surgery and was disabled. P5 said that after the knee surgery, he had experienced some personality changes and after effects. She speculated that the knee surgery had caused some circulatory problems that were affecting his brain. She noted that his decision-making had become impaired and that he had trouble finding the right words. This latter problem made him angry. P5 opined that dealing with him was like dealing with someone with dementia. She was afraid that she was "on the cusp" of losing him, of getting to the point where he no longer recognized her.

An interesting aspect of P5's crying experience was that she stated she only cried like this ("hard core") when the stressor that tipped her cup over affected her personally, that is, was directed at her core being. While P5 said one of the reasons she chose to cry alone was that she didn't want her crying to upset others, she also stated that her crying allowed her to effect "self-recovery." Self-recovery meant that she had regained a state of calmness that permitted her to think and act rationally and reasonably. It also meant the stress was off. Her scrunched up crying face relaxed, the tension in her back and neck eased, her throat relaxed, her teeth unclinched, and she could breathe normally.

P5's crying in this instance lasted about 15 minutes. She said she couldn't stop replaying the conversation with her husband and couldn't stop crying. During this time, she admitted to addressing her hurt by carrying on a conservation, both aloud and in her mind, with an imaginary husband. Her imaginary husband was her husband before his knee surgery and its after effects. This was a husband she could reason with, could play with. In her conversation with her imaginary husband, she carried on a calm, reasonable discourse with someone who responded in kind. Through her tears and by way of a normal, if imaginary, conversation with her imaginary husband, she calmed down and her crying stopped. Admitting that this strategy for controlling

the situation "didn't really solve anything," P5 said, "in the end, it is cathartic." Her crying and the manner in which she dealt with it was "kind of refreshing… helps me tackle whatever is going to come at me next… I use it kind of like a cleansing agent to kind of shield me."

Although P5's crying incident was sparked by anger that resulted from her husband not trusting her, her stress level was also impacted by the changes in her husband's personality and mental well-being and the long-term ramifications of continuing changes that were likely to be further detrimental to his mental health. She also was dealing with the responsibility of working several jobs "to make their lives better," while he, being disabled, sat at home and did whatever. As she said, "I feel sorry for him 'cause he's disabled but, at the same time, I'm angry as hell because I'm carrying us." Aptly, P5 noted that her husband's disability had "changed the dynamics of our life."

An important point P5 made while discussing crying in front of people who see you as a strong person is that crying inhibits problem-solving. This is because crying may be judged a weakness, and that changes the way in which one is perceived by others. She seemed to be equating crying with compromising one's creditability as a serious, thoughtful person.

P5 also talked about two other crying incidents, one having to do with watching sad or touching TV shows or movies and the other having to do with the loss of a long-time pet that died unexpectedly. Regarding watching sad or touching visual media programs, P5 observed that crying in these instances was merely a response to an external trigger or stimulus. Oddly, although P5 compared the death of her beloved dog to that of losing a child, she said this was a different kind of stress that evoked a different type of crying, but not the "hard core" crying she experienced when she took a personal hit and was the target of someone's ire or vindictiveness. As she stated, "there was not a lot at stake there… I was not a target." Still, she took the passing of her old dog very hard, and she and her husband cried together grieving his loss.

Axial/Theoretical Coding

The Past Present Reality
-husband disabled, some personality changes, attributed to knee surgery and after effects
-believed to be some of circulation issue, vascular issue with brain
-husband has been indecisive, has judgment issues, switches words
-P5 had busy, stressful day at work
-our original relationship had changed, it's like dealing with dementia.
-felt like she was on cusp of husband no longer even recognizing her
-angry as hell because I'm carrying us.
-it's changed the dynamics of our life.
-I feel like I'm doing everything, working two or three jobs to make our lives better, he's sitting at home
-we have stress in our everyday lives, it's financial, it's everything.

Heaping More on My Already Full Plate
-husband questions where she has been when she's been at work

-what provoked it was that he didn't trust me, I felt like I was betrayed by my spouse for no reason
-I let it layer (stress), I take so much and then, maybe my, my cup's too full.
-If it's hard core, I cry by myself.

Tipping Over the Full Cup
-shocked, went into bathroom, replayed conversation and it hurt. I felt like I was wounded.
-I was angry, I was hurt, you could tell I was angry.
-then, the tears just sprang. I just cried, I didn't sob, I had a lot of tears, I'm a quiet crier.
-it (crying) just happens.
-in bathroom for a good 15 minutes just trying to get calmed down. I felt like I was losing him.
-It's not like I can stop my crying. I can't stop replaying it, I can't forget it.
-the more it replays, the more tears I have
-crying accompanied by stuffy nose
-crying sometimes preceded by throat closing up and getting flushed
-I can manage it for so long, but when I feel beat up on, you might tip my cup over.
-If I take a personal hit, feel like I've been wounded, become the target, that's when the cup runneth over.

Feeling Emotionally Stronger
-I remember talking to myself, giving him my defense
-if he were of right mind, I would have been able to defend myself, but instead went into the bathroom.
-it was easier that way for him
-crying very cathartic
-crying relieves internal stress
-feel almost like all the negative ju-jus are gone.
-I use crying as a kind of cleansing agent to kind of shield me.
-my throat's relaxed, tension in my shoulders and back of my neck is gone, my facial expression is looser, my teeth aren't clinched
-I feel better
-Stress relieving started when I started talking (the dual conversation with imaginary husband)
-the more I talked, the emotions released, I was calmer, the stress was going away, but it was exhausting having to play both parts

Getting a Handle on Things
-crying weakens your ability to solve problems-
-I got myself under control… by playing both parts (her and her husband) in an imaginary discussion with the husband she used to know
-I controlled the situation, I could rationalize myself into control
-I was trying to put a positive spin on it had it been real.
-the crying stopped when the P5 felt the situation had been managed, if only in an imaginary way
-I feel pretty good, the stress was off.
-the crying stopped, I was calm, was that healthy? It didn't really solve anything.

Getting Back to Life

-I had recovery, it was a self-recovery
-it's kind of refreshing, helps me tackle whatever is going to come at me next
-I essentially reset the whole experience
-when I got through talking, it was like my body reset
-I just blew my nose, and went on outside
-We went on about our way, it was like it never happened.

Memo 19 Theoretical: Thoughts from P5's Interview

Theoretical
April 2, 2016
Thoughts from P5's Interview

Prior to the incident that provoked her crying, P5 was under a good deal of stress already. Her husband's seeming mental deterioration was, in and of itself, a stressor that added to what might be called the normal stress of everyday living. Additionally, speculating as to the cause of her husband's mental problems and personality changes added another layer of stress. On top of that, she was worried about what the future would bring, a future that might well involve the de facto loss of the husband she had known and loved for over 30 years. Further compounding this heightened level of stress was the knowledge that she might have to care for someone suffering from dementia for many, many years.

I thought it was interesting that P5 recognized that crying about something seen in a sad or touching movie or TV show was different than crying that resulted from emotional stress. This is a point that several researchers seemed not to consider, at least beforehand, when they designed experiments that had college students watching sad movies to evoke crying. She saw the events portrayed on screen as external stimuli that triggered crying as a detached emotional response, but these stimuli were not stressors, nor did they require resolution. To P5, her emotional crisis triggered an internally-based crying response. She felt betrayed by her spouse, and part of her definition of who she was derived from how she thought he perceived her. This caused a disruption, a wounding, of her core self, and it had the potential to destabilize that core self by making her question who she was, possibly forcing a redefinition of her Self.

Among her many insightful revelations, P5 observed this particular incident with her husband signaled that "Our original relationship had changed…. It changed the dynamics of our life." This was both discerning and predictive: it is a statement that acknowledges one's perception of reality is always in flux, it is never static. Consistent with symbolic interactionism, it also underscores the necessity for the individual to assume a proactive mentality in adapting to his or her environment.

P5's comparison of her dog's death to that of losing a child as an emotional event was interesting. While she cried because she had lost a beloved, long-time pet, she said it wasn't the "hard core" crying that she experienced when she felt personally attacked. This begs the question as to why one cries (hard core) because of certain events or experiences but not because of other events or experiences. This might be a difficult question to research. I think most people would consider the loss of a child or beloved pet an emotional event to evoke hard core crying. (Ex post facto note: In fact, P8 did experience what P5 would call hard core crying when she lost her pet.)

As with P1-P4, P5 noted that one of the reasons she went off to cry by herself was that she didn't want to hurt or cause consternation for the individual who had precipitated the crying event. Taking into consideration data from other interviews, this action seems to be based on a combination of caring and compassion, an effort not to exacerbate the problem, and a desire not

to change the focus from the problem to the crying itself. When talking about crying in front of people with whom a close personal relationship did not exist, all participants thus far have expressed a fear of being perceived as weak or vulnerable.

Appendix E

Example Data Tabulations and Model Outline

A GT Inquiry into Crying in Women Dealing with the Emotional Stress of Personal Crisis

Memo 4 Axial Coding: Properties and Dimensions of Categories and Subcategories

Axial Coding: Properties and Dimensions of Categories and Sub-Categories
March 17, 2016
P1

All categories and sub-categories are provisional.

Category	***Sub-category***	***Property***	***Dimensional Range***	***Participant Dimension (P1)***
Getting Back to Life (in vivo)				
Personal Crisis that Preceded Crying	Loss of Family Member	Relationship	Mother, father, spouse, sibling, etc.	Father
		Closeness of relationship	Not close – Very close	Very close
		Timing of Event	Expected – Sudden, Unexpected	Pretty quick when it happened, very shocking, very difficult
Reaction to Loss	Grieving Process	Guilt	None – Extreme	None. She was there if he needed anything and had done as much as she possibly could for him prior to his death. She had been functioning in a quasi-caretaker role.
		Feeling Sorry for Self	Not at all – Very Much	Some, but mostly feeling sad about dad's passing and missing him. He's not there. Doesn't want to feel sorry for self.
		Interference w/ADL	None – Extreme	Substantial (Didn't even take shower, couldn't sleep, things were pretty muddled at first)
		Physical Manifestations other than Crying	Specify	Pacing while crying

The Stress/Crying Process	Progress of Crying and Attenuation of Emotion	Mental Triggers	Memory, start feeling emotional	Cry or tear up when thinking about father or doing things that reminded her of him. Things that bring up sad memories, things that move her.
		Physical Precursors	Specify	Lump in throat when younger; eyes well up when confronted with something sad;
		Physical Aspects of Crying	Duration of Specific Events	10 minute splurges
			Time Period Over Which Crying Occurred	From father's death until week after funeral. Still cries when visiting gravesite.
			Type	Bawling, whole body experience
			Vocalization	Loud (described what could be classified as sobbing: lose my breath, sucks in breath, breathing more difficult)
			Frequency	Couldn't stop crying at first with maybe minutes or hours between events; gradually decreasing until essentially stopping a week or so after funeral
		Social context	Alone – with someone	Crying alone, doesn't have to be with someone, Ok to cry with mother and sisters. Didn't like to cry in church
		Influences of Age	Younger - Older	Propensity for crying has lessened as she got older
		Familial Propensity	No – Yes	Indicated sisters controlled propensity for crying with drugs
	Effects of Crying	Relieve Anxiety	Not at all - Completely	Feel better when it's over, clean, refreshed (although wasn't so refreshing when it was new). Crying is almost like cleansing, cathartic… getting through it.
		Response to Anxiety	Specify	Views crying (along with pacing) as anxiety working its way through her. Seems to help getting the anxiety out.
	Stress of Crying	Social/Cultural/ Familial Prohibitions	Specify	Feels crying is a sign of weakness and inability to control her emotions, other people in church not crying

				when she was, doesn't remember being told not to cry as a child. Still, the attitude in her family was stop feeling sorry for yourself and get back to life.
		Personal Feelings About	Specify	Not normal. Hates crying, wonders why am I crying when no one else is? Still, crying is good as long as you can keep it from taking over your life.
Controlling Crying	Using Medication			Sisters on medication (anti-depressants?) and that helps them control crying
	Desire to Control	Fear of Losing Control	Specify	Couldn't help it. Prayed not to cry so much when younger. Wanted to be able to control it. Identifies herself as a little bit of a controlling person—likes to control things in her life to some extent. Equates going through it to process. Doesn't want to feel sorry for self, that's a reason she wants to control her crying.
Understanding the Reasons for Crying	Crying as Part of Self	Forgiving Self	Specify	Maybe not crying would take away from who she is (inherent in her being). Forgives herself for still crying when thinking about father's death.
	Crying as Reality			Taking a deep breath seems to cleanse and bring her back to reality. Her reality is being able to control crying, because the process is beneficial as long as it doesn't get out of control.
	Self Perception			The oldest child, gotta be a big girl and get back to work, has always been in charge. Sees herself as pretty good at nursing because she's kind of intuitive and can be empathetic.

Memo 15A Theoretical: First Provisional Model

Theoretical – First Provisional Model
March 28, 2016

Analyses of the first three of these interviews, as well as a comprehensive familiarity with the data from all nine of the interviews thus completed, suggests the following provisional model. This model still needs a good deal of refinement. The provisional categories and concepts are evolving and don't quite have "the grab" that Glaser advocated.

The Precipitating Crisis

Specific Crises

The Tipping Point

Mounting Stress
Emotional Aspects
Physical Aspects
Social Aspects
Losing Control

Muffling the Interference

Crying as Distraction
Crying as Communication
Crying as Transition
Crying as Illumination

Adjusting to the New Reality

Regaining Emotional Control
Perceiving the New Reality
Recognition of the Need to Adjust and Adapt

Getting Back to Life (in vivo)

The New Self
Moving On
Taking Action (or not)

Memo 29 Theoretical: GT Model 3, Outline Form

Theoretical – GT Model 3, Outline Form
December 14, 2016

Categories are provisional. All **major categories** are in vivo. Subcategories subject to revision to make them more illustrative of the concepts embodied.

The Past **Present Reality**

- Filling the Cup
  - Everyday stressors
  - Added stressors

Heaping More on My Already Full Plate

- Family Crisis
  - Loss of family member
  - Illness of family member
  - Threat to family cohesiveness
  - Loss of Pet
- Extra-family Crisis
  - Loss of friend

Tipping Over the Full Cup

- Emotional Meltdown
  - Spontaneous crying
- Inability to Control Emotions

Feeling Emotionally Stronger

- Relieving Tension
- Attenuation of Crying and Emotion

Getting a Handle on Things

Letting Go

Regaining emotional control

Accepting and Adapting

The new status quo

Getting Back to Life (core category)

Resetting

Reorganizing and Renewing Emotional Control

The New Reality

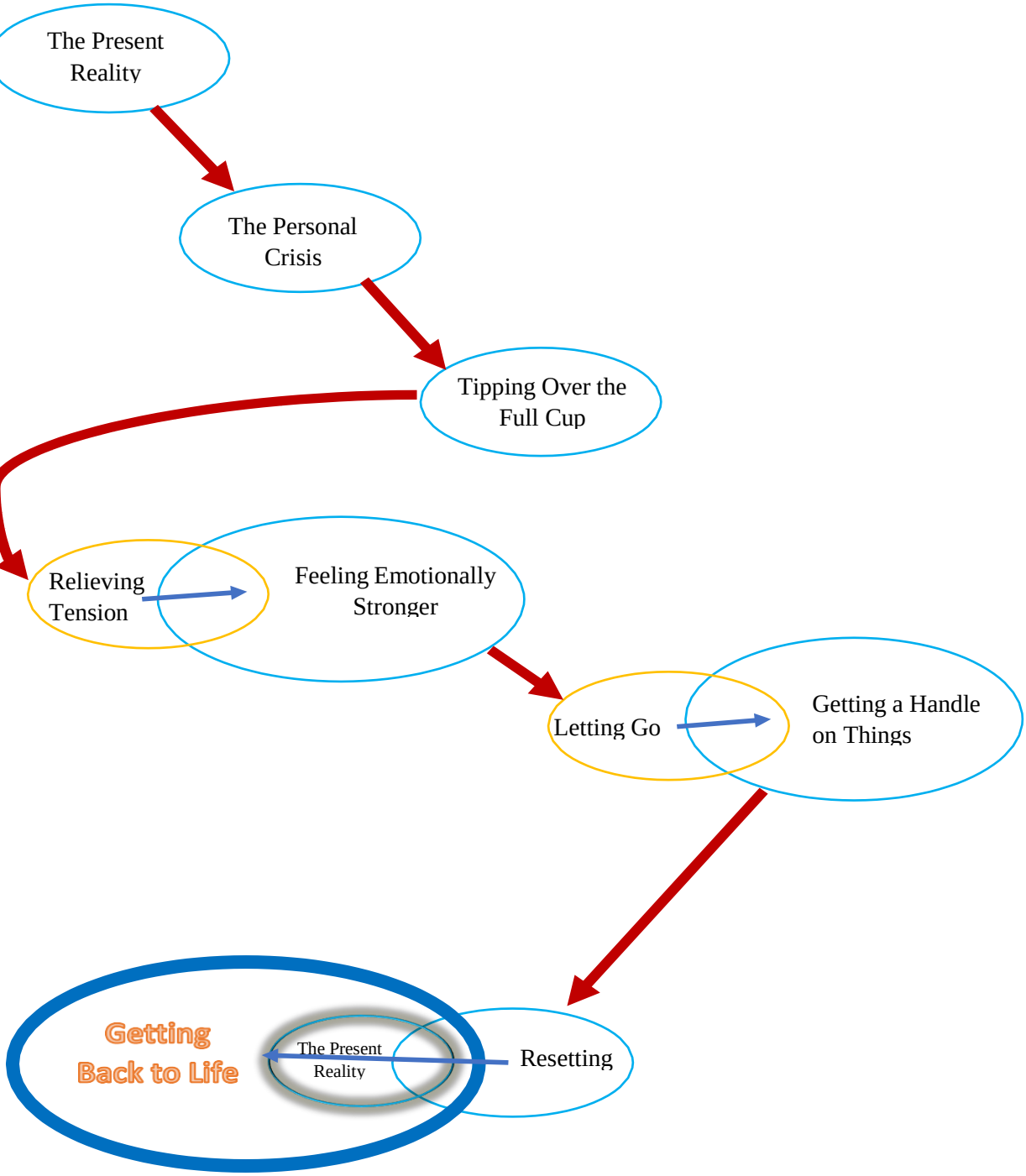
Preservation of Self

Appendix F

Model Diagram Examples

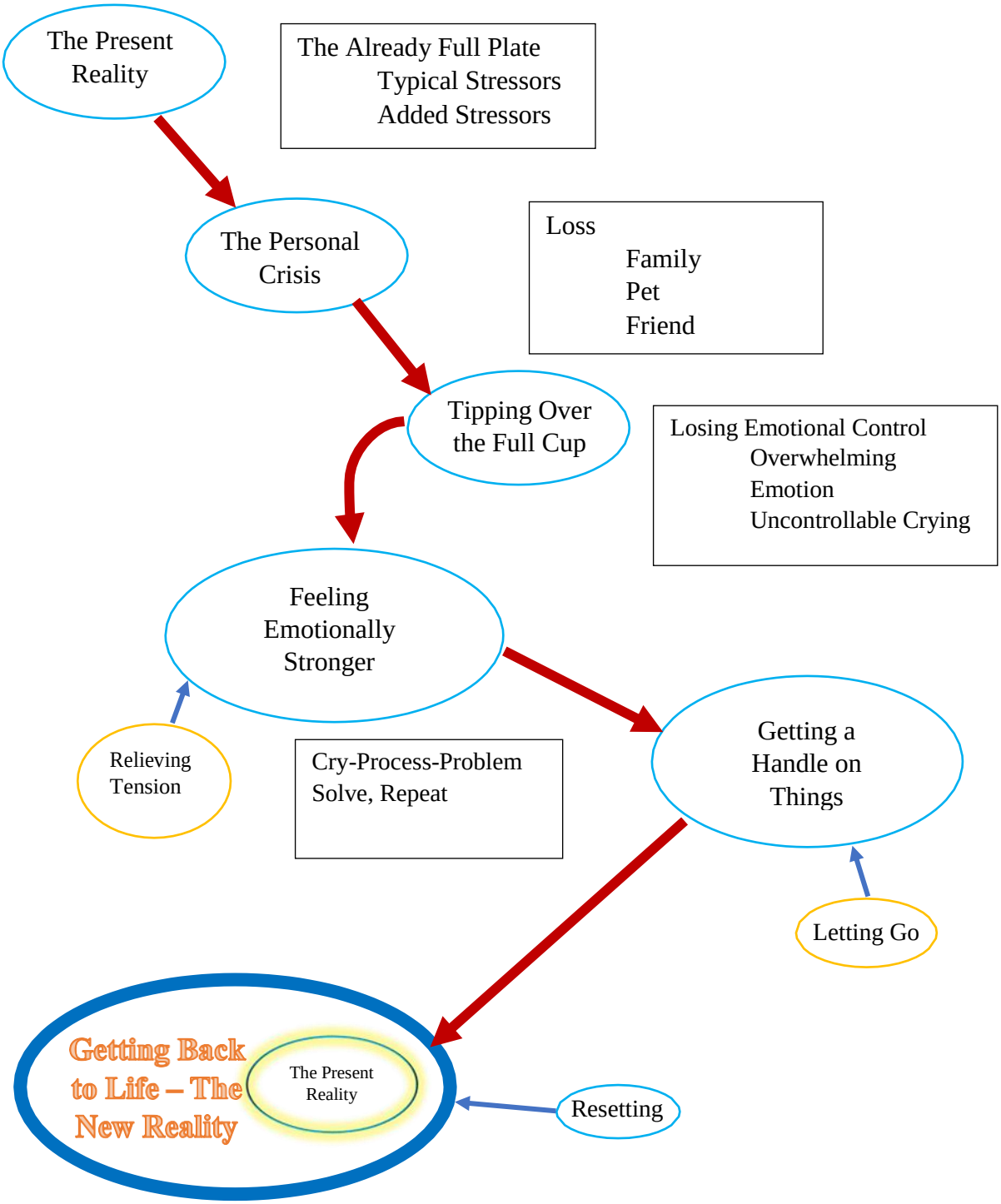
Memo 27 Theoretical: Provisional GT Model 1

Theoretical – Provisional GT Model 1, December 9, 2016



Memo 28: Theoretical: Provisional GT Model 2

Theoretical – Provisional GT Model 2, December 14, 2016



VITA

Mary Bess Griffith was born in Union City, Tennessee, on August 7, 1955. She graduated from Obion County Central High School in May 1973. In August 1973, she entered the University of Tennessee at Martin and transferred into the University of Tennessee Center for Health Sciences (UTCHS) in August 1974. She graduated from UTCHS in June 1977 with a Bachelor of Science degree in Nursing. Ms. Griffith was licensed as a Registered Nurse in August 1977. In August 1982, she re-entered UTCHS to pursue a Master of Science in Nursing, which she received in May 1985. While enrolled in graduate studies at UTCHS, she was inducted into the Sigma Theta Tau Nursing Honor Society and received the Faculty Award for Highest Scholastic Average. In May 1995, Ms. Griffith completed the Family Nurse Practitioner (FNP) curriculum at UTCHS and was licensed as an FNP the following month. In May 2009, she enrolled in the University of Tennessee, Knoxville, and received a Doctor of Philosophy in Nursing degree in August 2017.