Psychotherapy
2017, Vol. 54, No. 2, 159–166

0033-3204/17/$12.00 http://dx.doi.org/10.1037/pst0000110

BRIEF REPORT

Patients' Crying Experiences in Psychotherapy: Relationship With the Patient Level of Personality Organization, Clinician Approach, and Therapeutic Alliance

Pietro Zingaretti, Federica Genova, Francesco Gazzillo, and Vittorio Lingiardi
Sapienza University of Rome

The present study sought to further understand patients' crying experiences in psychotherapy. We asked 64 clinicians to randomly request one patient in their practice to complete a survey concerning crying in psychotherapy as well as a measure of therapeutic alliance. All clinicians provided information regarding their practice and patient diagnostic information. Fifty-five (85.93%) patients cried at least once, and 18 (28.1%) had cried during their most recent session. Patients' frequency of crying episodes in therapy was negatively related with psychotic level of personality organization, while patients' tendency to feel more negative feelings after crying was positively related to lower levels of personality organization. Patients' feeling more in control after crying was positively related with an interpersonal therapeutic approach, while patients' perception of therapists as more supportive after crying was positively related to a psychodynamic approach. Patients' tendency to experience more negative feelings after crying was significantly related with both lower levels of personality organization and patients' perception of the therapeutic alliance as weak. In regard to their most recent crying event in treatment, therapeutic alliance was related to gaining a new understanding of experience not previously recognized by the patient. Further, patients' experiences of having never told anyone about their experience related to a crying episode, as well as their realization of new ideas and feeling of having communicated something that words could not express was positively related to the goal dimension of alliance. Patients' perception of crying as a moment of genuine vulnerability, greater feelings of self-confidence and self-disclosure as well as having had a therapist response that was compassionate and supportive, was positively related with the bond dimension of alliance. Clinical implications and future research directions regarding patient crying experiences in psychotherapy are discussed.

Keywords: crying, affect expression, therapeutic alliance, personality

In psychotherapy, the expression of feelings may play a key role in helping patients to process their emotional experience (Horowitz, 1986; Kennedy-Moore, & Watson, 1999), leading to some kind of resolution involving the source of significance distress (Stanton, Danoff-Burg, Cameron, & Ellis, 1994; Stanton et al., 2000). Empirical data have shown that actively expressing painful feelings provides an opportunity for individuals to understand their distress as painful but not unbearable, learning to tolerate these feelings (Greenberg, & Safran, 1987; Greenberg, Wortman, & Stone, 1996; King, & Emmons, 1990) and increasing the sense of personal control (Major & Gramzow, 1999; Lepore, & Helgeson, 1998; Lepore, Ragan, & Jones, 2000). Moreover, articulating their feelings can help people understand them with greater clarity and provides the opportunity to explore the causes and implications of those feelings (Pennebaker, 1993a, 1993b; Pennebaker & Francis, 1996; Pennebaker, Mayne, & Francis, 1997).

Crying represents a ubiquitous and compelling form of emotional expression (Vingerhoets, Cornelius, van Heck, & Becht, 2000), which may lead to a resolution of emotional conflicts, reducing tension and negative feelings (Frey, 1985; Efran, & Spangler, 1979). Empirical data seem to support these hypotheses, suggesting that up to 94% of people characterize crying as beneficial (Cornelius, 1986). Vingerhoets (2013) reported that >70% of individuals from 37 countries felt that crying improved the way they felt. In another study, 88.8% of participants reported at least some mood improvement after crying (Rottenberg, Bylsma, Wolvin, & Vingerhoets, 2008). Other studies have found that some personality traits influence the way people feel after crying. In particular, extroversion has been found to predict more positive feelings following crying, while high scores of dutifulness have been shown to predict

Pietro Zingaretti, Department of Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome; Federica Genova, Francesco Gazzillo, and Vittorio Lingiardi, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome.

The authors thank all the clinicians who contributed their data to this research.

Correspondence concerning this article should be addressed to Pietro Zingaretti, Department of Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Via dei Marsi 78, 00185 Rome (Italy). E-mail: pietro.zingaretti@uniroma1.it

more negative feelings. Further, female gender, neuroticism, and anxiety have been found to correlate with use of weeping as a coping mechanism. But no significant relationship has been found between personality characteristics and mood improvement following crying (De Fruyt, 1997; Rottenberg et al., 2008). In summary, crying seems to be an adaptive capacity that allows people to express feelings that are otherwise difficult to express through words (Barbalet, 2005; Vingerhoets, 2013).

However, the lack of systematic investigation of crying in the psychotherapeutic setting is surprising. It would be valuable for clinicians to know whether similar findings are consistent within the therapeutic context and among clinical populations. The small amount of empirical data about crying in psychotherapy demonstrates that patients cry in approximately 14% to 21% of therapy sessions (Robinson, Hill, & Kivlighan, 2015; Trezza, Hastrup, & Kim, 1988), suggesting that crying is frequent and relevant in this context. Additionally, individuals with lower global functioning, greater emotional dysregulation, and borderline personality disorder symptoms have been found to cry more frequently (Capps, Fiori, Mullin, & Hilsenroth, 2015), but no significant correlation has been found between Axis I or II diagnoses and crying in therapy to date (ibid.).

Moreover, crying can be viewed as one index of client involvement in the psychotherapy process, and a patient's ability to cry may be seen as an indicator of a healing process (i.e., Cornelius, 1986; Frey, 1985; Efran, & Spangler, 1979; Rottenberg, Bylsma, Wolvin, & Vingerhoets, 2008; Vingerhoets, 2013), especially when a crying episode is followed by an integration of relevant emotions or a deepened understanding of self or others. However, only a few studies have examined the relationship between patients' crying behavior and the therapeutic process. A recent study by Robinson et al. (2015) found that crying was a way for patients—at least in part—to communicate to their therapist their attachment needs; but therapist effects were actually found to be stronger than client effects in this study, which suggests that crying may not have universal meaning but might vary according to participants' attachment styles and attachment with their therapist. Capps et al. (2015) reported that crying behavior had a negative impact on patient's experience of the session (i.e., is experienced as painful), but yet the quality of the therapeutic alliance remained unaffected. That is, alliance may remain strong despite patients experiencing a session in which they cried as difficult. Furthermore, therapeutic interventions that focused on affect, gaining a new understanding of old patterns, and exploring patient fantasies appeared to be associated with crying in session. These data seem to support prior clinical and empirical work showing that difficult emotional sessions are not necessarily detrimental to a productive treatment relationship (Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011).

The aim of the present study was to replicate and extend prior work investigating patient crying in psychotherapy, and to fill significant gaps in the current literature. To do so, we first sought to examine the association between patients' personality organization and their crying experience in therapy. Second, we explored the association between therapists' clinical approach and patients' crying experience in therapy. Third, we investigated any association between patients' crying experience and their perceptions of the therapeutic alliance.

Method

Participants

Of the 64 patients, 45 (70.3%) were female and 19 (29.7%) were male. Their average age was 33.7 years (SD = 9.6, ranging from 18 to 52), and their ethnicity was Caucasian.

On average, the patients had been in treatment for about a year (M = 12.4 months, SD = 7.3, range 3–24 months).

Clinicians

The sample included 64 clinicians, all of whom were psychologists; 34 were female and 30 were male. Their average age was 40.55 years (SD = 8.6, ranging from 27 to 59). Twenty had 1 to 5 years of clinical licensed experience, 15 had 6 to 10 years of experience, and 29 had more than 11 years of experience. On average, each clinician treated 11 patients per week (ranging from 1 to 30 patients). Forty-eight clinicians (75%) had a dynamic theoretical orientation, three (4.7%) had a cognitive–behavioral orientation, three (4.7%) had a humanistic orientation, two (3.1%) had an interpersonal orientation, and eight (12.5%) had an orientation they classified as "other." All the clinicians worked in independent practice settings, where they met with these patients once or twice per week.

Measures

Clinician Form. We constructed an ad hoc questionnaire for clinicians to provide general information about themselves, their patient, and their clinical approach. Clinicians provided basic demographic and professional data relating to their discipline, years of licensed experience, number of patients in treatment, and prevalent theoretical orientation (psychodynamic, cognitive–behavioral, interpersonal, humanistic, systemic, or other). Clinicians also provided data on a range of techniques they used in their clinical work on a 5-point Likert scale ranging from 1 (*never*) to 5 (*almost always*). In this study, clinicians used mainly a psychodynamic approach (M = 4.19, SD = 1.32) followed by interpersonal (M = 2.47, SD = 1.23), systemic (M = 2.31, SD = 1.25), cognitive–behavioral (M = 2.00, SD = 1.13), and humanistic (M = 1.84, SD = 1.14). Finally, clinicians were asked to assess the degree of similarity between the patient's profile of personality organization and three prototypical descriptions of psychotic, borderline, and neurotic levels of personality organization (see Table 1) on a 5-point Likert scale ranging from 0 (*no match*) to 4 (*prototypical match*). These prototypical descriptions were derived from the Psychodynamic Diagnostic Chart (PDC)—a quick practitioner rating form that integrates the *International Classification of Diseases (ICD)* with the *Diagnostic and Statistical Manual of mental disorders (DSM)* or *DSM*. The personality organization scale of the PDC shows good 2-week retest reliability (0.92) and good convergent validity (Gordon & Stoffey, 2014).

Crying in Therapy Survey. Patients were asked to complete the Crying in Therapy Survey (Hilsenroth, 2015). This survey consists of three sections. The first one includes general demographic questions pertaining to gender, occupation, education, ethnicity, and household income. The second contains questions about crying in general life, and derives questions from the Adult

Table 1
Descriptions of Patients' Levels of Personality Organization

Psychotic Level
(A person characterized by a low overall functioning, with extreme difficulties in family, relationships, and work environment. He has poor reality testing, little structure of identity, and the tendency to use a low level of defenses and coping mechanisms [such as, for example, delusional projection, denial etc.]. Often, these individuals have too little or too accelerated communication style, making underlie a deficient functioning of thinking. Sometimes, the speech is disorganized or otherwise hard to follow. They may or may not have a personality disorder but their behavior and the way of thinking subtending a functioning with prospective dysfunctional personality traits typical of this level).
Borderline Level
(A person characterized by a general problematic functioning, recurrent relationship problems, difficulty with tolerance and regulation affect, and poor impulse control. These individuals can show, often but not always, signs of dependence [relational, gambling, substances, etc.]. They usually use a low level of defenses and coping mechanisms [such as, for example, splitting, projective identification, devaluation/idealization, acting]. They may or may not have a personality disorder but their behavior and the way of thinking subtending a functioning with prospective dysfunctional personality traits typical of this level).
Neurotic Level
(A person characterized by a good general functioning but that usually use rigidity and limited range of defenses and coping mechanisms. He shows good reality testing, good tolerance, and regulation affect even stress factors may make in difficulty. He can have family, relationships and work problems but they are not serious and not so much as to implicate her present lifestyle. They may or may not have a personality disorder but their behavior and the way of thinking subtending a functioning with prospective dysfunctional personality traits typical of this level).

Note. Clinicians assessed the degree of similarity between the patient's profile of personality organization and these three prototypical descriptions of levels of personality organization on a 5-point Likert scale ranging from 0 (*no match*) to 4 (*prototypical match*).

Crying Inventory—Short Form (Vingerhoets, 2001)—a validated measure that describes the frequency, proneness, and influence on mood of crying behavior. The third section, which specifically focuses on crying during therapy sessions, was developed on the basis of items from two prior surveys of therapists' crying behavior during psychotherapy (Blume-Marcovici, Stolberg, & Khademi, 2013; Tritt, Kelly, & Waller, 2015). It is composed of 21 items: 9 items explore the frequency of crying episodes in therapy within different time periods (from the last session, last 4 weeks, over the last year, etc.), the influence of crying on mood both in general and after the most recent episode of crying (on the basis of increasing [1], unchanged [0], decreasing [−1] intensity of emotions, such as being relaxed, tense, in control, depressed, sad, happy, and relieved, felt after crying as compared with just before), the effect of a crying episode on the therapeutic relationship (i.e., the perception of its changing for better [1], unchanged [0], or worse [−1]), as well as the feelings and emotions felt during the most recent episode of crying in therapy (assessed on the presence [1] or absence [0] of a list of 22 emotions such as fear, humiliation, dismay, warmth, and so forth); and 12 items describe different aspects of crying experiences. Patients were asked to assess their degree of agreement to these items on a 7-point Likert scale ranging from *Strongly Disagree* (−3) to *Strongly Agree* (3). Example items included: "Crying was a moment of genuine vulnerability for me" and "My therapist responded with compassion and support."

Working Alliance Inventory–Short Form–Patient. The Working Alliance Inventory–Short Form–Patient (WAI-SF-P; Hatcher & Gillaspy, 2006) is a 12-item adaptation of the original 36-item instrument (Horvath & Greenberg, 1989). Patients rate each item on a 7-point Likert scale. The items comprise three subscales, representing the three components of the therapeutic alliance: Bond ("My therapist and I trust one another"), Goal ("My therapist and I are working towards mutually agreed upon goals"), and Task ("I believe the way we are working with my problem is correct"). The three subscale scores are summed to create a total score (ranging from 12 to 84) that represents a global measure of the strength of the alliance.

Procedure

We contacted psychotherapists through a clinical independent practice network. All the clinicians were members of the Dynamic and Clinical Section of the Italian Psychology Association (AIP). To minimize selection biases, we asked each therapist to select the last patient they had seen during the previous week who met the following inclusion/exclusion criteria: at least 18 years old; no psychotic disorder or syndrome with psychotic symptoms; no organic pathologies or brain damage; not undergoing any psychopharmacology treatment for a psychotic disorder or addiction. Moreover, the patient had to be in treatment for at least four sessions and a maximum of 24 months, at a frequency of once or twice per week.

To minimize therapist effects in our data, we asked each clinician to involve only one patient in the study. Our clinicians were asked to complete the Clinician Form, taking into account the patient's clinical profile at the time of this assessment. Both clinicians and patients were informed that the study aimed at investigating the expression of emotions in psychotherapy and how this expression relates to different aspects of the treatment process. None received any compensation for participation. Patients were also informed that their responses would be completely confidential and not available to their therapists. The study was approved by the ethics committee of the Sapienza University of Rome.

Data Analyses

All analyses were conducted with SPSS 22 for Windows (IBM). To study the relationships between patients' crying experience and their level of personality organization, their therapists' theoretical and clinical approach, and the therapeutic alliance, we performed a series of bivariate correlations (Pearson's r, two-tailed) with an inclusion significance level set to $p < .05$. According to Cohen (1988), correlation coefficients of approximately .10 are "small," those of approximately .30 are "medium," and those of approximately .50 are "large."

Results

Crying in Therapy

Of all patients, 9 (14.06%) reported that they had never cried in therapy, while 55 (85.93%) reported crying during treatment at least once. It should be noted that the following analyses are based on 55 patients of the total sample ($N = 64$), those who had cried at least once during therapy. On average, patients reported 1.5 crying episodes over the prior month ($SD = 1.3$, ranging from 0 to 6) and 12.7 over the prior year ($SD = 22.9$, ranging from 0 to 150). Their mean general tendency to cry in therapy was 4.98 ($SD = 2.98$, ranging from 1 [*I have never cried in therapy*] to 10 [*I cry often in therapy*]). Thirty (45%) patients had experienced their most recent crying episode in the previous week and 40 (62.5%) had experienced this during the prior month. The prevalent negative emotions reported after the most recent episode of crying were sadness for 36 patients (56.3%), dismay for 19 (29.7%), and powerlessness for 18 (28.1%). The main positive feelings were relief for 37 patients (57.8%), a sensation of being emotionally touched for 24 (37.5%), and gratitude for 18 (28.1%). These percentages total more than 100% because patients were allowed to select more than one emotion from a list of 22. Finally, 44 (68.8%) patients talked about their crying with their therapist, 32 (50%) thought that crying in session improved their relationship with their therapist, 21 (32.8%) did not perceive any difference in the relationship, and 2 (3.1%) thought that crying in session worsened this relationship.

Crying Experience and Clinicians' Technical Approach

Data showed some associations between clinicians' tendency to use different clinical approaches and techniques with some aspects of patients' crying experiences. Specifically, there was a positive and significant correlation between therapists' tendency to use an interpersonal approach and patients' sensation of being more in control ($M = .20$, $SD = .704$) after their most recent experience of crying in therapy ($r = .287$, $p = .034$). Findings also showed a positive and significant correlation between a psychodynamic approach and patients' perception that the therapist was supportive ($M = 2.18$, $SD = 1.107$) during their most recent experience of crying in therapy ($r = .341$, $p = .011$).

Crying Experience and Level of Personality Organization

We calculated the frequency of the different levels of personality organization taking into account the categorical diagnosis of personality organization, that is a score ≥3 on one or more levels of personality organization. It is worth specifying that in nine of our cases, the patients received a score ≥3 both on the neurotic and the borderline levels of personality organization; in such cases, we considered the patients having a higher, less severe, level of borderline personality organization.

Clinicians classified 33 (51.6%) patients at the neurotic level of personality organization and 29 at (31.2%) the borderline level of personality organization. Again, of which 9 (14.1%) were at the higher, less severe, level of borderline personality organization. Finally, two patients did not receive any personality organization diagnosis. Overall, the dimensional rating, 0 (*no match*) to 4 (*prototypical match*), mean and *SD* scores of the neurotic level of personality organization was 2.80 ($SD = 1.36$), of the borderline level was 1.91 ($SD = 1.46$), and of the psychotic level was 0.23 ($SD = 0.53$), taking into account that their level of personality organization match ratings. These results are consistent with those in a previous study conducted by Gazzillo et al. (2014) on 600 patients from the United States and Italy in which the neurotic and the borderline levels of personality organization were the more prevalent.

We found a positive and significant correlation between the borderline level of personality organization with tension ($M = -.55$, $SD = .633$, $r = .267$, $p = .048$) and depression ($M = -.44$, $SD = .660$, $r = .297$, $p = .028$), as well as between the psychotic level of personality organization with the feeling of being uncomfortable with tears ($M = -.55$, $SD = 2.035$, $r = .522$, $p < .001$) after the most recent episode of crying in therapy. Moreover, a negative significant correlation emerged between the dimensional rating of psychotic level of personality organization with both patients' happiness ($M = .11$, $SD = .629$) after their most recent crying episode in therapy ($r = –.314$, $p = .020$) and the frequency of crying episodes over the past month ($r = –.268$, $p = .048$).

Crying Experience and Working Alliance

General crying experiences in psychotherapy and working alliance. Our data showed a significant, negative, correlation between the patients' general overall tendency to feel more tense ($M = -.55$, $SD = .633$) after crying in therapy and Bond WAI dimension ($M = 22.31$, $SD = 5.947$, $r = –.307$, $p = .023$) as well as between the patients' overall tendency to feel more depressed ($M = -.40$, $SD = .627$) after crying and the Goal WAI dimension ($M = 23.50$, $SD = 5.989$, $r = –.290$, $p = 032$). In addition, the findings showed negative trends toward significance between the patients' overall tendency to feel more depressed after crying and the overall quality of the therapeutic relationship ($M = 68.06$, $SD = 17.353$, $r = –.259$, $p = .056$) as well as the Bond WAI dimension ($r = –.232$, $p = .088$).

Most recent crying episode experiences in psychotherapy and working alliance. We observed a positive and significant correlation between the patients' belief that crying made them realize new things they had been previously unaware of ($M = .62$, $SD = 1.581$) and the overall quality of the therapeutic relationship ($r = .304$, $p = .024$). Noteworthy, we found a positive trend toward significance ($.052 < p < .090$; see Table 2) between four items and the overall quality of the therapeutic relationship.

Furthermore, data from this study showed a significant, negative, correlation between the patients' sensation of being more tense after their most recent episode of crying and the Bond alliance dimension ($r = –.272$, $p = .044$), but a positive and significant correlation between the Bond dimension of alliance and the patients' perception of the crying episode as a moment of genuine vulnerability ($M = 1.45$, $SD = 1.288$, $r = .271$, $p = .045$), their feeling of being prepared to handle the crying moment ($M = -1.24$, $SD = 1.699$, $r = .325$, $p = .016$), their lack of previous disclosure about experiences related to crying ($M = -.27$, $SD = 2.095$, $r = .282$, $p = .037$), and their perception

Table 2
Pearson Correlations Between WAI Scales and Crying in Therapy Survey (n = 55)

Crying in Therapy Survey Questions	WAI Scales							
	Total		Bond		Goal		Task	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
How do you **generally** feel **after** a crying episode **during a psychotherapy session** as compared with just before?								
Tense	−.22	.103	−.31	.023	−.12	.375	−.12	.380
Depressed	−.26	.056	−.23	.088	−.29	.032	−.14	.299
How did you feel after your **most recent experience of crying in therapy**								
Tense	−.24	.082	−.27	.044	−.13	.336	−.17	.203
Crying was a moment of genuine vulnerability for me	.08	.558	.27	.045	.11	.435	−.15	.288
I was prepared for how to handle crying in therapy	.23	.090	.32	.016	.12	.366	.12	.380
I had never told anyone about the experiences related to my crying	.24	.077	.28	.037	.32	.016	.03	.819
My therapist responded with compassion and support	.20	.145	.34	.012	.17	.224	.09	.952
Crying made me realize things I felt that I had not realized before	.30	.024	.24	.078	.41	.002	.14	.305
My tears communicated something that words could not have expressed	.26	.052	.21	.128	.32	.015	.15	.283

Note. WAI = Working Alliance Inventory.

of their therapist's response to their tears as supportive ($r = .338$, $p = .012$). Noteworthy is also the positive trend between Bond alliance dimension and the patients' sensation that crying made them realize new things they had been previously unaware ($r = .239$, $p = .078$).

Finally, the same positive and significant correlations were found between the Goal dimension of WAI and patients' experiences of having never told anyone about their experience of crying ($r = .325$, $p = .016$), their realization of new ideas ($r = .414$, $p = .002$), and their feeling of having communicated something that words could not express ($M = -1.22$, $SD = 1.696$, $r = .325$, $p = .015$).

Since our results showed a significant, positive, correlation between patients' feeling that their therapist responded with compassion and support to their tears with both a psychodynamic technical approach of the therapist ($r = .341$; $p = .011$) and the Bond dimension ($r = .338$, $p = .012$), we sought to investigate these findings further. That is, to determine whether the correlation between patients' feeling that their therapist responded with support and the Bond dimension would remain significant when the therapist's psychodynamic technical approach was controlled for, we performed a partial correlation. Results showed that this correlation remained positive and significant ($r = .403$, $p = .003$).

Likewise, we also explored the association between the patients' perception of therapists as supportive and the therapist's psychodynamic technical approach controlling for the effect of Bond alliance dimension. Consistent with the previous findings, we found that the correlation remained positive and significant ($r = .405$, $p = .002$).

Discussion

The results of this study suggest that most patients cry during the course of treatment, and crying episodes are relatively frequent in therapy, with patients crying approximately once a month. In fact, regardless of the patient's level of personality organization and the clinician's theoretical approach, 30 (45%) of our patients had experienced their most recent episode of crying in the previous week and 40 (62.5%) in the prior month. These results are in line with those of previous studies, which have found that patients cry in approximately 14% to 21% of therapy sessions (Robinson et al., 2015; Trezza et al., 1988). These results confirm that patient crying experiences in therapy are a widespread phenomenon that is worth investigating. Moreover, the majority of our patients (68.8%) talked about their crying with their therapist and half thought that crying changed their relationship with their therapist in a positive manner; this suggests that crying is a significant event in therapy and may have a relationship to various aspects of the treatment process, such as therapeutic alliance.

With respect to patients' level of personality organization, the results of the present study were that a higher level of match between patient personality and the prototypical description of a psychotic level of personality organization was related to a lower frequency of crying in psychotherapy. These findings are consistent with those of other studies (Vingerhoets, 2013; Vingerhoets, Van Tilburg, Boelhouwer, & van Heck, 2001), which have found patients with higher neuroticism, as opposed to the more severe psychoticism, to cry relatively more than others. Further studies are necessary to understand the nature of the relationship between the patients' level of personality organization and crying behavior in therapy. Moreover, our data point out that patients with lower levels of personality organization (borderline and psychotic) tend to feel more negative emotions after crying, suggesting that the degree of impairment of patients' level of personality organization may have an impact on their experience of crying as a useful therapeutic moment. Previous studies have reported that, in most cases (70%–94%), people feel at least some mood improvement after crying (Cornelius, 1986; Nelson, 2000; Rottenberg et al., 2008; Trezza et al., 1988; Vingerhoets, 2013). In addition, findings in the present study are consistent with literature that stresses the relevance of emotional dysregulation and borderline level of personality organization on patient crying experiences (Capps et al., 2015; Coifman, Berenson, Rafaeli, & Downey, 2012). Nonetheless, no casual direction can be assumed from these relationships and further research is required.

Data from this study also show that when the therapists used a more interpersonal approach, the patients felt more in control after

crying. With a focus on relationships in dealing with patients' stressful and difficult experiences may allow them to implement more adaptive behaviors to the experience of crying and perhaps helps the patient to better understand what is related to these feelings. In addition, the relationship between therapists' use of a psychodynamic approach and patients' perception of them as more supportive, may be consistent with psychodynamic interventions designed to help patients explore painful feelings, relational patterns, and fantasies associated with crying experience (i.e., Capps et al., 2015). These results may suggest that therapists' clinical approach influences both the quality of patients' crying experience and the degree to which patients perceive their therapist as supportive. It is worth noting that the clinicians' tendency to use different theoretical approaches, styles, or technique in their clinical work was assessed only with a clinician-report questionnaire. Thus, clinicians' assessment of technical interventions may be less accurate than scored by independent raters. Further research should use independent raters of clinicians' technique, such as Capps et al. (2015), to better understand whether our results emerged by therapists adapting their approach to suit each patient at different moments of psychotherapy or to therapists' individual difference. This need seems to be suggested by other studies (Robinson et al., 2015; Mallinckrodt, Gantt, & Coble, 1995; Lopez & Brennan, 2000) where clients cried more with some therapists than with others, suggesting that some therapists elicit more crying or are more receptive to crying than are others.

In regard to the relationship between general experiences of crying and the therapeutic alliance, findings from present work show that the more tense patients generally felt after crying, the less they perceived their therapeutic bond as good and that the more depressed they generally felt, as well as the less they felt they were working toward shared therapeutic goals with clinician. In general, these results suggest that when a crying experience is followed by an increase in negative feelings—in particular tension and depression—this could indicate a poor therapeutic alliance. However, several studies have revealed that difficult emotional sessions are not necessarily detrimental to a productive treatment relationship (Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011) and that alliance may remain strong despite the difficulty patients feel during a session in which they cried (Capps et al., 2015). Overall, these results suggest that crying experiences that were regularly followed by an increase of negative feelings and a poor quality of the therapeutic alliance need to be further examined. That is, was the therapeutic alliance already poor before the crying episodes, or because the therapists were not regularly able to help patients in processing the negative feelings related to crying episodes, contributing to a poor therapeutic alliance, or both.

Concerning the relationship between the most recent patients' crying episode experiences and working alliance, data from this study show that when the crying experience was followed by increased awareness and new realizations, patients felt the therapeutic relationship as good, overall. Also, when our patients experienced crying episodes as moments of genuine vulnerability, felt prepared to handle these moments, and felt their therapist was supportive, they perceived their therapeutic relationship to have higher levels of mutual trust and acceptance (Bond alliance dimension). Similarly, when patients declared that they had never told anyone but their therapists about their experiences related to their crying, they tended to feel greater trust with their therapist (Bond alliance dimension), as well as perceived that their therapists were able to understand their problems and that they were working together toward their therapeutic goals (Goal alliance dimension). Further, when patients declared that their tears enabled them to communicate something they could not express with words, they felt more strongly that they were working together with their therapist to solve treatment problems (Goal alliance dimension).

Regarding the quality of the crying experiences described by our patients, these results seem to support those of previous studies that suggest actively expressing painful feelings may provide an opportunity to learn to tolerate these feelings (Greenberg, & Safran, 1987; Greenberg, Wortman, & Stone, 1996; King, & Emmons, 1990), increase the sense of personal control (Major & Gramzow, 1999; Lepore, & Helgeson, 1998; Lepore, Ragan, & Jones, 2000), and to understand them with greater clarity, providing the opportunity to explore the cause and implications of those feelings (Pennebaker, 1993a, 1993b; Pennebaker & Francis, 1996; Pennebaker, Mayne, & Francis, 1997) that may be otherwise difficult to express through words (Barbalet, 2005; Vingerhoets, 2013). Data seem to support that, in psychotherapy, crying experiences, along with the expression of the feelings associated to these experiences, may be related—at least in part—to an understanding and resolution of emotional conflicts, reducing tension and negative feelings (Frey, 1985; Efran, & Spangler, 1979). Moreover, findings seem to suggest that crying experiences may be related to an integration of relevant emotions or a deepened understanding of self, when they happen in a context of a good therapeutic alliance. This hypothesis seems to be supported by the fact that, when the crying experiences were regularly followed by an increasing of negative feelings, the therapeutic relationship was perceived by patients as weak.

In summary, these results seem to support the premise that a crying experience might foster the therapeutic process if it is perceived by the patient as a moment of self-understanding, realization, and helps lead to integration of the experiences and feelings related to the crying episode. In fact, our data show that when patients experienced the crying episode as useful, they also perceived the therapeutic alliance as good. Conversely, when the crying experience was followed by more negative feelings, patients' perception of the therapeutic alliance quality was often poor. It is worth noting that only one study (Capps et al., 2015) has investigated the relationship between patient's crying behavior in therapy and its relation to the therapeutic alliance, as perceived by both the patient and the therapist. In this study, the therapeutic alliance did not vary according to the frequency of crying. Even patients who generally associated their crying with difficult moments perceived the therapeutic alliance as high. Thus, this study showed that patients' experience of crying in therapy is not, in itself, an index of a poor therapeutic alliance; rather, the quality of the crying experience and its perception as a moment of self-understanding and greater awareness seem to relate with a good therapeutic alliance. Overall, results seem to suggest that a crying experience that includes the expression of negative feelings relates to a good therapeutic alliance (as perceived by patient) only if the crying episode is accompanied by some elaboration and integration of the negative emotions communicated by the tears. How-

ever, we do not know if the therapeutic value of the crying experiences is facilitated by a good therapeutic alliance or if it is the usefulness of the crying experiences that deepens the therapeutic alliance.

The first limitation of this study is the small number of patient and therapist participants. Moreover, the clinicians were only psychologists, and most primarily psychodynamic in their theoretical orientation. Even if our findings are based on clinicians' ratings of different types of techniques in their clinical work despite their preferred theoretical orientation, they probably cannot be generalized to all clinicians from different specific orientations. Furthermore, in the present sample we did not have patients with a psychotic level of personality organization, so that level of personality organization, assessed dimensionally in all the patients, may not fully support findings with regard to psychotic level of functioning as adequately if more of these severe patients were included in this investigation. Finally, in this study the patients' level of personality organization and therapist technical focus were assessed by the clinicians only with a clinician-report questionnaire; so, we do not have external measures or independent ratings to verify the validity of these assessments. Future work should overcome these limitations. Moreover, we used a patient self-report to assess the therapeutic alliance, and did not explore the therapists' perceptions of the alliance. Despite these limitations, we believe that findings in this study improve our understanding of the experience of crying in psychotherapy—a topic that needs much more empirical investigation. In sum, patient reported crying experiences in therapy supports prior work in nonclinical populations that crying is a complex phenomenon that can elicit various responses, reactions and reveal individual differences (De Fruyt, 1997; Rottenberg et al., 2008; Vingerhoets et al., 2000).

References

Barbalet, J. (2005). Weeping and transformations of self. *Journal for the Theory of Social Behaviour, 35,* 125–141. http://dx.doi.org/10.1111/j.1468-5914.2005.00267.x

Blume-Marcovici, A. C., Stolberg, R. A., & Khademi, M. (2013). Do therapists cry in therapy? The role of experience and other factors in therapists' tears. *Psychotherapy, 50,* 224–234. http://dx.doi.org/10.1037/a0031384

Capps, K. L., Fiori, K., Mullin, A. S., & Hilsenroth, M. J. (2015). Patient crying in psychotherapy: Who cries and why? *Clinical Psychology and Psychotherapy, 22,* 208–220. http://dx.doi.org/10.1002/cpp.1879

Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). New Jersey, NJ: Erlbaum.

Coifman, K. G., Berenson, K. R., Rafaeli, E., & Downey, G. (2012). From negative to positive and back again: Polarized affective and relational experience in borderline personality disorder. *Journal of Abnormal Psychology, 121,* 668–679. http://dx.doi.org/10.1037/a0028502

Cornelius, R. R. (1986). *Prescience in the pre-scientific study of weeping? A history of weeping in the popular press from the mid-1800s to the present*. Paper presented at the 57th Annual Meeting of the Eastern Psychological Association, New York, NY.

De Fruyt, F. (1997). Gender and individual differences in adult crying. *Personality and Individual Differences, 22,* 937–940. http://dx.doi.org/10.1016/S0191-8869(96)00264-4

Efran, J. S., & Spangler, T. J. (1979). Why grown- ups cry: A two-factor theory and evidence from the miracle worker. *Motivation and Emotion, 3,* 63–72. http://dx.doi.org/10.1007/BF00994161

Frey, W. H. (1985). *Crying: The mystery of tears*. Minneapolis, MN: Winston Press.

Gazzillo, F., Gordon, R. M., Lingiardi, V., Del Corno, F., Bornstein, R. F., & McWilliams, N. (2014, January). *Empirical research with Psychodynamic Diagnostic Prototype (PDP) and the Psychodiagnostic Chart (PDC): Towards PDM-2*. Paper presented at the national meeting of the American Psychoanalytic Association, New York, NY.

Gordon, R. M., & Stoffey, R. W. (2014). Operationalizing the psychodynamic diagnostic manual: A preliminary study of the psychodiagnostic chart. *Bulletin of the Menninger Clinic, 78,* 1–15. http://dx.doi.org/10.1521/bumc.2014.78.1.1

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy*. New York, NY: Guilford Press.

Greenberg, M. A., Wortman, C. B., & Stone, A. A. (1996). Emotional expression and physical health: Revising traumatic memories or fostering self-regulation? *Journal of Personality and Social Psychology, 71,* 588–602. http://dx.doi.org/10.1037/0022-3514.71.3.588

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16,* 12–25. http://dx.doi.org/10.1080/10503300500352500

Hilsenroth, M. (2015). *Crying in Therapy Survey*. Unpublished manuscript, Derner Institute of Advanced Psychological Studies, Adelphi University, Garden City, NY.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Aronson.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36,* 223–233. http://dx.doi.org/10.1037/0022-0167.36.2.223

Kennedy-Moore, E., & Watson, J. C. (1999). *Expressing emotion: Myths, realities, and therapeutic strategies*. New York, NY: Guilford Press.

King, L. A., & Emmons, R. A. (1990). Conflict over emotional expression: Psychological and physical correlates. *Journal of Personality and Social Psychology, 58,* 864–877. http://dx.doi.org/10.1037/0022-3514.58.5.864

Lepore, S. J., & Helgeson, V. (1998). Social constraints moderate the relation between intrusive thoughts and mental health in prostate cancer survivors. *Journal of Social and Clinical Psychology, 17,* 89–106. http://dx.doi.org/10.1521/jscp.1998.17.1.89

Lepore, S. J., Ragan, J. D., & Jones, S. (2000). Talking facilitates cognitive-emotional processes of adaptation to an acute stressor. *Journal of Personality and Social Psychology, 78,* 499–508. http://dx.doi.org/10.1037/0022-3514.78.3.499

Lopez, F. G., & Brennan, K. A. (2000). Dynamic processes underlying adult attachment organization: Toward an attachment theoretical perspective on the healthy and effective self. *Journal of Counseling Psychology, 47,* 283–300. http://dx.doi.org/10.1037/0022-0167.47.3.283

Major, B., & Gramzow, R. H. (1999). Abortion as stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology, 77,* 735–745. http://dx.doi.org/10.1037/0022-3514.77.4.735

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the client attachment to therapist scale. *Journal of Counseling Psychology, 42,* 307–317. http://dx.doi.org/10.1037/0022-0167.42.3.307

Nelson, J. K. (2000). Clinical assessment of crying and crying inhibition based on attachment theory. *Bulletin of the Menninger Clinic, 64,* 509–529.

Pennebaker, J. W. (1993a). Overcoming inhibition: Rethinking the roles of personality, cognition, and social behavior. In H. C. Traue & J. W. Pennebaker (Eds.), *Emotion, Inhibition, and Health*. Seattle, WA: Hogrefe & Huber.

Pennebaker, J. W. (1993b). Putting stress into words: Health, linguistic, and therapeutic implications. *Behaviour Research and Therapy, 31,* 539–548. http://dx.doi.org/10.1016/0005-7967(93)90105-4

Pennebaker, J. W., & Francis, M. E. (1996). Cognitive, emotional, and language processes in disclosure: Physical health and adjustment. *Cog-*

nition and Emotion, 10, 601–626. http://dx.doi.org/10.1080/026999396380079

Pennebaker, J. W., Mayne, T. J., & Francis, M. E. (1997). Linguistic predictors of adaptive bereavement. *Journal of Personality and Social Psychology, 72,* 863–871. http://dx.doi.org/10.1037/0022-3514.72.4.863

Robinson, N., Hill, C. E., & Kivlighan, D. M., Jr. (2015). Crying as communication in psychotherapy: The influence of client and therapist attachment dimensions and client attachment to therapist on amount and type of crying. *Journal of Counseling Psychology, 62,* 379–392. http://dx.doi.org/10.1037/cou0000090

Rottenberg, J., Bylsma, L. M., Wolvin, V., & Vingerhoets, A. J. J. M. (2008). Tears of sorrow, tears of joy: An individual differences approach to crying in Dutch females. *Personality and Individual Differences, 45,* 367–372. http://dx.doi.org/10.1016/j.paid.2008.05.006

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational guide*. New York, NY: Guilford Press.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48,* 80–87. http://dx.doi.org/10.1037/a0022140

Stanton, A. L., Danoff-Burg, S., Cameron, C. L., Bishop, M., Collins, C. A., Kirk, S. B., . . . Twillman, R. (2000). Emotionally expressive coping predicts psychological and physical adjustment to breast cancer. *Journal of Consulting and Clinical Psychology, 68,* 875–882. http://dx.doi.org/10.1037/0022-006X.68.5.875

Stanton, A. L., Danoff-Burg, S., Cameron, C. L., & Ellis, A. P. (1994). Coping through emotional approach: Problems of conceptualization and confounding. *Journal of Personality and Social Psychology, 66,* 350–362. http://dx.doi.org/10.1037/0022-3514.66.2.350

Trezza, G. R., Hastrup, J. L., & Kim, S. E. (1988). *Clinicians' attitudes and beliefs about crying behavior*. Paper presented at the 59th Annual Meeting of the Eastern Psychological Association, Buffalo, New York, NY.

Tritt, A., Kelly, J., & Waller, G. (2015). Patients' experiences of clinicians' crying during psychotherapy for eating disorders. *Psychotherapy, 52,* 373–380.

Vingerhoets, A. J. J. M. (2001). Adult Crying Inventory (ACI). In A. J. J. M. Vingerhoets & R. R. Cornelius (Eds.), *Adult crying: A biopsychosocial perspective* (pp. 303–316). Hove, England: Brunner-Routledge.

Vingerhoets, A. J. J. M. (2013). *Why only humans weep: Unraveling the mysteries of tears*. New York, NY: Oxford University Press. http://dx.doi.org/10.1093/acprof:oso/9780198570240.001.0001

Vingerhoets, A. J. J. M., Cornelius, R. R., Van Heck, G. L., & Becht, M. C. (2000). Adult crying: A model and review of the literature. *Review of General Psychology, 4,* 354–377. http://dx.doi.org/10.1037/1089-2680.4.4.354

Vingerhoets, A. J. J. M., van Tilburg, M. A. L., Boelhouwer, A. J. W., & van Heck, G. L. (2001). Personality and crying. In A. J. J. M. Vingerhoets & R. R. Cornelius (Eds.), *Adult crying: A biopsychosocial perspective* (pp. 115–134). Hove, England: Brunner-Routledge.

Received April 5, 2017
Accepted April 6, 2017 ■