



A Clinical Practice Review of Crying Research

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The goal of this clinical practice review is to assess the current state of the theoretical and empirical literature on emotional crying (i.e., crying in response to an emotional stimulus), a topic that has received surprisingly limited attention of behavioral scientists and clinicians. Although the empirical research on emotional crying remains in a nascent state, we draw upon the existing scientific knowledge to provide preliminary suggestions for clinicians on how to interpret and respond to crying in clinical contexts. We also identify research gaps and provide recommendations for further research to improve our understanding of this intriguing and still poorly understood human behavior. We suggest that a better understanding of individual differences in crying behavior and the postulated intraindividual and interindividual functions of crying is of critical importance for clinicians, given its frequent occurrence and notable associations with emotional and social functioning. An improved characterization of this important phenomenon will lead to improvements in clinical assessment, treatment planning, and psychotherapy interventions.

Clinical Impact Statement

Question: We review the state of the empirical literature on human crying behavior, with a focus on crying of both patients and therapists in the clinical setting. **Findings:** Findings may help guide how clinicians interpret and respond to crying in the clinical setting. **Meaning:** Generally crying of therapists or patients appears to be beneficial in a clinical context, but this seems to depend on a number of contextual factors. **Next Steps:** As current research on crying in the context of clinical assessment and psychotherapy is still very limited, further research is needed to fully understand how crying of patients and therapists impacts the therapeutic process, as well as how crying behavior manifests in various forms of psychopathology.

Keywords: crying, tears, psychotherapy process, individual differences

Human emotional crying (i.e., the production of tears in response to an emotional stimulus, which may be accompanied by sobbing, vocalizations, and/or bodily movements) is thought to have evolved from the separation calls or distress vocalizations that can be observed in all mammals and several bird species when the offspring are separated from the mother (Gračanin, Bylsma, & Vingerhoets, 2018; Newman, 2007). Along these lines, Ostwald (1972) described human infant crying as an “acoustical umbilical

cord,” and Bowlby (1969, 1980) first conceptualized crying in humans as an attachment behavior, functioning primarily to maintain and/or restore the physical contact with one’s mother or other caregivers. In humans, as a child develops, the importance of the auditory component diminishes, whereas the visible component (i.e., the tears) gains prominence (see Gračanin et al., 2018). Despite the purported common origin, crying in animals is mainly limited to vocal activity (i.e., distress vocalizations), whereas the production of emotional tears is unique for humans (Vingerhoets, 2013).

Not surprisingly, crying is commonplace in the context of psychotherapy. Based on primarily self-report research (Benecke, 2009; Blume-Marcovici, Stolberg, Khademi, Mackie, & ’t Lam, 2017; Robinson, Hill, & Kivlighan, Jr, 2015; Trezza, Hastrup, & Kim, 1988; Zingaretti, Genova, Gazzillo, & Lingiardi, 2017), it is estimated that crying occurs at least once in ~15%–30% of therapeutic sessions. This high prevalence is not surprising, as this unique and universal human emotional expression occurs relatively frequently across a wide variety of emotional situations, including loss, interpersonal conflict, and personal failure, which

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are all situations typically addressed in a therapeutic setting. Nevertheless, crying, particularly in the context of the clinical setting (of both therapists and patients), has received only modest attention of the scientific community. Similarly, empirically supported psychotherapeutic approaches also offer little guidance on how to address crying in the context of psychotherapy, particularly therapist tears. Indeed, therapists often report a lack of formal training or guidance on how to manage their tears in psychotherapy (Blume-Marcovici, Stolberg, & Khademi, 2013, 2015; Labott, 2001; Morgan & Nutt Williams, 2020). Therefore, although our insights have significantly improved in the past few decades, we still have limited knowledge of this behavior.

Because there are many strong beliefs about the benefits of crying including several misconceptions about crying and criers in the popular literature (Cornelius, 1986; Vingerhoets, 2013), the primary objective of this practice review is to summarize, especially for clinicians, the current state of scientific research. We start with what is known about normative adult crying, including the antecedents or triggers of crying across the life span, and the putative interpersonal and intrapersonal functions of crying. We will also consider individual differences in crying behavior and its effects, including sex differences, personality characteristics, capacity for empathy/morality, attachment style, mental health symptoms, as well as cultural and environmental differences. In the second part of this practice review, we focus on the theoretical and empirical literature on crying in the clinical context, including crying of both therapists and patients, and implications of patient crying for both assessment and the psychotherapy process. We conclude with some preliminary suggestions for clinicians on how to understand crying based on the currently available knowledge. We also provide recommendations for future research. Given the focus of this practice review on emotional crying (i.e., in contrast to basal and reflex tears that lubricate, cleanse, or protect the eye), throughout this article, we refer to emotional crying simply as “crying.”

Antecedents of Crying Across Development

Like other emotional responses, crying involves a range of diverse antecedents or triggers that vary among individuals and contexts. Although these can be a challenge to classify systematically, Vingerhoets (2013) made a preliminary qualitative distinction among five broad classes of antecedents of emotional tears derived from anecdotal evidence and nonsystematic observations on the frequency of specific crying antecedents in different age-groups. The first two antecedents, *loss/separation* (i.e., grief, separation anxiety, homesickness, lovesickness) and *helplessness/powerlessness*, remain significant antecedents throughout the life span. These feelings of helplessness or powerlessness, and the consequent need for support and (re-)connection with others, may also sometimes be accompanied by a variety of other emotions, including sadness, fear, anger, frustration, shame, regret, and even strong positive emotions like joy. In the latter case, the individual may feel overwhelmed by the intensity of the emotions and has no adequate verbal or other behavioral response available.

In contrast, other antecedents show notable changes across the life span, which may reflect changes in social, cognitive, and emotional development. In particular, *physical pain and discomfort* are frequent triggers for infants and toddlers that seem to lose

importance beginning in adolescence (see Rottenberg & Vingerhoets, 2012, for review). Indeed, crying has long been considered a reliable marker of pain behavior when a child is still too young to provide a verbal description of their pain (Grunau & Craig, 1987; Mills, 1989). On the other hand, *empathic crying* (i.e., where an emotional reaction of another individual is the antecedent) shows the opposite pattern and appears to increase with age. Similarly, tears triggered in response to *extraordinarily positive or moving situations* also increase with age, such as when we witness altruism, self-sacrifice, comradeship, virtuosity, or powerful connections (or reconnections) among individuals. These situations are typically associated with the emotion of being moved (Cova & Deonna, 2014), also known as *Kama Muta* (Seibt, Schubert, Zickfeld, & Fiske, 2017). The increasing importance of these triggers with age (e.g., empathy, *Kama Muta*) suggests a possible link with socioemotional and moral development (Vingerhoets, Hoevenaer, & Gračanin, 2018).

Individual Differences in Crying Behavior

The most notable individual difference in crying frequency and proneness is the sex differential, which has been observed across cultures in 37 different countries (van Hemert, van de Vijver, & Vingerhoets, 2011). Although male and female infants do not significantly differ in crying frequency (Vingerhoets & Scheirs, 2000), it is well established, via self- and other-reports, that adult women on average cry significantly more frequently than adult men (2–5 vs. 0–1 times per month, respectively; Bylsma, Croon, Vingerhoets, & Rottenberg, 2011; Vingerhoets, 2013). Similarly, women are also more prone to cry (i.e., they have a lower crying threshold), based on both self-report and laboratory findings (Gračanin et al., 2015). The sex differences in the occurrence of this behavior emerge in late childhood (Rottenberg & Vingerhoets, 2012; Vingerhoets & Scheirs, 2000). There is currently no evidence of a relation to the development of an individual's secondary sex characteristics and, in girls, the onset of menstruation (Van Tilburg, Unterberg, & Vingerhoets, 2002) although research on crying in adolescence is limited. Preliminary data instead suggest that the sex differential in crying behavior starts developing before adolescence (Jellesma & Vingerhoets, 2012), which may be related to differential neurodevelopment, exposure to emotional situations, or socialization processes (Brody & Hall, 2010; Chaplin & Aldao, 2013; McClure, 2000; Rottenberg & Vingerhoets, 2012). The antecedents of crying also show some apparent sex differences, where women tend to cry more quickly in response to minor frustrations, conflicts, and daily hassles relative to men. In contrast, for intense emotional events, such as loss or separation, the observed sex differential is much smaller (Vingerhoets, 2013).

Besides sex differences, researchers also have identified several other individual differences that are associated with crying proneness and crying frequency (Rottenberg, Bylsma, Wolvin, & Vingerhoets, 2008; Vingerhoets, 2013; Vingerhoets, Van Tilburg, Boelhouwer, & Van Heck, 2001). For example, some specific personality features have been associated with crying proneness or frequency relatively consistently. More specifically, Rottenberg, Bylsma, and Vingerhoets (2008) found extraversion and empathy to be associated with higher crying proneness in response to both positive and negative triggers, whereas neuroticism predicted higher crying proneness for negative triggers only. Recent theo-

retical developments and empirical findings also suggest that the self-reported tendency to cry is associated with a greater self-reported proneness to display prosocial behaviors and moral functioning (Vingerhoets et al., 2018).

Given the purported interpersonal functions of crying, it is not surprising that attachment styles have also been related to crying behavior. For example, based on self-report research, individuals with an avoidant attachment style report crying significantly less relative to individuals with a secure or anxious attachment style (Bartholomew & Horowitz, 1991; Denckla, Fiori, & Vingerhoets, 2014; Laan, Van Assen, & Vingerhoets, 2012). Similarly, Drenger, Mikulincer, and Berant (2017) found that attachment anxiety is associated with more exaggerated and emotionally ambivalent crying (i.e., the presence of both positive and negative emotional reactions to one's tears), whereas attachment avoidance is related to more restricted and negatively experienced crying.

Bekker and Vingerhoets (2001) developed a preliminary model identifying four relevant factors that may help explain individual differences in crying: (a) the degree of an individual's (self-selected) exposure to (or avoidance of) emotional stimulation (e.g., choice of movies, books, professions, hobbies, as well as attendance or participation in emotionally evocative events like funerals); (b) the individual's appraisal of the emotional situations (e.g., as more or less helpless); (c) variation in an individual's crying threshold or crying proneness (i.e., dependent on both temporary factors such as sleep deprivation, hormonal status, alcohol/drug use, and fatigue, as well as more stable person features such as genetics, personality, relationship status, chronic disease, etc.), and (d) the individual's willingness and capacity to suppress tears. These different explanations for individual and group differences may have clinical relevance, as we will show later on.

Given differences in cultural norms for emotional expression, it is not surprising that there is evidence of cultural influences on crying frequency and sex differences in crying. For example, individuals living in more affluent, democratic, extraverted, and individualistic countries tend to cry more often; and more substantial sex differences in crying proneness (i.e., greater crying proneness in women relative to men) are found in wealthier, more democratic, or more feminine countries (van Hemert et al., 2011). Further, in a cross-cultural study, Sharman et al. (2019) found women to be more likely than men to endorse more feminine or less traditional gender roles, and these gender roles and attitudes were associated with a higher crying intensity and greater beliefs that crying is helpful relative to individuals self-identifying as having more masculine gender roles (Sharman et al., 2019).

How Crying Influences Others (Interpersonal Processes)

Given that crying is thought to serve crucial communicative functions, it is not surprising that tears have an impact on observers, which may be influenced by the social context (Bylsma, Vingerhoets, & Rottenberg, 2008; Gračanin, Bylsma, & Vingerhoets, 2017; Vingerhoets & Bylsma, 2016). In the most basic sense, laboratory research using digital photos or film clips with posed facial expressions with or without tears suggests that the presence of visible tears helps observers better recognize emotional expressions, particularly of sadness (Provine, Krosnowski, & Brocato, 2009; Reed, Deutchman, & Schmidt, 2015). In general,

crying individuals are not only seen as individuals in need of help and support, but also as warmer, more empathic, reliable, sincere, less aggressive, and less emotionally stable relative to their tearless counterparts, consistent with the idea that tears represent an evolved adaptation that promotes helping behavior in others through the induction of feelings of empathy and social connectedness (see Gračanin et al., 2018, for review; Píco et al., 2020).

Other laboratory findings demonstrate that the presence of tears may impact the response of observers, such that tearful faces tend to elicit more sympathy, willingness to help, and feelings of connection (Provine et al., 2009; Riem, Van IJzendoorn, De Carli, Vingerhoets, & Bakermans-Kranenburg, 2017; Vingerhoets, Van de Ven, & Van der Velden, 2016). Laboratory findings also suggest that observers may draw inferences about the expresser in relation to the situational context, such that the perceived contextual appropriateness of tears seems to have a strong influence on observers' reactions (Cheshin, 2020). Further, regulatory demands of the situation may also influence the amount or type of support provided to criers by observers (Pauw, Sauter, van Kleef, & Fischer, 2019). Similarly, laboratory research using standardized film clips and self-report ratings suggests that how the observer perceives the crying influences the observer's general perceptions of the crying individual. For example, if the tears are regarded as genuine, the observer is more likely to feel a strong connection with the crier, and the observer is more likely to perceive the crier as more reliable and trustworthy and thus fit for professions where these traits are critical, such as judge, physician, scientist, or teacher (van Roeyen, Riem, Tončić, & Vingerhoets, 2020), which would likely also apply to mental health professionals.

The aforementioned findings are all based on laboratory studies using standardized stimuli and artificial conditions, which limits generalizability to daily life or clinical contexts. In the most extensive study of everyday crying episodes collected to date, the International Study on Adult Crying (ISAC; van Hemert et al., 2011), participants reported on the specific context of their most recent crying episode. In terms of the social context of crying, participants reported preferring to cry at home in the evening, either alone or in the company of someone they are close to, whereas the presence of strangers seems to inhibit tears. Importantly, the ISAC participants also reported on how strangers and intimates reacted to their last crying episode, and these data revealed that the specific relationship between the crier and observer might be a significant moderator, such that strangers were less likely to react to crying individuals with the provision of comfort (i.e., physical or verbal) and understanding relative to familiar individuals (Bylsma et al., 2008). These findings are consistent with conceptualizations of crying as an attachment-related behavior (Bowlby, 1969, 1980).

More recent qualitative research has also focused on possible factors that determine the reactions to crying individuals in a naturalistic setting, including characteristics of both the crier and the observer, their mutual relationship, the perceived appropriateness of the crying (Elsbach & Bechky, 2018). Specifically, these authors examined crying in a workplace setting and observed that the specific trigger of the tears is a significant determinant of how observers react to the tears, such that significant losses were typically met with understanding, whereas triggers related to self-pity, incompetence, or failure, led to relatively strong negative reactions from others. Further, in other naturalistic qualitative

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research, Hepburn and Potter (2007) analyzed the effects of crying on the responses to callers to a child protection helpline for reporting abuse and identified two specific reactions of the child protection officers to crying calls (10% of all calls) that were rare in noncrying calls. First, they gave more often the advice to “take-your-time,” which was mainly used when the crying severely interfered with talking, and, second, they provided more signs of empathy, particularly when callers failed to react to actions like advice-giving (Hepburn & Potter, 2007).

How Crying Impacts the Crier (Intrapersonal Processes)

Despite the widespread popular belief that crying makes people feel better (the “catharsis” hypothesis; Cornelius, 1997), the empirical evidence reveals a more complex picture. Specifically, only 50% of individuals from the ISAC study retrospectively reported feeling better after crying in their most recent crying episode (Bylsma et al., 2008), and in a daily diary study of over 1,000 crying episodes in women, only 30% of individuals reported experiencing a mood benefit from crying (Bylsma et al., 2011). In both studies, 10% of individuals reported feeling worse following crying. However, it is important to note that these surveys asked about crying in general, which involved a wide range of antecedents, situations, and social contexts.

The self-reported emotional benefits of crying seem to depend on a number of individual differences and specific contextual factors. First, the specific social context is critically important in the emotional effects of tears. Not surprisingly, when bystanders express understanding and/or provide support or comfort, criers more likely benefit from their tears; in contrast, when observers become angry or start laughing, or if the crier feels embarrassed because of his or her crying, then the crier tends to feel worse after crying (Bylsma et al., 2008; Sharman et al., 2019). There is further evidence that the specific nature of the antecedent may be relevant—for example, after uncontrollable situations (e.g., the loss of a significant other), people less often report a mood improvement than after a crying episode triggered by a controllable situation (e.g., a conflict; Bylsma et al., 2008). In addition, although gender, self-ascribed gender roles, and gender role attitudes are found to be related to behavioral crying responses, they do not seem to show an association with the self-reported mood change following crying (Sharman et al., 2019). Instead, variation in mood changes following tears appears to be strongly related to one’s beliefs about the helpfulness of crying, such that the belief that crying is helpful is associated with greater mood benefit (Sharman et al., 2019). In contrast, depression, anxiety, and alexithymia are associated with less self-reported mood improvement following crying (Rottenberg, Cevaal, & Vingerhoets, 2008; Rottenberg, Bylsma, Wolvin, et al., 2008). Finally, there is evidence from a daily mood diary study that the intensity of crying seems to positively predict the end-of-the-day postcrying mood improvement (Bylsma et al., 2011).

In contrast to retrospective questionnaires or diary studies of crying in daily life, laboratory investigations in which participants are exposed to standardized emotional stimuli (e.g., sad movies) consistently observed a self-reported worsening of mood following crying, which may be a result of the artificial social context (see Rottenberg, Bylsma, & Vingerhoets, 2008, for review), although

there is also evidence that the mood benefits may take longer than a few minutes to appear (i.e., the assessment window of most laboratory studies), as mood benefits of crying were demonstrated in a laboratory setting 90 min following a sad film (Gračanin et al., 2015).

Laboratory studies have also attempted to examine intrapersonal biological processes that may underlie crying and associated mood benefits, such as the activation of the autonomic nervous system (Hendriks, Rottenberg, & Vingerhoets, 2007; Rottenberg, Gross, Wilhelm, Najmi, & Gotlib, 2002; Rottenberg, Wilhelm, & Gross, 2003). For example, in laboratory studies using standardized film clips to elicit crying, healthy individuals show increases in sympathetic activity (arousal) until just before the initiation of crying, followed by increases in parasympathetic activity (associated with restorative or regulatory processes), whereas individuals with major depression fail to show this pattern, suggesting that crying may serve a homeostatic regulatory function that is impaired in depressed patients (Rottenberg et al., 2003). However, these examinations are currently limited to laboratory settings, so it is unclear how well they generalize to daily life or clinical contexts. Further, little is known regarding the neural mechanisms underlying human emotional crying although some examinations in neurological patients and animal models have yielded clues regarding the neural substrates of crying (see Bylsma, Gračanin, & Vingerhoets, 2019, for review). Finally, there are speculations that crying stimulates the release of neurotransmitters such as endorphins or oxytocin (Gračanin, Bylsma, & Vingerhoets, 2014), but these eagerly await empirical testing.

Tears in the Clinical Setting

How Do Psychiatric and Neurological Disorders Influence Crying?

Crying behavior has been examined across a range of mental health conditions in both clinical and research settings. Most of the empirical research on crying and mental health has focused on depression, primarily based on cross-sectional self-reporting studies, yielding somewhat inconsistent conclusions (see Vingerhoets, Rottenberg, Cevaal, & Nelson, 2007). For example, Frey, Hoffman-Ahern, Johnson, Lykken, and Tuason (1983) observed in a daily diary study that females with elevated depression symptoms cried significantly more relative to health controls, with common stimuli including interpersonal relations, sad thoughts, or sad TV/movies. Further, a self-report study with clinically depressed patients (Rottenberg, Cevaal, et al., 2008) found that depressed patients reported an overall higher crying frequency relative to healthy controls, specifically for negative triggers, although patients reporting an inability to cry also reported the greatest level of depression symptoms. There was also considerable overlap between the crying frequency distributions of healthy controls and patients, suggesting that changes in crying behavior alone is not a diagnostic indicator of a mood disorder. Indeed, crying is not among the formal symptoms of depression in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (although it was included as a symptom for dysthymia in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*). Although a majority of depression measures that assess

crying consider a greater tendency to cry or a higher frequency of crying as an indicator of an increased depression symptomatology, the Beck Depression Inventory (Beck, Steer, & Brown, 1996) attributes the highest score to the loss of ability to cry. Indeed, it has been suggested that crying frequency and depression have a nonlinear association, such that mild depression generally goes together with an increased frequency of crying, whereas more severe depression may result in the loss of the capacity to cry (Vingerhoets et al., 2007). Laboratory findings also further complicate the picture regarding the relationship between crying frequency and depression. For example, Rottenberg et al. (2002) failed to demonstrate differences in the crying threshold of depressed and nondepressed individuals in response to a sad film under controlled laboratory conditions, which may be due to the nature of the crying stimulus or the artificial environment.

Given the heterogeneity of depression, differences in crying frequency may also be related to specific symptom presentation. Along these lines, in a subclinical sample, Rottenberg, Bylsma, and Vingerhoets (2008) found that alexithymia and anhedonia were associated with a relatively low frequency of crying, whereas subclinical symptoms of anxiety (but not depression) were characterized by relatively higher frequencies of crying behavior. Alternatively, Keller and Nesse (2006) suggested that the underlying cause of the depression may explain which specific depression symptoms are manifested, which may also lead to mixed findings in the association between depression and crying frequency. In support of this hypothesis, these authors demonstrated that crying was a more predominant feature of depression attributed to a social loss (perhaps due to defensive processes; see McCullough et al., 2003); in contrast, crying was less likely to occur in depression associated with a perceived failure, where symptoms like guilt, rumination, fatigue, and pessimism prevailed. Notably, these associations may be adaptive, as crying in the former case may have the function of promoting a formation and/or strengthening of alternative social bonds and facilitating supportive responses from others, whereas in the latter case the functional value of crying would be less obvious (e.g., in comparison with the benefit of effort reallocation, for example). A further possibility is that reduced crying in more severely depressed individuals may be the consequence of the use of antidepressant medication, as selective serotonin reuptake inhibitors (SSRIs) have been shown to reduce crying independent of changes in mood (Hackett, Yang, Anderson, Horrocks, & House, 2010; Holguín-Lew & Bell, 2013).

As noted earlier, besides differences in frequency of crying behavior, there is also evidence that depression may be associated with alterations in the intrapersonal function of tears. For example, mood-disordered patients or those with subclinical depression or anxiety symptoms are less likely to report mood improvement following a crying episode relative to healthy individuals (Rottenberg, Bylsma, Wolvin, et al., 2008; Rottenberg, Cevaál, et al., 2008). In contrast to healthy individuals, those with major depression also fail to show the characteristic physiological arousal (e.g., increase in sympathetic activity) during crying in the laboratory (Rottenberg et al., 2002) or evidence of the putative physiological self-regulatory mechanisms invoked by crying (e.g., activation of parasympathetic activity with the onset of crying; Rottenberg et al., 2003).

Much less is known about the relationship between crying and other mental health conditions. Clinical observations suggest that

crying may be inhibited in patients with eating disorders (Benecke, 2009), and these patients are more likely to associate crying with negative feelings (Mangweth et al., 1999). Patients with eating disorders often relate their disordered eating to a strong desire for control (Reid, Burr, Williams, & Hammersley, 2008), which seems consistent with the clinical observation that these patients have negative feelings toward crying, as crying may feel like a loss of control. Similarly, although there is no systematic empirical research on posttraumatic stress disorder (PTSD) and crying, clinical observations (Watermann, n.d.) suggest that PTSD patients who experience emotional numbing have difficulty crying or may even lose their capacity to cry, which may be due to fears of losing control of their emotions or of expressing vulnerability. In addition, a lack of crying in PTSD patients may be considered a sign of experiential avoidance of difficult emotions (see Orcutt, Reffi, & Ellis, 2020). It is also possible that there may be similar mechanisms underlying loss of the ability to cry in severe depression and PTSD.

For other psychiatric disorders, a specific relation with crying may be postulated given the observed correlational relationships between crying and empathy or attachment style. These relationships may be particularly relevant for personality disorders. For example, one might expect that individuals with antisocial personality features who typically score low on affective trait empathy cry less frequently compared with the average individual. On the other hand, sociopaths have also been described as the champions of the crocodile tears (Stout, 2005). One could further expect that patients suffering from borderline personality disorder (BPD), who are typically characterized by an anxious attachment style and a high degree of emotional lability, would cry significantly more often than the average person, a pattern observed by Capps, Fiori, Mullin, and Hilsenroth (2015). Interestingly, compared with healthy controls, BPD patients report a higher crying frequency, whereas their self-reported crying proneness does not differ from that of the healthy controls, suggesting that the increased crying of these patients is likely related to their more frequent exposure to situations that elicit strong negative emotions, particularly in the interpersonal domain, rather than reflecting a temperamental disposition for a low crying threshold (Peter, Arntz, Klimstra, & Vingerhoets, 2019). Along these lines, Capps et al. (2015) also observed that a greater severity of childhood sexual abuse was also associated with a greater frequency of crying. Further, given that BPD individuals fear interpersonal rejection and loneliness, but at the same time avoid proximity and intimacy (Gunderson, 1996), their increased crying might thus be viewed as a way to convey their need for social attention and bonding.

Other research has evaluated the relationship between crying and well-being more generally. Given popular belief regarding the attributed role of crying for an individual's well-being and health (Cornelius, 1986, 2001; Vingerhoets & Bylsma, 2007), one would expect that those who cry less frequently would report a poorer health status. However, cross-sectional correlational studies in general samples have found no overall relationship between self-reported crying frequency and well-being or health status (Hesdorffer, Vingerhoets, & Trimble, 2018; Vingerhoets, Van den Berg, Kortekaas, Van Heck, & Croon, 1993), and Capps et al. (2015) observed a greater frequency of crying among patients with poorer overall global functioning. However, laboratory findings suggest that the suppression of tears is associated with increased

physiological arousal in response to a sad film, particularly for those who behave in contrast to their natural tendencies (Labott & Teleha, 1996). There is also some evidence that crying may indirectly influence well-being (e.g., intrapersonal benefits) via interpersonal processes (Gračanin et al., 2014; Rottenberg, Bylsma, & Vingerhoets, 2008). Consistent with this idea, Benecke (2009) found that patients with a range of psychiatric disorders who cried during a clinical interview reported feeling closer or related more to others and were also less aggressive in both their self-reported emotions and facial expressions relative to noncrying patients. Similarly, Hesdorffer et al. (2018) observed that noncriers (relative to criers) had lower empathy scores and reported feeling less connected with others and receiving of less social support.

Research on noncrying suggests that a lack of tears might also be a deliberate choice or the result of specific social or cultural factors rather than the result of a mental health condition. For example, Hesdorffer and colleagues (2018) examined 475 noncriers (i.e., those who reported that they had lost the capacity to cry) and 179 control criers and observed that noncriers were more likely to be male (70%), and the vast majority of them did not see their lack of tears as a significant problem. More precisely, only 2.9% of the noncriers had sought help for this symptom, and those that sought help were more likely to be women. In general, noncriers reported their last crying episode as over 15 years ago (vs. 1–5 days ago for control group participants), and it was often the case, especially in women (36%), that the noncrying period began when they had experienced a particular event. Interestingly, 46% of the participants (primarily male) reported that they learned not to cry, and noncriers were less likely to have seen their fathers crying and associated a lack of tears with strength (Hesdorffer et al., 2018).

Changes in crying frequency also may be associated with neurological disorders, emphasizing the importance of considering potential neurological influences on crying behavior in addition to mental health conditions. For example, Green, McAllister, and Bernat (1987) investigated excessive crying in medically and surgically hospitalized patients and observed that 20% suffered from a psychiatric disorder (primarily depression), 33% had a neurological disorder, 43% had both psychiatric and neurological conditions, and in 4% no apparent reason could be identified. Pseudobulbar affect (PBA), also known as pathological crying, is the term most commonly used when the excessive crying is thought to be due to neurological origins (Arciniegas et al., 2005; Miller, Pratt, & Schiffer, 2011). Its prevalence in different neurological populations ranges quite widely (e.g., 9.4–37.5% among patients with amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Alzheimer's disease, Parkinson's disease, stroke, or traumatic brain injury [Ahmed & Simmons, 2013]). PBA can result in a significant impact on the patient as well as their family and caregivers, particularly in regard to their social and occupational functioning, quality of life, health status, feelings of embarrassment or shame, and associated anxiety symptoms (Ahmed & Simmons, 2013; Colamonic, Formella, & Bradley, 2012; Rudolph et al., 2016). Not surprisingly, PBA is also associated with a higher prevalence of comorbid psychiatric conditions, particularly depression (i.e., 30–35%; Ahmed & Simmons, 2013). Miller et al. (2011) made a clear distinction between affective lability (i.e., when the expressed emotion is exaggerated relative to the stimulus but is still congruent with the person's experienced emo-

tional state and the stimulus) and pathological laughter and crying (i.e., when the expressed emotion is seemingly incongruent with both the stimulus and the experienced emotional state and is sometimes described as a purely motoric act with no connection to affect). Thus, pathological crying may at first glance resemble affective lability associated with mental health disorders such as depression or BPD; however, in the case of pathological crying, the crying is typically mood incongruent (Arciniegas et al., 2005; Miller et al., 2011).

In sum, both psychiatric and neurological conditions can contribute to notable changes in crying behavior although associations are not always consistent. Excessive crying, but also the inability to cry, can lead to psychological distress and/or social impairment. However, there are significant individual differences in what an individual may experience as problematic that are likely shaped by sociocultural factors.

Patient Crying in the Psychotherapy Context: Theoretical Perspectives and Clinical Conceptualizations

Crying in psychotherapy is generally thought to facilitate the psychotherapeutic process (Knox et al., 2017; Mills & Wooster, 1987; Nelson, 2005, 2007). First, patient crying can provide important information to the therapist about situations or relationships that are important to the patient (Beck, Rush, Shaw, & Emery, 1979). For the patient, crying is typically seen as a healthy emotional release, which is essential for the psychotherapeutic process, an indication of client engagement with the psychotherapy process, or a sign of the initiation of a healing process (Robinson et al., 2015). This is consistent with meta-analytic evidence that therapist facilitation of patient emotional experience or expression in general is associated with favorable patient outcomes (Diener, Hilsenroth, & Weinberger, 2007), although research specific to crying is based primarily on clinical observations and qualitative research. Along these lines, one exploratory study using an observational coding system found that client crying during family therapy sessions predicted successful completion of treatment (Cuevas-Escorza & Garrido-Fernández, 2015). Mills and Wooster (1987) described the act of weeping in therapy as an essential stage for patients to facilitate contact with their experience and feelings although they also noted that some therapists may consider crying as an interruption of the therapeutic process that may also place implicit or explicit demands on the patient to suppress their tears. In the same vein, Beck et al. (1979) described situations in which tears may interfere with the treatment process because they postpone therapeutic movement, or because they result in feelings of embarrassment. Further, tears may, in some circumstances, also be perceived as manipulative or as disruptive of the therapeutic alliance (Alexander, 2003; 't Lam, Vingerhoets, & Bylsma, 2018; Trezza et al., 1988). Finally, a *sine qua non* is that the therapist is keenly aware of her/his own responses (i.e., countertransference reactions) to crying in the context of psychotherapy to be able to fully support clients both during and after their crying experiences (Albornoz, 2013).

Psychoanalytic and psychodynamic therapeutic orientations have a long history of valuing the expression of emotions in the context of a therapy session, where emotional expression, including crying, is seen as a cathartic experience involving a healthy

release of emotion or tension (Breuer & Freud, 1895/1974; Greenacre, 1965; Groen, 1957; Löfgren, 1966; McCrank, 1983). Similarly, interpersonal psychotherapy approaches (IPT) would likely see patient crying during a psychotherapeutic session as an opportunity to facilitate the expression of affect and process the emotional experience. If a patient describes an episode of crying outside of the session, an IPT therapist would likely explore the social context of the situation and any communicative function of the tears. In contrast, cognitive-behavioral therapeutic approaches (CBT) consider crying to be the result of an appraisal of the situation rather than a spontaneous emotional response. From this perspective, crying is considered as any other behavior, with a focus on the antecedents and consequences to elucidate its functional significance, with cognitive therapists likely focusing on emotions and thoughts experienced just before, during, or immediately following the crying episode. Related to cognitive conceptualizations of crying, Efran and Spangler (1979) suggested that crying follows an initial physiological activation stage and occurs in conjunction with relinquishing an existing cognitive schema during a recovery phase. Thus, crying may be a marker of a positive cognitive shift regarding the situation that initiated the tears. Humanistic approaches (i.e., existential, client-centered, Gestalt) have so far not systematically addressed crying, but as these approaches generally focus on present-oriented emotional experience (Greenberg & Rice, 1997), crying in a therapeutic session would be an opportunity to focus on the present emotional experience of the patient or therapist. For example, in emotion-focused therapy, which incorporates multiple humanistic perspectives, a primary goal is to teach the client appropriate expression of affect and proper emotion regulation, including the healthy expression of tears when sad (Greenberg, 2004; Robinson et al., 2015). Along these lines, a published case example representing a humanistic approach to trauma describes a therapist joining a patient's story and laughing and crying along with the patient through an experiential connectedness (Serlin & Cannon, 2004), suggesting that the shared emotional experience of the patient and therapist through crying may be particularly vital.

Potential beneficial effects of crying in the psychotherapeutic context may be further related to the client having learned how to express affect in a safe environment, which is a crucial general principle across psychotherapeutic approaches. In that regard, it is essential to create an environment where patient crying is validated, which often stands in contrast to their experiences in other interpersonal situations outside of the therapeutic setting (Mayotte-Blum et al., 2012). In particular, by learning to cry in certain therapeutic contexts, the client may learn to recognize and appropriately express helplessness and vulnerability, as well as gain more insight and comfort with their own emotional experience. Crying in the context of psychotherapy along with therapist-guided processing via in-session discussion following the crying episode may provide clients with a template for more adaptive expressions of emotion in interpersonal relationships. Along these lines, the expression of intense emotional experiences through crying followed by positive and validating responses by the therapist may also allow clients to gradually learn to become more comfortable with their own emotional experience (see Hilsenroth, Mayotte-Blum, Kuutmann, & Umphlet, 2017).

The benefits of crying might further depend on the type of crying. For example, McCullough et al. (2003) distinguished be-

tween adaptive (genuine) and maladaptive (defensive) affective expressions. Along these lines, crying in response to the acceptance of loss may be considered adaptive and leading to feelings of relief, whereas defensive crying is regarded as maladaptive and leading to feelings of frustration, hopelessness, and despair. For example, crying in a bereaved individual may be an expression of anger turned inward, as the individual tries to avoid grief because of implicit anxiety or fear that the experience of grief would be too painful, or to overcome the inhibitory feelings of guilt and shame. Such angry crying thus may represent a defensive reaction that replaces another, potentially more painful emotional response (Robinson et al., 2015). The client's negative attitudes toward tears may represent his or her defensive stance toward certain emotional experiences (e.g., grief), which is currently being replaced by an emotion such as shame that may also have a defensive role. Therefore, the discussion of tears in a psychotherapeutic context may facilitate identification and removal of psychological defenses (McCullough et al., 2003). Avoidance or fear of strong emotional experiences has been termed *affect phobia*, and the appropriate experience and expression of emotions (including those expressed via tears) may be achieved by systematic desensitization aimed at increasing comfort with the experience of emotions and removing defenses that hinder their expression (McCullough et al., 2003), an idea also consistent with exposure therapy, a form of CBT (Foa, Hembree, & Rothbaum, 2007).

There has also been some limited work employing a detailed clinical analysis of case examples of specific crying episodes. Specifically, using comprehensive process analysis, a therapeutic tool used to understand clinically significant psychotherapeutic change better, Labott, Elliott, and Eason (1992) analyzed a crying event of a client, which resulted in a four-factor model of crying in psychotherapy. The first factor that accounted for the crying was that the client had a significant amount of unresolved emotion from earlier stressful life events. The second and third factors implied that the client felt safe with the therapist and that the therapist was able to deal adequately with the patient's crying. Finally, the tears appeared when the client accessed her early memories and feelings and the schemata associated with them, more specifically, when she became aware of the crucial role of her past experiences, which contribute to her current problems. What further might have facilitated the client's tears was the physical condition of the client: She felt tired and drained and complained of a headache. This case example thus illustrates the complex interplay of several factors and the potential importance of crying eliciting or inhibiting events in a therapeutic setting.

As it becomes clear from this brief overview of different theoretical perspectives and approaches to the role of tears in psychotherapy, there has been a gradual shift in thinking, where initial ideas about the cathartic functions of tears were supplemented with an emphasis on the possible effects of crying on the cognitions and insights into the problems of the patients as well as the importance of the therapeutic alliance, which may contribute to the beneficial effects of crying (Nelson, 2007). This change in how crying might exert its positive influence on the therapeutic process seems to parallel the more general change in thinking about the effects of tears, such as the increasing evidence that crying may have beneficial effects via interpersonal processes (Gračanin et al., 2018). Importantly, if the crying is not perceived as authentic and sincere, the connection with the therapist may be compromised (Alexander,

2003). However, it is also essential to consider that an apparent lack of authenticity of crying, or lack of crying when it would seem appropriate, may also reflect maladaptive defensive reactions (McCullough et al., 2003).

Patient Crying in the Psychotherapy Context: Empirical Findings

The importance of emotional expression in the context of psychotherapy has been described for decades (Greenberg & Pascual-Leone, 2006; Greenberg & Safran, 1989), and, recently, a meta-analysis of therapist and client emotional expression found positive relationships with favorable clinical outcomes for both therapist and client emotional expression in session, with a somewhat stronger effect for client emotional expression (Peluso & Freund, 2018). The clinical setting is an extraordinary type of social context that thus far has not yet been systematically examined in terms of mood benefits from crying. Although depressed and anxious individuals may be less likely to report experiencing gain from crying in daily life, this may not necessarily be the case in the context of psychotherapy. If a supportive and experienced therapist facilitates the expression of affect in a healthy and appropriate manner, it may be possible for the clients to experience benefits of crying in this context, which then may potentially generalize to their daily life experience.

However, empirical research specific to crying in psychotherapy remains very limited, and the influence of crying may not necessarily be comparable with the effects of other forms of emotional expression. To date, there are surprisingly few empirical studies addressing the crying of patients in the therapeutic setting, and much of what we know about crying in therapy is based on case studies, informal observations by clinicians, or patient self-report. Here we review both quantitative and qualitative findings, primarily based on self-report data. In terms of frequency of patient crying in the psychotherapy context, as mentioned earlier, it is, not surprisingly, quite a common occurrence (Robinson et al., 2015; Trezza et al., 1988; Zingaretti et al., 2017). For example, Zingaretti et al. (2017) found that over 85% of randomly selected patients reported having cried at least once during therapy, with over 28% having cried during their most recent session and patients reporting crying on average approximately once per month.

A handful of studies have focused on characteristics of criers and the therapeutic relationship as well as specific triggers of tears in the psychotherapeutic setting using self-report methods (Capps et al., 2015; Zingaretti et al., 2017). In one of the few studies to use direct observational coding of therapeutic sessions, Capps et al. (2015) found that crying during psychotherapy was more likely to occur toward the beginning of treatment and was associated with therapists' encouragement of the exploration of painful or uncomfortable affect (e.g., affect facilitation), exploring new cognitive perspectives on important issues, or the patient's fantasies and wishes (Capps et al., 2015). Further, patients also reported that crying was associated with the session being more difficult although crying-in-session was not associated with the quality of the therapeutic alliance, and therapists (who were psychodynamically trained advanced doctoral students) typically responded to patient crying with acceptance, validation, and normalization of the patient's emotional experience (Capps et al., 2015). Importantly, Robinson et al. (2015) reported that over half of the variance on the occurrence of crying in their study was between (rather than

within) therapists, meaning that whether a patient will cry depends mainly on the therapist's characteristics. Further, Zingaretti and colleagues (2017) conducted a study on crying in psychotherapy and therapeutic alliance among primarily psychodynamically trained psychologists with a range of years of experience, based on self-reports from randomly selected patients. For this purpose, they employed the Adult Crying Inventory (Vingerhoets et al., 2001) and the Crying in Therapy Survey (Hilsenroth, 2015). Using a psychometrically validated measure of working alliance (i.e., the Working Alliance Inventory–Short Form; Hatcher & Gillaspay, 2006), these authors found that negative experiences with crying during therapy were often associated with a weak therapeutic alliance and therefore speculate that whether crying facilitates the therapeutic process depends on the quality of the therapeutic alliance, as a strong alliance leads to greater self-understanding and awareness of the factors that led to the crying episode. Along these lines, in qualitative research with doctoral student therapists from a variety of theoretical orientations, Knox et al. (2017) observed that patients tended to report experiencing crying in therapy as useful when there was also a strong therapeutic relationship. However, the self-reported quality of the therapeutic relationships was not associated with self-reported crying frequency.

Based on adult attachment theory and clinical observations, Nelson (2005) placed crying in a relationship context by defining three broad categories of crying most relevant for antecedents of loss or separation: (a) *inhibited crying* (noncrying), which reflects detachment and withdrawal from the emotional experience; (b) *protest (angry) crying*, which involves defensive crying aimed to avoid or undo a loss or separation; and (c) *sad crying of despair*, which acknowledges that the loss or separation is inescapable and may aid the individual's acceptance and grief process. According to this theoretical view, it is specifically this third type of crying, which is linked to a secure attachment style, which is expected to elicit comfort and compassion from others (Nelson, 2005, 2007).

Nelson's typology of crying was later examined empirically by Robinson et al. (2015), who explored crying and attachment throughout therapy. Their findings revealed that therapists with high attachment avoidance tend to have clients who frequently cried initially but less over time, whereas therapists with high attachment anxiety had clients who applied more protest crying throughout therapy. Also, clients with high attachment anxiety cried initially with more protest crying and inhibition, which decreased over time, whereas clients with low attachment anxiety increased protest crying over time. Further, clients with an insecure attachment to their therapist cried less during therapy, whereas those with more secure attachment to their therapist cried more, particularly with a higher intensity of protest crying. It may be that this increase in protest crying over the course of therapy may signify therapeutic progress although further research is needed to understand better how these changes may relate to clinical outcomes. Attachment-related processes may thus be important for understanding the meaning of crying in psychotherapy. Along these lines, Robinson et al. (2015) concluded that therapists should consider attachment-related processes in both the therapist and patient and recommended establishing a secure attachment with one's clients so that the clients feel comfortable with their crying and the exhibition of other strong emotional expressions. These investigators further emphasize that a therapist should not

assume that crying is necessarily good, but instead consider what the client is trying to communicate to their therapist via tears. Here we want to highlight the conceptual correspondence between Nelson's protest crying and the defensive crying as described earlier, as well as between sad crying and genuine crying described above.

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However, Robinson et al. (2015) also noted some limitations of Nelson's (2005) categorization of crying, in that it was too heavily focused on crying due to loss, rather than due to the experience of other negative or positive situations, implying that further refinements of Nelson's crying typology are needed. Based on their empirical work, these authors hence proposed the following four categories of crying: (a) inhibited, (b) sadness/despair, (c) anger/protest, including frustration, and (d) acceptance, including the experience of relief, joy, or happiness. In another related conceptualization of categories of crying, short-term dynamic psychotherapy considers the following two broad categories of crying: (a) activating (i.e., involving opening up and engaging with others) and (b) inhibiting (i.e., closing down or withdrawing from others; McCullough et al., 2003; Robinson et al., 2015). Examination of if and how these different types of crying relate to therapeutic success or interfere with the therapeutic process has not yet been examined empirically.

Psychotherapeutic and Pharmacological Approaches to Patient Inhibited or Excessive Crying

There are currently no empirically supported manualized interventions specifically for excessive crying or lack of ability to cry although a handful of case studies exist. Given the lack of systematic interventions targeting crying behavior in patients specifically, psychotherapeutic and pharmacological approaches often indirectly address crying as an aspect of emotional expression in general. For example, for patients who experience a loss of the ability to cry, such as those with severe depression or PTSD, a psychotherapy approach that facilitates the processing and expression of, especially negative, emotions may be helpful, such as acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), IPT (Kiesler, 1996), or radically open dialectical behavior therapy (RO-DBT; Lynch, 2018). RO-DBT may be particularly relevant, given the theoretical focus of this approach on the importance of social signaling for psychological health. Along these lines, RO-DBT encourages patients to improve their nonverbal expression of authentic emotions to facilitate their social connections with others and alleviate psychological distress. As tears seem to function to elicit social support, encouraging the appropriate expression of tears would fit with this theoretical model and may help strengthen a patient's relationships with other supportive individuals. Exposure therapy in the context of trauma work, such as prolonged exposure (Foa et al., 2007; Peterson, Foa, & Riggs, 2011), may also facilitate the processing of emotions, including crying, where crying may be a sign of therapeutic progress. Tearless patients may also experience a more general emotional numbness that hinders their ability to connect with others, and tearlessness may hinder the solicitation of emotional support, which may be a critical mechanism involved in the facilitation of the beneficial effects of crying (see Gračanin et al., 2014; Hesdorffer et al., 2018). Psychotherapy to facilitate emotional processing and expression may also help tearless individuals to use interpersonal support better. Although crying itself is generally not the main

focus of therapy, one case study of behavioral therapy has been reported with a female client with intense anxiety who had lost the ability to cry where a combination of assertiveness training regarding emotional expression, watching videos of crying, role-playing of crying, and systematic shaping of crying behavior was successful as the client became desensitized to the experience of the uncomfortable affect and learned to regulate their emotions and reduce their anxiety (Linton, 1985).

For excessive crying where treatment is warranted (i.e., where the crying interferes with daily functioning and compromises the individual's quality of life), this condition can be treated with either psychotherapy and/or pharmacological approaches. For example, although there are no specific treatment approaches targeting excessive crying, general strategies to improve emotion regulation skills where excessive crying is due to extreme negative emotions (e.g., sadness, distress, anger) as part of a mental health condition may also be beneficial for these patients, such as dialectical behavioral therapy (Linehan, 2014). Further, a case study of excessive crying was reported by Crits-Christoph et al. (1996) describing parents who relied upon their child's crying as a way of avoiding their own conflicts, and through family therapy, the child was able to learn to identify the physiological triggers of crying and gain more control over its affective expression. Other case examples have been reported in which behavioral approaches such as desensitization (Field, 1970) and contingency management (Redd, 1982) have resulted in favorable decreases in crying. In other cases, either assertiveness training for anger expression (Rimm, 1967) or imagery of others getting angry (Tasto & Chesney, 1977) was successful at decreasing crying frequency. In addition, reducing excessive crying and limiting crying to situations in a suitable safe, and supportive context may also improve the social functioning and well-being of the affected patients. Among a palette of existing emotional expressions (e.g., anger, sadness, fear), crying seems to represent an outstanding and reliable signal of neediness and helplessness, and as such, it may bring more benefits if individuals can use it in an appropriate manner and context.

Regarding pathological crying (and laughing), both SSRIs and, more recently, dextromethorphan/quinidine (which has antiglutamergic properties) are recommended as first-line pharmacotherapy for this disorder (Hackett et al., 2010; Miller et al., 2011). When these agents are not sufficiently effective or poorly tolerated, alternative treatment options, including dopaminergic agents, uncompetitive NMDA receptor antagonists, tricyclic antidepressants, and noradrenergic reuptake inhibitors may be good alternatives. There is also some evidence that even a low dose of SSRIs may increase the crying threshold in nonpatients (van der Veen, Jorritsma, Krijger, & Vingerhoets, 2012), so SSRIs may also be helpful for excessive crying due to mental health disturbance.

Therapist Crying in the Psychotherapy Context

In the therapeutic setting, it is not only the patients who cry. Indeed, tears are also not uncommon among therapists and other health professionals (Blume-Marcovici et al., 2017; Janssens, Sweerts, & Vingerhoets, 2019). For example, 't Lam and colleagues (2018) reported that as many as 87.4% of their large

sample of over 800 mental health providers endorsed having cried at least once during a therapy session (with many likely crying more than once), with no significant difference between male and female therapists.

Therapist crying is common throughout all stages of psychotherapy, but it has been observed to occur most typically in the mid to late stages, often after rapport with a patient has been established (Blume-Marcovici et al., 2015). Paralleling these findings, patients more likely respond positively to therapist tears when they do not appear too early in the therapy process (Blume-Marcovici et al., 2017; 't Lam et al., 2018). The reasons why therapists cry are diverse. For example, because they are touched by the story of the patient, when the story of the patient rekindles personal memories, or when seeing his or her suffering, but also when a patient shows his gratitude for the given therapy or makes a therapeutically desired change, as well as when the therapy with a patient is terminated. Finally, occasionally the therapists reported that their crying was meant as a model for the patient how to handle grief or as an aid to accelerate the therapeutic process of a patient ('t Lam et al., 2018). Positive effects of therapist tears were found by Morgan and Nutt Williams (2020), who showed that, overall, the therapists had a consistent positive perception of the consequences of their own tears, both on therapy in general as well as on the patient–therapist relationship.

As mentioned earlier, individuals who cry with tears that are perceived as genuine are found to be fit for more reliable professions in general, which may also apply to the tears of mental health clinicians (Van Roeyen et al., 2020). However, there is also evidence that patients may differ substantially in their attitudes toward crying clinicians. Among several factors, the demeanor of the therapist seems to have a substantial impact on how the tears are perceived by patients. For example, in a study of eating disordered patients, the patients generally judged the clinician's crying positively (based on self-report) although it depended to a great extent on their perceptions of the demeanor of the therapist and their understood meaning of the crying (Tritt, Kelly, & Waller, 2015). More precisely, if a therapist was perceived by the patient to have a positive demeanor (i.e., defined as high patient-perceived self-report ratings of the therapist on happiness, firmness, and consistency), there was a higher frequency of therapist tears, and the patient tended to evaluate the therapist's tears more positively. In contrast, a negative demeanor of the therapist (i.e., defined as high patient-perceived ratings of anxiety, boredom, or anger) correlated negatively with the frequency of crying openly. Overall, the therapists' tears were found to have a positive impact on therapy if the patients evaluated the therapist as having a positive demeanor, including a greater willingness by the patient to express emotions in therapy and a feeling that the therapist understood their experience. Therapist's tears have also been associated with poorer self-reported outcomes if the therapist was perceived as having a negative demeanor, including less willingness to express emotions in therapy and blaming oneself for the therapist's tears. Potential negative effects of the therapist's tears are also evident when the tears induce in the patient feelings of guilt, confusion, or the experience of feeling burdened (Blume-Marcovici et al., 2015).

Interestingly, the patients' responses to therapist tears are much more likely to be perceived as positive when these tears are discussed although only 39% of therapists report discussing their tears with patients (Blume-Marcovici et al., 2015; Blume-

Marcovici et al., 2017). In a qualitative study with doctoral student therapists-in-training, Knox et al. (2017) reported that, in retrospect, therapists often wished they had discussed their tears more with their patients when they did occur. However, even in cases where the therapist's tears were not explicitly discussed, relationship improvement was still often reported (66% overall), as therapists reported feeling that their tears communicated something to their patients that they were unable to adequately express verbally (Blume-Marcovici et al., 2015). In this way, the tears did the speaking for them. On the other hand, Tritt et al. (2015) emphasized that therapists' tears were more likely to have a negative impact when they were not discussed. However, these authors also reported that in certain cases, patients preferred therapists' tears not to be discussed if the therapist was perceived to have a negative demeanor, as discussed earlier.

Discussion of a therapist's tears can also be viewed in the context of therapeutic immediacy, which refers to disclosures of the therapist's feelings in reaction to their patient, patient's reactions to the therapist, as well as the patient–therapist relationship, with a focus on the here and now of the experience (Hill, 2004; Hilsenroth et al., 2017; Mayotte-Blum et al., 2012). The discussion of episodes in which patients and therapists cry together may influence the patients' beliefs about the expression of emotion, such that the patient can learn that crying is not something that should be condemned and avoided. In that regard, the therapist's expression of authentic affect (i.e., tears) allows the patient to safely focus on his or her own tears and related emotional experience. Such crying exchanges may facilitate the patient's emotional authenticity by enabling him/her to learn how crying may increase closeness and comfort within the safety and comfort of the therapeutic relationship, allowing the patient to make meaning of tears in the context of these emotional transactions that can then be translated to the patient's other interpersonal relationships (see Hilsenroth et al., 2017).

How therapists regard their own tears in therapy seems to be influenced by their specific discipline and therapeutic background ('t Lam et al., 2018). Overall, clinicians generally tend to feel positive about therapist tears in psychotherapy as long as the tears do not burden the patient and do not interfere with the therapeutic process ('t Lam et al., 2018). Blume-Marcovici et al. (2015) noted that although therapist crying in therapy is not a technique that is typically intentionally used (85%), it often leads to the perception of valuable new clinical insights (e.g., 28% of the reported cases). Along these lines, psychodynamically oriented therapists may consider therapists' tears to be due to the projection of unprocessed emotion by the patient, which reveals insights regarding the patient's defensive structure (Blume-Marcovici et al., 2015). The most common emotions with their in-session tears reported by therapists were sadness and feeling touched, whereas feelings of warmth, powerlessness, gratitude, and joy were reported as well, albeit to a lesser extent (Blume-Marcovici et al., 2017). However, in a qualitative study with doctoral student therapists, Knox et al. (2017) found that these therapists-in-training often worried about potential negative effects of their crying, such as how their crying might be perceived by the patients, whether it would upset or overwhelm the patients, or that they would not be able to stop crying once they started, suggesting that less experienced therapists may be less comfortable with their own tears in their work with patients.

Recommendations for Clinical Practice

To date, we thus only have very limited empirical findings of how crying (of both the patient and the therapist) might impact the therapeutic process. Consequently, there is still only limited guidance for therapists as to how to respond to crying in the context of psychotherapy, especially when it comes to their own tears (Blume-Marcovici et al., 2015). It is, however, encouraging that we are currently witnessing a growing interest in this topic. The preliminary evidence thus far suggests that therapist crying may be relevant for the clinician–patient relationship because it increases the perceived empathy of the clinician. Indeed, empathy has generally been shown to be critical for maximizing therapeutic potential in clinician–patient relationships (Larson & Yao, 2005). Although there is the implicit conviction that patient crying may contribute to their emotional recovery, either by its positive effects on the therapeutic alliance or via other mechanisms, there is a great need for more studies in this specific area. Here we present preliminary recommendations for clinical practice and suggestions for future research. Because the available research on crying in the clinical context is still surprisingly limited, we are aware that we should be modest, and we are reluctant to come up with firm conclusions and recommendations.

First, the assessment of crying behavior may have utility in clinical assessment and case conceptualization. For example, the crying frequency, the antecedents of crying, the context of crying, and the mood changes associated with crying seem to have associations with well-being and socioemotional functioning. As such, it might have diagnostic potential to learn more about what makes patients cry and with whom they cry. More insight into the antecedents that make people cry may help therapists to learn more about the social and moral functioning of the patient. Crying may also help to index aspects of attachment, therapeutic alliance, or emotion regulation processes, although more research is still needed to understand these relationships better.

For patients who report excessive crying or a lack of ability to cry, it may be helpful to explore possible reasons for these changes, including biological, social, cognitive, behavioral, and emotional factors. In assessing whether alterations in the frequency of crying are a manifestation of underlying psychopathology, it may be helpful to rule out possible underlying neurological or other medical conditions and treatment factors (medication such as antidepressants or hormone therapy). Importantly, excessive crying and the lack of tears are themselves not necessarily pathological conditions that require professional help. As with any other mental health condition, treatment is only indicated if it causes severe impairment in daily functioning and/or significant distress.

In terms of psychotherapy, some significant first steps have been made, especially when it comes to studying the functions of crying in general and of patient's and therapists' tears in particular, including individual differences in crying. Both patient and therapist tears may have a beneficial role for the patient when certain conditions are met. For example, therapist crying seems to be positively received after rapport has been established, and if it does not take the attention away from the patient's concerns. The patient's positive experiences with crying (either of therapist or patient) may be a sign of a strong therapeutic alliance, which may parallel the empirical findings that crying is generally more likely to lead to benefits when in a safe and supportive social context.

Patient crying may bring attention to relevant material to work on that session under the guidance of the therapist, which may be critical to experience the beneficial effects of crying. Finally, insights from the recent research on crying do provide some support for the idea that clinicians should encourage the expression of affect and avoid any suggestion that patients should suppress their tears. Although there is evidence that individuals with depression and anxiety seem less likely to benefit from their crying in their daily lives, we would not necessarily conclude that crying for these patients in a psychotherapy context would lead to negative outcomes. Rather, crying in a supportive therapeutic setting may help these patients move from more maladaptive to adaptive emotional expressions, which could lead to the experience of greater benefit from crying.

Therapists should consider attachment-related processes in both the therapist and patient and work on establishing a secure attachment with patients so that the patients feel comfortable with their crying and the exhibition of other strong emotional expressions. Although empirical findings and clinical observations suggest that crying is usually perceived as beneficial, therapists should not always assume that crying is necessarily good, but instead, consider what the patient is trying to communicate to their therapist via tears. Similarly, therapist tears may be perceived differently depending on the therapeutic alliance and patient perceptions of the therapist. Findings also suggest that, in most cases, it may be useful for a therapist to discuss their tears with the patient, unless there is evidence that this may be detrimental, for example, if the therapeutic alliance is poor or if it is felt that the meaning of the tears is already clearly understood.

In terms of how to respond to patient crying in psychotherapy, patient crying should likely be addressed similarly to other notable expressions of affect, which many psychotherapeutic approaches already address in some form. Recommendations for responding to patient crying in psychotherapy. Specific recommendations for responding to patient crying may also vary by psychotherapeutic orientation. Efran (2017), in a clinical training video, provided several specific recommendations. Specifically, he suggests treating crying as a natural process indicating helpful emotional processing is occurring that should be allowed to flow freely and uninterrupted, holding questions for afterward: "If tears are flowing, do nothing." Following the crying episode, Efran advised asking what the crying is in connection with, rather than asking, "What made you cry?" as that implies a negativity causality or lack of agency. Further, Efran suggested asking what thoughts are associated with crying rather than feelings, as asking about feelings may lead to a less productive focus on physiological sensations. However, other more emotion-focused approaches, such as interpersonal therapy, may differ in this regard and may suggest asking more directly what emotions the patient is feeling or experiencing at this moment rather than focusing on thoughts. The following text illustrates an approach to addressing patient tears in therapy following resolution of an episode of crying that addresses both thoughts and feelings in connection with the tears:

Therapist: *What were you thinking just before you started crying?*

Patient: *I was thinking that I feel that I've let my children down, and that I haven't been a very good mother to them.*

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Therapist: *What emotions did that bring up for you?*

Patient: *I was feeling a sense of guilt and a great sadness.*

What happens next will largely depend on the specific psychotherapeutic orientation. For example, a CBT-oriented therapist may focus on challenging maladaptive patterns of thinking that are associated with the distressing emotions (i.e., exploring the evidence that she has let her children down), whereas an IPT therapist may give a great focus to the facilitation of affect and interpersonal processes, such as examining the mother's relationship with her children.

Whether therapist tears are appropriate and helpful in the clinical context likely depends on several factors, including the therapist-patient rapport, the psychotherapeutic orientation, and whether the therapist tears would augment or distract from the therapy. Indeed, as advised by Morgan and Nutt Williams (2020, p. 1),

In making decisions about when to cry or to suppress their tears, psychotherapists will need to assess on a case-by-case basis whether their tears, as a form of self-disclosure, are in the best service of the patient and will enhance the therapeutic process or detract from it.

It seems that well-timed therapist tears may be positively received by some patients, in that they can improve the patient's connection with the therapist and increase the patients' feelings that the therapist is empathetic to their concerns. More specifically, when therapists' tears are experienced positively by patients, it is often because they are validating the patients' messages, increasing their sense of connection in the (therapeutic) relationship, permitting them to emote themselves, and allowing them to experience their affect and connection to another person. As we reviewed, qualitative findings of patient and therapist reports suggest that discussion of therapist tears may be beneficial; indeed, Knox and colleagues (2017) explicitly recommends for such discussions to occur. For example, Morgan and Nutt Williams (2020) suggest based on case examples that statements such as "I feel for your story" or "I feel this for you" may be an appropriate way to discuss therapist tears with a patient. An example of how to address therapist tears is illustrated in the following text:

Patient: *Now I've made you cry too!*

Therapist: *I see you've noticed my tears. I'm glad you brought that up. I was really with you there in the moment, and feeling this experience along with you. What do you think about that?*

Patient: *That means a lot to me that you are sharing this experience with me. Usually, I feel that I need to hold back my tears in front of others, because I am afraid that they will be upset or angry.*

It is also recommended to discuss how to handle both therapist and patient tears in supervision with trainees. Such discussions will help trainees to better understand what provoked their crying and the effects of their crying, as well as to increase their comfort level with crying, which will improve the likelihood that these processes will lead to therapeutic benefit (see Blume-Marcovici et al., 2015; Knox et al., 2017). Further, Knox et al. (2017, p. 302), specifically suggested,

Such discussions may be especially prudent as trainees approach termination, a phase of therapy where crying frequency may increase. As with other potentially provocative events in therapy (e.g., immediacy and therapist self-disclosure), direct discussion of the motivations for and repercussions of such interventions may enable therapists to manage them more effectively.

AQ: 14

Some patients may be distressed by their apparent excessive crying or lack of crying relative to others. In these cases, it may be essential to provide education to the patient about normal variation in crying behavior and determine whether or not the distress or social impairment associated with individual differences in crying warrants intervention. For individuals expressing distress or impairment resulting from excessive crying or an inability to cry, psychotherapeutic or pharmacological approaches may be beneficial. However, besides a handful of case examples, none of these approaches have systematically been developed to target crying behavior specifically. Hence, more work needs to be done to establish empirically supported treatments for these specific issues.

Suggestions for Future Research

Greater insight into the crying of an individual may be a unique window into his or her emotional and moral functioning, as it is a measurable emotional behavior that is indicative of what specific kinds of negative and positive situations are essential to the individual or what the individual's values are. This also raises the intriguing question about the possibilities of objectively assessing crying behavior and associated responses as a method to evaluate therapy outcomes, particularly for interventions aimed at increasing flexibility in emotional experience and expression. Objective methods to study different aspects of crying behavior (Gračanin et al., 2015; Znoj, 1997) in the laboratory and reactions to tearful individuals may also be useful in assessing individual differences that may be clinically relevant, such as the capacity for empathy and prosocial functioning, especially in forensic populations. Observational coding in the psychotherapy context is also badly needed to have a better understanding of the frequency, duration, and antecedents of crying in the clinical setting that may be relevant for improving our understanding of the importance of crying for psychotherapy process and treatment outcomes.

In addition, given that previous attempts to categorize types of crying or specific antecedents of crying were based on preliminary observations and theory rather than systematic empirical investigation, more psychometric research is needed to characterize better a typology of crying both in the clinical context and in the natural environment, including consideration of how crying behavior may manifest differently over the course of treatment across different therapeutic modalities. We strongly feel that additional qualitative and quantitative research is needed to investigate further the impact of crying in therapy. This would include more in-depth interviews and surveys with larger sample sizes, in different patient populations and various therapy forms, and with adequate attention for potential moderators. Moreover, the use of a systematic observation method of crying-related behavior (Znoj, 1997) and/or the associated facial expressions (e.g., on the basis of the application of the observational facial coding methodology; Ekman, Friesen, & Hager, 2002) might be helpful to obtain a better understanding of which specific elements of crying are most

critical as determinants of the effects on several clinically relevant outcomes. **AQ: 15**

Most research on individual differences in crying is based on cross-sectional self-report findings. Given the notable lack of longitudinal research in this area, we do not know if and how crying behavior can change in individuals over time. For example, it is unknown if the frequency or correlates of crying change during or following psychotherapy and what these changes might mean for overall functioning and well-being. Further, as shown earlier, the specific mechanisms underlying individual differences in crying may vary considerably, depending on the individual difference construct. For example, highly empathic individuals may cry more often because they experience more situations that move them to tears, whereas individuals high on neuroticism may cry more often because they have a lower threshold for the experience of distress. The influence of cultural differences on crying in psychotherapy also remains unexplored. Thus far, cross-cultural research only examined cultural factors on a very broad level, based on overall country characteristics. How cultural differences might impact crying in the context of psychotherapy is currently unknown, but it is likely that specific cultural or social rules for emotional expression (“display rules”; Matsumoto, 1990) may affect the extent to which individuals feel comfortable with tears also in this context.

Still much is unknown regarding the relationship of crying to psychopathology, emotional functioning, and its role in therapy. For example, more research is needed to track crying longitudinally during the course of psychotherapy to examine how crying relates to psychotherapy process variables (i.e., therapeutic alliance) and predicts clinical outcomes. The careful assessment of crying may offer unique insights into the socioemotional and moral development and emotional (dys)function, as well as into the potential benefits of crying in the therapeutic process. Further, more research is needed regarding individual differences and clinical characteristics (including associations with mental health diagnoses and symptoms) that may be associated with crying behavior and its functional significance, including sociocultural influences. There is also a great need for more developmental longitudinal research to examine how changes in crying behavior may be associated with socioemotional development and risk trajectories for psychological disorders, such as depression. For example, it remains to be established if and how risk for psychopathology or the early manifestation of psychological disorders may be related to (the development of) crying behavior in response to specific antecedents.

Finally, more research is needed to elucidate the mechanisms underlying mood changes associated with crying. For example, research incorporating ambulatory physiology in daily life and in the clinical setting may help elucidate the biological underpinnings of these processes, including dyadic physiological processes between patient and therapist. Studies examining neural mechanisms underlying both crying and the perception of tears are also badly needed to improve understanding of emotional and social processes associated with crying. Most investigations of neural activity are limited to standardized laboratory settings, but some methods such as functional near-infrared spectroscopy can even be implemented in a clinical setting to examine dyadic neural processes between a patient and therapist associated with crying and emotional processing. A better understanding of the neurobiolog-

ical and psychological mechanisms underlying putative crying-related mood changes may help guide therapeutic interventions to facilitate the occurrence of beneficial effects of crying.

In conclusion, although empirical data on emotional tears has been accumulating over the past few decades in general samples, many important questions remain to be addressed to improve our understanding of crying in the clinical setting in relation to the clinical assessment and psychotherapeutic process. We hope that the present contribution stimulates researchers and clinicians to take up this important challenge.

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