Mind Those Tears:
Thinking about Crying in the Therapeutic Relationship

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Attestation of Authorship

I hereby declare that this is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: ________________________________ Date: ________________________

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Abstract

Crying is generally understood to be an expression of emotion and is therefore, considered a useful activity within the therapeutic relationship; yet little is written about why this is so. This dissertation explores the ways in which crying has been thought about in therapeutic theory and practice. The methodology used is a modified systematic literature review with clinical illustrations.

This work seeks not to look at the causes for crying per se, rather it addresses what happens between individuals when crying occurs, and how crying impacts on and is influenced by the therapeutic relationship. The literature reviewed lends itself to three main areas for investigation from a macro-to-micro view of tears. Firstly, literature provides a historical context for the notion that crying can be cathartic, which leads to an exploration of what in particular might be needed in the therapeutic relationship for catharsis to occur. Secondly, crying as attachment behaviour from infancy to adulthood is explored. This lays the basis for specifically looking at how attachment styles and crying behaviour might play out in the therapeutic relationship. Thirdly, the literature from a more intersubjective viewpoint on crying is examined and the occurrence of the therapist crying with the client is considered. Findings indicate that catharsis through crying may create intrapsychic change through the interpersonal relationship in which it occurs. Clinical implications and areas of further research are proposed.

Chapter One – Introduction

Lorenzo! Hast thou ever weigh'd a Sigh?
Or study'd the Philosophy of Tears?
(A Science yet unlectur'd in our Schools!)
Hast thou descended deep into the Breast,
And seen their Source? If not descend with me,
And trace these briny Riv'lets to their Springs.

Edward Young from Night Thoughts (Night V, 1. 516) cited in Levitz, 2006

The seeds for this dissertation were sown during my clinical practice as a student. Working with different clients, I came to notice the diversity in the expression of tears each client had; there were those who would sob profusely and those that seemed unable to shed a single tear[1]. I also noticed how my internal reaction varied in response to people's tears. For a long time I dismissed my noticing, I think primarily because weeping was never theorised throughout my training. My understanding at the time was that crying was considered a positive expression of emotion, largely due to the deepening of rapport between therapist and client. Yet, this did not seem to fully account for my subjective experiences with tears, both personally and with clients. In many ways, the idea of studying tears felt like examining the proverbial elephant in the therapy room; it seemed invisible by its obviousness.

Clarifying the research topic

My decision to research crying as a dissertation topic was greatly influenced by a wondering by Karen Maroda (1999). Her thinking resonates with me, both on a personal level and in my psychotherapy practice. She writes:

> In my clinical experience I have observed that the patients who seem to change the most are those who are capable of deep grieving, that is crying profusely or sobbing. Patients who achieve equal levels of insight without this profound affective experience do not change to the same degree. (p. 16)

[1] Throughout this work the words 'tears,' 'tearing up,' 'crying,' 'weeping,' and 'sobbing' are used interchangeably, and should be taken to mean the emotional state in which tears are produced.

Maroda's words raised a question in my mind about the therapeutic value of tears and how psychoanalytic writers have thought about crying. As I began to research the subject of crying, it became clear that there was little written evidence; most authors comment on its lack of visibility in psychoanalysis and related fields, both in training and theory (Booth, 2006; Hayes, 2006; Hoover-Dempsey, Plas, & Wallston, 1986; Kottler, 1996; Lutz, 1999; Nelson, 2005). This may be because crying is often interwoven into the fabric of the therapeutic practice, thus making it difficult to translate into spoken language (Nelson, 2005).

This current study attempts to make the topic of crying more visible by reviewing the available psychoanalytic[2] literature and related disciplines. Two of the key writers on crying in the therapeutic relationship are Nelson (2005) who has written extensively on crying as an attachment behaviour, and Kottler (1996) who understands crying to have a language system of its own. Although this dissertation incorporates both theorists' thinking, crying in relation to catharsis is largely ignored by each of these writers.

From Nelson's (2005) perspective, catharsis relies on internal individual dynamics namely a process of intrapsychic change. As this does not fit within her theory that denotes crying to be a two person interpersonal attachment behaviour, she does not incorporate catharsis into her framework (p. 153). In contrast to Nelson, my literature review has lead me to argue that catharsis through crying may result in an intrapsychic change but that this might be largely due to the interpersonal context in which the person cries. Kottler (1996) explores the complexity of tears and sees crying as a form of communication with self and other, as a language that has hundreds of dialects. For that reason, he suggests it can be very difficult to detect both what emotion people might be feeling when they cry and the reason for their tears.

This current study focuses not on why someone might cry per se, for I suggest no one can really know that except for the crier him or herself. Rather, I explore how crying has been interpreted in the literature and the meanings that have been given to it within the psycho-

[2] I use the words 'psychoanalysis' and 'psychotherapy' interchangeably in this work in recognition of the compatibility of analytic psychotherapy with psychoanalysis. The word 'client' may also alternate with the word 'patient' in accordance with the varying terminology used by different theorists.

therapeutic paradigm. Early on in my research, I became aware that the simplistic idea that crying was always positive belied its very complex and contradictory nature. For example, Kottler and Montgomery (2001) state:

> Adult crying has been hypothesized by some to be a cry for help, by others as a sign of surrender. It is conceptualized by some theorists as a form of healthy self expression while others view it as a symptom of psychopathology. It is described as the ultimate in human authenticity, or in manipulation. It is a sign of utter, abject helplessness, or the courage to reveal one's inner most feelings. There is even considerable disagreement as to whether it represents emotional arousal, or emotional recovery from arousal. (p. 2)

An illustration of the diverse ways crying can be thought about is shown in the theories of Weiss (1952), Feldman (1956) and Bergler (cited in Wood & Wood, 1984). Each writer explores the possibility of being able to shed happy tears and all three surmise there is no such thing. They each offer similar but slightly different interpretations of why this might be so. Weiss (1952) suggests humans delay grief until a happy occasion when the threat of the sad event is over. Feldman (1956) argues that tears shed at a happy event are in response to the contrast between the happy current event and the previous sad ones and Bergler proposes that individuals build up psychic masochism over time and when a rare happy event occurs, this build up must be released. These examples begin to highlight the complexity of the subject of crying.

Nelson (2005) describes tears as a "liquid metaphor" (p.157), suggesting that a session of crying can be the result of a whole lifetime of wounds compressed together. She likens tears to dream images that are a condensed version of multiple conscious and unconsciously repressed material. Similarly, Wood and Wood (1984) emphasise that the difficulty in interpreting tears can be due to the "flooding" (p.128) experiences clients may have when they feel overwhelmed by a deluge of associations, memories and wishes. These ideas reveal the belief that tears may contain layers of conscious and unconscious images and highlight the complexity of deciphering how they impact upon the crier, the therapist and the work of psychotherapy.

Gender, cultural and subjective differences

In order to study the significance of crying in any specific setting, Kottler (1996) suggests "one must look at the larger context including the person's gender, culture, family, background and what might be considered normal for that person" (p. 75). For the purpose of this dissertation, I exclude exploring the areas of gender and culture in relation to weeping behaviour because of the enormity of these areas in relation to psychoanalysis. There is room for the relationship between crying and gender and cultural differences to be whole dissertation subjects in themselves[3].

From a cultural perspective it needs to be acknowledged that there are vast differences, particularly involving how, when and who might cry in different social contexts[4]. This dissertation is written from a Pakeha woman's perspective. The majority of my client base, both male and female has also been Pakeha. Therefore, I acknowledge my experiences with tears in the therapy room will be different to those therapists and clients from other ethnicities. I also acknowledge that I write this dissertation through the lens of an intersubjective perspective, which resonates most closely to my philosophical style. I believe that the therapist cannot help but be influenced by the client and vice versa, and that something is created together in the present moment of the relationship. This is a bias I bring to my work.

Dissertation outline

My dissertation has followed an organic process and has developed into a 'macro-to-micro' perspective on weeping. I interweave clinical discussions and therapeutic implications into each chapter and re-visit these in my summary. In Chapter 2, I describe the methodology used for this dissertation and outline some advantages and disadvantages of this research method. Chapter 3 begins by taking a historical view of crying and how it has been shaped by religious influences. I explore how psychoanalysis has developed the idea that crying is cathartic with particular reference to Freud's cathartic method. I investigate what might be needed in the therapeutic relationship for someone to experience catharsis through crying.

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[3] Shoan-Golan (2003) explores why women cry more than men in her PhD and suggests women may carry the grief of others.
[4] For further reading see Lutz (1999) and Kottler (1996) both provide some investigation into cultural differences in crying.

Chapter 4 focuses on the relationship between crying and attachment. I use the work of Bowlby (1982, 1988) and Nelson (2005), who argue that crying is an interpersonal behaviour. I explore how crying either develops or becomes stunted through the attachment bond with a mother figure, then address how the influence of these early attachments might impact on adult crying, specifically in the psychotherapeutic context.

In Chapter 5, the work of Stern (2004) and Maroda (1999), among others, are used to take a 'micro-view' of crying within the therapeutic relationship by addressing moment-to-moment occurrences of tears. I further expand the ideas of previous chapters and bring together aspects of the intrapsychic and interpersonal nature of tears, seeing them as complementary to each other rather than separate. In this chapter, I also explore the literature on the tears of the therapist and discuss how they might influence the work of psychotherapy. Finally, in my conclusion in Chapter 6, I synthesise and summarise the findings. I also address the limitations of this study and propose areas for further research.

Symbolically, crying in psychotherapy might be represented by the box of tissues that has its place in every psychotherapy room. Yet I believe the tears that the box of tissues represent have been an invisible aspect of the work; a belief supported by the lack of writing in this area. My hope for this dissertation is that it will stimulate thinking on the subject of crying and make a seemingly obvious but intrinsically important aspect of psychotherapists' work, more transparent.

Chapter Two – Methodology

This dissertation employs the methodology of a modified systematic literature review. The majority of literature reviewed features qualitative studies and case material from experienced therapists. In addition, I include two case vignettes from my own clinical work that aim to illustrate rather than provide evidence. In using qualitative case material, I acknowledge that I am modifying the traditional systematic review, which typically relies on quantitative, evidence based material from the randomised control trial (RCT)[5]. This chapter explains the context of evidence-based practice in which this review is placed. I outline my search strategies, inclusion and exclusion criteria and the research question.

The systematic review in evidence-based practice

It has been suggested that Evidence Based Medicine (EBM) was conceived to bridge the gap between research and practice (Reynolds, 2000) by producing knowledge that will help patients achieve positive health outcomes and "increase reflective professional discourse" (Brown, 1999, p. 4) within disciplines. The systematic review grew out of the recognition that other professions wanted to also produce best evidence based practice (EBP) and that the RCT was not the only appropriate form of evidence. Now considered to be the "gold standard" (Earlam, Brecker, & Vaughan, 2000, p. 3), the systematic review works to evaluate best interventions for practice in a range of disciplines.

According to Hamer and Collinson (1999), an advantage of using systematic reviews is that it is a way of "bringing together and assessing all available research evidence on a subject" (p. 42). Greenhalgh (1997) adds that a systematic review will contain an explicit statement of objectives, materials and methods and is conducted according to "explicit and reproducible methodology" (p. 111). Specifically, Hamer and Collinson state this will include "defining the research question, identifying methods for research, selecting studies for inclusion, appraisal, extraction and finally synthesis of the data" (p. 44).

[5] The RCT was borne out of the concept of Evidence Based Medicine (EBM) and is highly regarded as a method for assessing the efficacy of medical interventions.

Despite the clear objectives of the systematic review, Reynolds (2000) suggests that some distortion has occurred as different professional groups interpret and adapt the core concepts of EBM into the broader realm of EBP. Perhaps this is particularly evident in the discipline of psychotherapy whose evidence base lies mostly in qualitative clinical case studies. According to Reynolds, within the paradigm of EBP, the single case study is considered "very much a poor relation to the RCT" and yet this does not acknowledge that it may be the most appropriate method when "use of the RCT is impractical and unethical" (p. 32). Trinder (2000) also notes that although the original definition of EBM includes the need to integrate evidence with clinical experience and patient preferences and values, the reality is that its scientific roots often seem to dominate and possibly devalue other forms of knowledge.

In response, Starcevic (2003) argues that psychotherapy must insist on producing its own criteria for usefulness, as it cannot hope to meet the requirements of EBM. This is not a new idea. Lacan argued that a major task for psychoanalysis is to claim its own realm of knowledge and make it legitimate by "identifying as much as it can its own method and field of investigation" (cited in Benvenuto & Kennedy, 1986, p. 64). Overall, I believe the systematic review remains a 'good enough' fit for the purpose of this dissertation; while acknowledging that the paradigm of psychoanalysis needs to also identify, embrace and make transparent its own understandings and subjects of enquiry.

No matter what form of evidence is used in research whether it is RCTs or qualitative case material; I believe all forms will be modified in the research process through the researcher's subjective beliefs, knowledge and practice. Brown (1999) argues that humane and effective health care recognises that its knowledge base "has always been a blend of art and science" which includes experience, logic, intuition, context, values and creativity (p. 3); his statement perhaps epitomises the very heart of my study into crying. I will show in this dissertation that the research into crying illustrates this blend of science and art and the ensuing debate about what is evidence, particularly when the paradigms of psychology and psychotherapy come together.

Defining the research question

As previously stated, my interest in the subject of crying arose largely from my clinical work, Maroda's question, and the general lack of focus on it during my training. This led me to the question: How is crying thought about in psychoanalytic literature? Yet as I read, I found little written from a psychoanalytic perspective; rather, much of the research came from the fields of psychology and counselling. By carefully selecting articles from related fields that focused solely on crying as a primary subject I believe I have enhanced my dissertation and that these varied perspectives can enrich psychotherapy practice. This formed a more broadly encompassing question: *How has crying been thought about in psychotherapeutic settings and how can this knowledge enhance clinical practice?*

Inclusion/exclusion criteria

I have included articles and literature from the related fields of counselling and psychology; provided the main focus of the writing was on an aspect of crying relevant to the therapeutic relationship. To begin with I read more broadly on the topic, in order to increase my understanding and contextual knowledge of the subject, particularly from the perspectives of medicine, history and English literature. I have excluded articles not written in English and those that I was unable to obtain.

Search strategies

I began my search for literature using PsychINFO, primarily because this database acts as an index for other catalogues such as Psychoanalytic Electronic Publishing (PEP). PsychINFO currently has over two million psych related references from the early 1800s to the present and is published by the American Psychological Association. Below is the process I used in searching for relevant material. The symbol $ refers to truncating the word in order to allow for all variants of the word.

1) cry or crying or cries or weep$ or tears = 3324 hits.
2) adult$ = 222453 hits.
3) psychotherap$ or psychoanaly$ or counsel$ = 231531 hits.
4) Combine 1 and 2 and 3 = 32 hits.

From this point, I was able to read the abstracts of the 32 articles produced in the fourth search, and exclude any that did not fit my inclusion criteria. Continuing my search using cry$ AND psych$ AND adult$ NOT infant (and variations of these words such as weeping and tears) I also searched the following databases.

PEP = 27 hits

PROQUEST (dissertations and theses) = 39 hits.

PsychArticles = 14 hits

PROQUEST = 2 hits

From each of these selections I found one or two relevant articles.

I discovered much of the literature in databases such as OVID and EBSCO only bought up crying in relation to physical pain from illness or injury. A number of databases also only bought up crying in relation to infant crying, of which there are a vast number of articles. I therefore had to narrow my search in order to exclude infant crying, with the exception of Chapter 4, which looks at attachment.

My next strategy was to search the e-journal subject database at Auckland University of Technology (AUT) library under the headings of ‘psychology’ and ‘psychotherapy’. This produced a further four articles as well as a number of the articles I’d already obtained; thus it proved a good cross-referencing technique. I then collated relevant titles from the reference lists of those primary sources for more literature. This process was repeated on the secondary sources of literature until I reached saturation point; that is when I began to find that the same articles and authors were appearing in the reference lists and bibliographies of the gathered material. I knew then I had systematically collected the relevant literature for review.

To obtain further literature related to catharsis and attachment I added these words respectively to my searches. However, I did not systematically search the literature under the subject of catharsis or attachment on their own as my enquiry was about their contextual relationship to tears.

Hamer and Collinson (1999) state that "database searching is only one component of the literature search and its limitations need to be recognised" (p. 46). In one study, it was found that using electronic searches failed to find 12% of trials that were uncovered using hand searching techniques. In my experience, I found this to be true. I uncovered more articles by hand searching through researched based journals such as "Psychotherapy," "Counselling and Psychotherapy Research" and "Psychoanalytic Dialogues". I also obtained four books related to the topic through the AUT library inter-loan service and was referred to further sources by psychotherapy department staff and colleagues.

Ethics

Ethics approval for this research has been granted as mentioned in my acknowledgements. Two of my clients accepted my invitation to participate in this research and I obtained written permission from them to use case material in the form of clinical vignettes. I have protected their confidentiality by the use of pseudonyms and disguise of some elements of their material.

Summary

I have undertaken this dissertation using the principles of EBP via a systematic literature review, although I have modified this review by using clinical vignettes and qualitative data not normally used in a review. My purpose however, remains consistent with that of a systematic review; that is to select relevant material and critically evaluate it with the aim of informing clinical practice. The clinical vignettes are not intended to be seen as evidence, rather provide illustration to enhance understanding in this piece of work. This work aims to identify the contributions from research that might enhance how we think about crying in psychotherapeutic practice as well as indicate areas for further research.

Chapter Three - Crying, Catharsis and the Therapeutic Relationship.

'Sorrows which find no vent in tears may soon make other organs weep'
Sir Henry Maudsley (cited in Levitz, 2006, p. 1)

This chapter explores the premise that crying can be cathartic under some circumstances and the relevance of this premise to the therapeutic setting. I begin by examining the historical roots of the relationship between catharsis and crying, thus providing a context to investigate how beliefs around the cathartic effects of crying may have become integrated into a range of psychotherapeutic practices. I include arguments that imply catharsis leads to healing under certain circumstances, and illustrate the theory with a case vignette from my clinical work.

Historical influences

Catharsis is derived from the Greek word, *kathatikos,* meaning pure and the English word *cathar* which originally referred to a medieval sect who sought to achieve great spiritual purity (Thompson, 1995). In psychological terms, catharsis refers to the emotional release of repressed emotion by association with the cause and elimination by abreaction. The belief that crying can be cathartic has been held since early times (Levitz, 2006, Lutz, 1999; Vingerhoets & Cornelius, 2001). For example, Ovid wrote in the first century "by weeping we disperse our wrath. It is a relief to weep; grief is satisfied and carried off by tears" (cited in Lutz, 1999, p. 118). Ovid seems to suggest that crying has the power to 'carry off' unwanted agression.

The idea that tears might also purify or cleanse the soul has strong historical religious roots. Tears were considered a gift from God and weeping was believed to be a tribute to Him, making the crier pure in God's sight and exempt from retribution or punishment. In the thirteenth century, crying was considered a means to be cleansed of one's sins through the act of confession in the Catholic Church (Lutz, 1999). These historical beliefs have served to promote the idea that crying, through the process confessing one's darkest thoughts and feelings, might produce a sense of relief and release. It is perhaps not difficult to find parallels here also with the process of psychotherapy.

That tears have the ability to emotionally cleanse and even promote healing in the crier may be a tacit belief passed down through the centuries via the arts and sciences. The notion that 'crying is good for you' constitutes a type of folk wisdom ideology, a belief system so implicit that it remains largely unquestioned today[6]. The lack of enquiry into crying as a phenomenon even in therapeutic settings is perhaps testament to this ideology (Lutz, 1999; Maroda, 2002; Nelson, 2005).

Historically, there has also been an inherent set of beliefs in Western society regarding the ill effects on the body and soul if one does not weep (Cornelius, 2001; Crepeau, 1981; Kottler, 1996). Shakespeare (1988) wrote, "The grief that does not speak knits up to the o'er-fraught heart and bids it break" (p. 995). More recently, the idea that the body suffers from not expressing emotion is supported by those who practice gestalt and somatic therapies (Broom, 1997; Groen, 1957; Perls, Hefferline, & Goodman, 1994; Scheff, 1979). Similarly, psychotherapist Karen Maroda (1999) alludes to the link between crying and emotional healing as previously mentioned by suggesting that an internal affective change can occur through profuse crying. What might be needed then, in the therapeutic relationship, in order for this change through catharsis to occur? Some of the answers may lie with the work of Freud and Breuer who introduced catharsis as a psychological method in the nineteenth century.

Freud and Breuer's cathartic method

In *Studies in Hysteria* Breuer and Freud (1955) concluded that hysteria was caused by psychological disturbance. They believed at this time that emotional affect built up over time and needed to be released. In this way, they aimed to purge the memory of the trauma that caused the affect, through a process of hypnotizing patients and having them recall the original distress (Blum, 1991). The discharge of affect which Breuer and Freud (1955) describe as "crying oneself out" or "blowing off steam" (p. 8), would allow the ordeal of a painful memory to eventually fade for patients who engaged fully in this process. However,

[6] The death of Princess Diana in 1997 and the subsequent global mourning process created "the effect of a collective cathartic shudder" (Kerr & Steinberg, 1999, p. 178). This mass outpouring of grief resembles scenes from historical religious demonstrations of abreaction.

it seems Freud wrote little about actual tears being cathartic; instead he used the word ‘affect’ to describe the emotional outpouring of a feeling. It also seems that catharsis through crying has received little theoretical attention, “leaving the conditions under which crying may be cathartic virtually undefined” (Levitz, 2006, p. 3).

Badcock (1992) does attempt to define the conditions on which Freud’s cathartic method relied on. He describes the “safety and confidentiality of the therapeutic setting” and the “personal influence of the therapist” (p. 28) as pre-requisites for the client to have successful treatment. While the meaning of therapist’s personal influence might be debated, I suggest it might have to do with the analyst’s subjective empathy and engagement with the patient. The patient’s “special emotional attachment” to the analyst has also been emphasised as influencing the success of the work, without which Freud argues the client may fall silent reflecting their “indifference” to the analyst (Breuer & Freud, 1955, p. 43).

Given this argument, I posit that the conditions in which a client experienced catharsis in Freud’s day were based on the establishment and maintenance of safety, confidentiality, trust and attachment in the therapeutic setting. Booth (2006) adds there may also need to be a feeling of being accepted (and not judged) in order for the crier to let go of the control over their emotional state. She suggests the release of one’s emotional state through crying may produce cathartic results. It follows then, that when the conditions are optimal, the crier is more likely to be able to fully engage with the expression of feelings. This raises the possibility that it is not the just the act of crying that is cathartic per se but it is also the ‘being with’ a trusted, empathic other in a safe environment that creates the space in which to do so.

In Kottler’s (1996) view, Freud’s method created the discourse that catharsis is inherently therapeutic. Kottler concludes that this is the reason crying has been held in the “highest esteem of the counseling profession as the clearest evidence that good work is taking place” (p. 194). While Kottler acknowledges Freud’s authority regarding the belief that crying is therapeutic, I believe Freud himself would have been influenced by the historical context I have discussed; the foundations of which underpin the ideology that crying can produce emotional relief and benefit the crier.

Lear (2005) argues that Freud discarded his catharsis method soon after adopting it, seeing it as fundamentally flawed, possibly because the results of the catharsis method did not seem permanent and could not be replicated outside the clinical setting. In response to this finding, Freud altered his technique to replace hypnosis with free association, stating "I have actually come to confine myself to one form of treatment, to the method which Breuer called cathartic but which I myself prefer to call analytic" (cited in Levitz, 2006, p. 27). Despite changing the form of treatment Freud used, I have not found any evidence to suggest that catharsis itself became less desirable in treatment.

In Hayes' (2006) view, Freud's revised method meant he began to place more value on the patient putting the emotional experience into words rather than the abreaction itself, deducing that this was the therapeutic factor. Hayes writes, "the tears simply signified that the emotion had been re-awakened and brought fully into consciousness" (p. 45). Again, this puts forward the idea that catharsis has to do with the processing of tears in a particular context than simply an emotional discharge.

Modern day catharsis

Nearly a century after Freud and Breur's development of catharsis as a technique, Nichols and Bierenbaum (1978) extol the virtues of its use as a means of "disrupting long-held, rigid defences against emotional expression" (p. 728). They suggest that catharsis achieved through crying, is often subsumed under different titles such as "discharge", "implosion" or "release" (p. 726). Similarly, in more recent times, participants in a heuristic study carried out by Sussman (2001) described their crying in psychotherapy as helpful because it gave rise to feelings of "release," "cleansing" and "purification" (p. 96). Sussmann found that the ten long-term clients she interviewed considered the tears they shed in therapy to be a "vital feature of both their therapeutic process and spiritual development" (p. 96). She writes:

> One of the striking features was the sense of calm and stillness which followed these prolonged periods of weeping, although previously fraught issues were still being discussed. This certainly suggests the release of very long-held emotion and the transcendence of ego-based concerns. (p. 97)

Although these testimonies point to a continuing belief in the idea of catharsis through crying, Badcock (1992) suggests that catharsis was more easily obtained in Freud's day. He

surmises that this was due to the underlying societal repression of the time, particularly if it involved sexual matters. In other words, there was simply a greater build up of repressed emotion to be purged. Badcock speculates that due to today's more liberal society where emotions are expressed more easily, catharsis has become much harder to obtain. This claim may be difficult to substantiate and I suggest does not allow for the differences in client's experiences of catharsis nor the varying treatments that might facilitate it, as illustrated below.

Psychoanalytic technique and catharsis

While the cathartic methods described above, aim to induce emotional affect in the patient by actively breaking down the patient's defences, psychoanalytic techniques aim to interpret and understand the patient's tears, in order to facilitate change. In this respect, little has been written from a psychoanalytical perspective specifically relating to tears being cathartic. However, some psychoanalytic literature does allude to the idea that patients increased understanding of the meaning of their tears, may be cathartic in itself. For example, the psychiatrist Heilbrunn (1955) describes a case study of a patient who experienced infantile hunger as a result of insufficient breast milk from her mother. After many sessions of her client's relentless sobbing, Heilbrunn understood her client's constant weeping as a sign of regression and interpreted her sobbing as a wish to be returned to intrauterine life to a place of "satiation" (p. 251). Over a period of time, the patient was able to use these interpretations to work through her fear that Heilbrunn would clearly not meet her needs just as her mother had not. This resulted in her continuous crying subsiding, allowing the work to progress.

In this study, Heilbrunn (1955) identifies the similarity between her patient's copious tears with amniotic fluid, observing the almost identical composition of the two fluids. The idea that weeping may be an unconscious regression to a pre-natal state and that the chemical composition of emotional tears and amniotic fluid are similar[7] has been noted by other theorists (Szaz cited in Kingsley, Mills, & Wooster, 1987). Bowlby (1988) at least supports the notion that infants resent their "extrusion from the womb and seek to return there" (p.

[7] Frey (1985) in his fifteen years of research into tears found that emotional tears have a different chemical composition than irritant tears. He also found that tears remove a build up of chemicals, including manganese, a mineral known for its influence in mood disorders.

350). It is possible Heilbrunn's patient was protesting this very thing in her regressed state. Interestingly, it has been suggested by Vitanza (1960) that weeping originates in the womb from as early as the ninth week of gestation.

In other psychoanalytic writing, Löfgren (1966) describes the cleansing effect of tears and observes that tears are the only bodily secretion that is clean. There is an implication in his argument that tears are cathartic as they have the power to transform aggressive impulses into what he calls "harmless behavior" (Löfgren, 1966, p. 380). In other words, aggression may be dissipated via the secretion of tears, reminiscent of the words of Ovid "by weeping we disperse our wrath…" (Lutz, 1999, p. 118). This theory provides an explanation for the gender imbalance in crying, for example, Shoan-Golan (2003) suggests women cry more frequently, more intensely and for longer periods than men. Perhaps then, women may disperse more of their aggression through crying, whereas men generally cry less and therefore both hold on to and express greater anger when upset (Tremblay & L'Heureux, 2005).

Greenacre (1965) in contrast to Löfgren (1966), uses two case studies of her own where she understood her patient's prolonged crying to be an aggressive act in itself. She concludes that "the show of tears is under some control of the weeper" (Greenacre, 1965, p. 218). Kottler (1996) supports this, stating even sociopaths are able to elicit tears to win sympathy and that actors are able to weep on demand simply by revisiting a past tragedy. The idea that crying can be aggressive or seek to hide aggressive impulses is one that seems pertinent to the therapeutic relationship and will be explored further in the next chapter.

Using psychoanalytic case studies as evidence that crying is cathartic has come under criticism from Cornelius (2001), a psychologist, who deems the methods used for gathering evidence as being "unsystematic" (p. 200). He argues that those with a psychoanalytic orientation make presumptions that crying is followed by catharsis and that there exists in this setting an "unspoken demand to feel better" (p. 200). The idea that clients may feel better from crying purely because of a possible placebo effect is not the crucial issue according to Levitz (2006). He argues that if people believe crying has the power to make them well, then this itself holds essential value in the healing process.

Cornelius's (2001) review of literature on crying and catharsis concentrates solely of rigorous empirical studies with conflicting results. For example, research studies that asked university students to fill out questionnaires and diaries on their crying behaviour found a positive correlation between crying and feeling better afterwards (Bindra, 1972; Borgquist, 1906; Crepeau, 1981; Lombardo et al. cited in Cornelius, 2001; Frey, 1983; Kraemer & Hastrup, 1986). Conversely, laboratory research found opposing results to self-report methods. Labott and Martin (1988), Marston, et al. (1984) and Gross et al. (1994) (all cited in Vingerhoets & Cornelius, 2001) conducted laboratory studies involving participants watching a 'tear jerker' film while having their heart rates and body tension monitored. Using participant self-reports after the film, they conclude that in this setting, crying produced increased levels of sadness and anger and a decrease in happiness. In other words crying produced a negative affect in its participants.

These results seem to point to the importance of the social context in which a person cries and consequently whether he or she feels better afterwards. This is acknowledged by Cornelius (2001) who admits "perhaps people do not feel better after crying in the laboratory because their crying is in response to something in which they can do nothing and nothing in the situation changes as a result of their crying" (p. 206). He also suggests that the regard in which the crier is held by others and whether there is hope for some resolution of the issue about which they are crying; may have huge implications on whether the person feels better after crying. It seems ironic that, although Cornelius deems psychotherapeutic studies as unworthy of including in his review, his view of what the most optimal environment for catharsis to occur in, is in my opinion, largely epitomized by that of the psychotherapeutic relationship.

Cornelius (2001) also recognises that "it may be the case that crying does indeed have cathartic effects but these appear over a period of time longer than that assessed in most laboratory settings" (p. 205) and that this "raises the possibility that the putative cathartic effects of crying may be due to simply the passage of time" (p. 206). This proposition again appears to support the importance of the psychotherapeutic framework, particularly in long-term work, where both the therapist and client can bear witness to possible changes in the client over time.

The following case vignette from my work with a client illustrates some of the points raised thus far.

Clinical vignette: Julie

Julie defended strongly against feeling or displaying any emotion in our sessions – tears had never been safe to openly shed in her family. Experiencing a number of traumas in her early life, Julie grew up learning that she could cry herself to sleep with the sounds safely muffled into her pillow. Julie intellectualised her lack of affect, seeing herself as a thinker rather than a feeler and she remained in control of her emotional self in our sessions for many months.

After a period of time, in which we established a strong working alliance and a degree of mutual trust, I began to notice a change happening in Julie. She seemed less defended and more open to allowing small amounts of feeling. As our rapport deepened so did the level of the emotional material she was willing to work with. She particularly focused on her relationship with her mother to whom she had never felt able to show her true feelings for fear of being shamed. Several weeks into this phase, Julie entered the therapy room and immediately began to sob, letting tears run down her face and allowing her whole body to shake with grief. I felt a mixture of emotions - relief, sadness, protectiveness, curiosity, guilt and surprise at the overwhelming affect in the room, in contrast to the deadening feeling I would often experience with Julie. I sat with her, holding her with my eyes and voice, appreciating just how big a step it was for Julie to allow me to be with her in such a vulnerable state.

After deeply sobbing for some time, Julie began to put into words her recent feelings of depression; and how this manifested in her physically, as a feeling of nausea. She acknowledged that she had not felt able to cry in the presence of anyone since childhood. This realisation amplified her tears as she grieved for the little girl who had felt only shame for crying, never having had the experience of being empathically held in her grief. This was a deeply moving moment in our work in which I felt very connected to Julie and one in which from my perspective was also reparative and strengthened the attachment between us.

Julie would later describe this session as life changing, acknowledging that the most important thing for her in that moment was her sense of trust in me and the belief and hope that I would not shame her as she felt her mother had done all her life. She felt this had allowed her to express her feelings overtly through her tears, which felt enormously liberating for her and she noticed at the end of the session she felt "a huge weight" had been lifted from her and that the feeling of nausea had gone.

This session, for me also, felt like a catalyst for our work together. For the first time it appeared there was integration between Julie's mind and body that also gave me a felt experience of her emotional pain centred in my body. Julie's overt expression of tears so previously dangerous for her appeared to symbolise her ability to connect with my empathy and use it reparatively. Julie's crying episode seemed to open up a tolerance for the expression of her emotional self and over the next year in our work, Julie became comfortable with expressing a range of emotions both in and out of sessions.

Much of the literature I have discussed in this chapter seems to support my work with Julie. Firstly, the feeling that she was safe with me and had trust in our relationship (particularly that I would not shame her) I think was a significant factor in Julie's crying episode. It took many months of building our working alliance for her to get to that point. Here I am reminded the mutual attachment Freud saw as a pre-requisite for successful therapy and of Cornelius's (2001) observation of the importance of the response of the observer. In therapeutic terms, I felt like I was empathically holding her with my voice, gaze and gestures, a contrasting experience from being ridiculed and rebuked for crying. Julie very astutely waited until she felt she knew me well enough to know whether I would respond empathically to her tears before she 'allowed' them.

I also think Levitz (2006) makes a valid point that resonates with my session with Julie. He surmises that "experiencing emotion that had been previously squelched is a curative process in itself" (p. 30) and that this may be cathartic for the client. Certainly, it was the first time Julie had seemed to really engage with her emotions overtly in our work. The fact that she felt unburdened by her tears; as though a heavy weight had been lifted seems

reminiscent of metaphors such as ‘cleansing’ and ‘unblocking’ often used to describe the process of catharsis.

My experience with Julie also resonates with the idea of ‘surrender’ put forward by Maroda (1999). Maroda explains the process of surrender as “a giving over to the patient’s own emotional experience – losing herself to herself – within the containing framework of the analytic setting” (p. 54). She also uses the work of Russian psychologist Vgotsky to introduce the notion that intrapsychic change itself “occurs as a result of interpersonal exchanges” (p. 67). This lays support for the idea that catharsis through crying may be reliant on the quality and the attachment formed within the therapeutic relationship. Julie in this instance seemed to go through a process of ‘letting go’ that allowed her to cry with me. While I cannot know for sure that the cathartic effects of her crying were permanent, I was able to observe in her a growing capability for the expression of a range of emotions. This flourished over time in our work together and would also indicate greater ego strength in Julie.

Summary

Throughout history the belief that tears are a positive, healthy entity with properties that promote emotional cleansing and healing has been a prominent discourse in Western society. In the last century, theorists and researchers have tried to produce a theory of crying that proves or disproves its cathartic effects with mixed results. The evidence I have gathered suggests that the social environment in which a person cries and the response the person expects to get from others may have an influence on whether tears might be cathartic. I have shown through the lens of different therapeutic approaches, that each has its own technique for promoting catharsis. My own casework illustrates the premise that the relational quality of the therapeutic dyad may be important. I hypothesise that there is a connection between the quality of the therapeutic relationship and the client’s ability to surrender to his or her emotions. This may result in feelings of catharsis and over time, healing in the client. These thoughts lead to the idea that crying and attachment go hand in hand and this is the subject of my next chapter.

Chapter Four - Crying and Attachment

His tears ruffled the water,
And his image is dimly reflected back to
Him by the troubled pool
From Ovid (cited in Enterline, 1995, p. 1)

Introduction

> *Imagine that you are walking down the street and you see someone sitting on a bench, looking forlorn, staring into space. While disturbed by this scene, you would probably continue on your way. Now imagine a similar scene, but this time the person is cradling herself in her arms, sobs are shaking her body, and tears are streaming down her face. In the second case you are far more likely to stop and offer assistance than you would in the other instance. This second woman is drawing you in to help her far more effectively than the mere expressions of despondency without tears. (Kottler, 1996, p. 64)*

This chapter explores the premise put forward in Kottler's (1996) vignette, that human tears may be a form of communication with Self and Other, as a relationship seeking behaviour (Barbalet, 2005; Nelson, 2005). In the previous chapter I focused on the possible intrapsychic effects crying might have on the crier and what environment might be needed to facilitate catharsis. This chapter looks specifically at the interpersonal aspects of crying that intrinsically connect tears with attachment relationships (Bowlby, 1980; Karen, 1994; Kottler, 1996; Nelson, 2005). Attachment theory provides a context for conceptualising and understanding tears in infancy through to adulthood and is a useful lens for illuminating crying behaviour in the therapeutic relationship.

Crying as an early attachment behaviour

The recent resurgence of interest in Bowlby's (1982) theory of attachment[8] lays testament to its well grounded research into maternal/infant relationships (Mitchell, 1999; Orbach, 1999a) and throughout the human life span (Holmes, 1993). Bowlby proposes that in infancy, crying is an intrinsic aspect of attachment behaviour, alongside sucking, clinging,

[8] For further reading see Bowlby's (1973, 1980, 1982) three volumes on attachment loss and separation listed in reference section.

following and smiling; each response functioning to activate an instinctual care-giving response in the mother. The idea that infant crying is a pre-verbal, relationship-seeking behaviour is well supported in the literature (Appel & Healy, 2005; Holmes, 1993; Karen, 2004; Nelson, 2005). Research reveals infant cries are programmed to elicit attention and care-giving, evoking physiological responses such as increased heart rate, blood pressure and the 'let down' of breast milk in the mother (Kottler, 1996; Nelson, 2005).

In a "good enough" environment (Winnicott, 1990, p. 145), the instinctual responses of the parent (most often the mother)[9] will result in her responding sensitively to the child's emotional signals. This provides a critical context within which the child learns to organise emotional experiences and regulate a sense of "felt security" (Ammaniti, 1999, p. 786). Individuals who develop a healthy attachment to the caregiver may use them as a secure base from which they can explore their world (Bowlby, 1988). As a result, securely attached children successfully learn to tolerate, express and value a range of emotions, including crying.

However, literature suggests that the instinctual responses in the mother may not always be positive for the infant if the mother herself has unresolved attachment issues. (Appel & Healy, 2005; Hayes, 2006; Nelson, 2005). Winnicott suggests, "the advent of parenthood calls into being the new parent's own attachment history" (cited in Holmes, 1993, p. 73). This thinking may raise questions regarding the attachment histories of a group of young mothers surveyed in a New Zealand study, in which eighty percent reported feeling like "bashing" their babies in response to their infants crying (Kirkland, Deane, & Brennan, 1983, p. 539). Given that securely attached babies are known to cry less (Karen, 1994; Nelson, 2005) it is conceivable that the cries of the infants studied may have in fact stimulated unconscious memories of the mother's own cries in infancy and subsequent negative caregiver responses.

According to Nelson (2005), the mother with historic unmet emotional needs may become distressed by her child's cries, possibly resulting in the mother's abuse or neglect of her child. Perhaps the most relevant point here for clinical practice is Nelson's observation that

[9] See Holmes (1993) for a detailed account of the hierarchy of attachment.

"the feeling is that the crying must stop because it upsets them (the parent), rather than because the baby is upset" (p. 54). This raises the issue of whether infant crying and mother response also has implications for the therapist/client dyad. In other words, might unconscious attachment material be stimulated in the therapist in response to the sobbing of a client and how might that effect the therapist's ability to 'be with' the client? This idea is explored further in this chapter.

The ongoing relationship between tears and attachment

The infant's experience of how attuned the mother or caregiver is to his or her tears, appears to have a fundamental impact on the way the growing child sees, feels and thinks about crying as they develop into adulthood. Therefore, children who learn that crying is in some way unacceptable may also learn to suppress their tears, just as my client Julie did. Consequently, they may suffer detrimentally in their ability to express themselves emotionally as adults, particularly in relation to grief (Bowlby, 1982; Janov, 1970).

From a psychoanalytic perspective, Greenacre (1945a) links the suppression of tears with involuntary urination in boys. She suggests spontaneous urination in boys may occur at the same time that the boy learns he must control his crying in order to be a 'big boy'. She surmises that for girls excessive weeping may be in response to a related struggle with the parent over urinating during toilet training[10]. Perhaps more like her male counterparts in Greenacre's theory, Carmichael (cited in Nelson, 2005) remembers never crying as a young child when she was sent away to convent school. Instead, she wet her bed on a nightly basis. She writes, "every night my body wept at the wrong end" (p. 143).

The child that learns from a young age that the expression of tears and anger are unacceptable to the caregiver may develop an avoidant attachment, stifling feelings in order to reduce conflict and remain accepted and idealising of the parent (Ammaniti, 1999; Bowlby, 2005). Perls et al. (1994) argue that by adulthood, crying may be so cut off from the individual's emotional repertoire, that not only does the adult no longer have the feeling of wanting to cry, they have also become unaware of the inhibition in their body from

[10] Greenacre (1945b) also explores possible psychosomatic implications of the streaming of water from the eyes or in the form of urination, as an aggressive defence in adulthood. She argues this may be borne out of childhood disturbances in urination.

suppressing their tears. An adult with an avoidant attachment then is likely to be dismissive of (even incapable of) seeking comfort from or sharing his or her emotions with others (Karen, 1994). The result of which may lead to diminished attachments and intimacy in adulthood, described by Kottler (1996) as "emotional constipation" (p. 66).

It follows then that it may be very difficult for adults with avoidant patterns of attachment to cry in the therapy room. They may have learnt other ways in which to express their grief and sadness and may unconsciously avoid crying at all costs[11]. Yet the work of Greenacre (1965) seems to resonate with the possibility of what a patient with an avoidant attachment might 'look' like when they cry. She suggests that tears can act to protect the 'disappointed eye' that mourns the loss of *not being able to see* the object that has been lost to them. She states, "the eye is the most important sensory object in establishing a loss" (p. 210) and establishes a connection between tears and visual activity in humans. Greenacre's hypothesis is that "as weeping is an affair of the eye, it is worth while to examine the relation of weeping to looking and to seeing, or to looking and not seeing" (p. 212). In other words, she suggests that tears protect the crier from the reality of a loss until such time that the crier is able to come to a place of being able to see and accept the reality that the lost object is gone. While denial of the loss is, a common grief reaction, it might also be particularly fitting for the avoidant individual who has had to deny his or her own attachment needs.

Alternatively, those children who develop an ambivalent or even disorganised form of attachment (Appel & Healy, 2005) may internalise a heightened sense of distress, often reacting with fear and/or anger to the inconsistent parenting they have received. As they remain hyper-vigilant during separations and reunions, they are often difficult to comfort and soothe (Ammaniti, 1999). These characteristics may remain true for the adult who brings this attachment style to therapy. For example, their tears may symbolise their ambivalence to the therapist, oscillating between anger and fear.

This idea is supported by Booth (2006) and Perls et al. (1994) who propose that tears can serve as a protective mechanism against potential attack in the psychotherapy relationship,

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[11] For further reading on the absence of tears see Nelson's (2005) description of "inhibited" and "prohibited" crying (p. 113).

particularly when the client themselves feel like attacking the therapist. These clients may need to 'hide' their aggressive impulses toward the therapist for fear of rejection. As a result, they may hold the hope that their tears will be perceived by the therapist as non-threatening or as a sign of surrender (Kottler, 1996). This view appears to fit with Löfgren's (1966) theory, mentioned in the previous chapter, that suggests crying can act to dissipate uncomfortable aggressive impulses.

In this sense, crying in the clinical hour might also be seen as a way of *not* engaging with the therapist, for it may be difficult to think, reflect or even talk if one is racked by sobs. As Barbalet (2005) states "indeed weeping appears as a negation of speech in the stark sense that weeping physically prevents speech" (p. 134).

From the literature, it seems each client's unique relationship with tears will be embedded in their attachment style. Nelson (2005) states, "Crying that takes place in psychotherapy reveals volumes about a lifetime of attachment and care-giving successes and failures" (p. 153). Therefore, how a client expresses his or her tears (or not) in therapy, may be a good indication of the client's internal experience, both in the moment and historically from childhood (Mitchell, 1999).

The influence of the therapist's attachment history

Examining the clients' unique relationship with tears is only part of the equation within the therapeutic relationship. Just as the mother's parenting influences the child's developing attachment and relationship with tears, so will the therapist influence the client's ability to cry. In fact, as Nelson (2005) stresses, it seems vital that the therapist explore his or her own attachment history, specifically in relation to crying. Ammaniti (1999) asks, "How much does the analyst contribute to activating a secure attachment in the patient through his own personal relationships and representational world?" (p. 794). In other words, how do therapists' values, beliefs and experiences of tears fit with those of their clients? In relation to this idea, Torii (2005) raises the possibility that those who enter the psychotherapy field may do so, in part, to unconsciously to heal one's own emotional wounds. It follows that some therapists may have unmet attachment needs that have resulted in their own discomfort with tears (Orbach, 1999b).

One of the main threads of the previous chapter emphasised the importance of the reaction the crier receives and the context within which they cry. Nelson (2005) and Kottler (1996) go as far as suggesting that the therapist's own attachment style and relationship with tears may ultimately help or hinder their client's process of emotional expression and progress in the therapy. Hoover-Dempsey et al. (1986) might agree, surmising that in adulthood we are likely to be "taken back to the images and feelings of infancy when confronted with another adult crying" (p. 22). Debatably, this is why people might feel uncomfortable with their own tears and those of others (Booth, 2006; Kottler, 1996; Orbach, 1999b).

Kottler (1996) provides a clinical example of a therapy session in which he realised in hindsight that his offering of a tissue to a sobbing client was out of his own need to silence her tears, rather than out of empathy for her. He concludes that this cut off the important emotional work she was trying to do and in time he was able to acknowledge how similar this woman's tears were to his own depressed mother whose crying he often tried to prevent. This raises the importance of the therapists' own therapeutic process around crying, one that I suggest has been largely ignored due to the lack of theorising about crying in general.

The following case example from my own clinical work attempts to be transparent and reveal my own experience and responses to a crying client. My client's ambivalent attachment style seemed to be symbolised by her tears, which would often take up most of the session over a period of months. At times, when the room felt awash with tears I felt as if I did not exist for her, she could not see or use me, and her tears seemed to produce a saline barrier between us.

Clinical vignette: Mary

When I first met Mary, she appeared to me to be much more like a child than a woman in her early thirties. She worked with children, and it seemed to me as if by being with them she was trying to heal something very young in herself. Mary described her father as controlling and domineering and her mother as weak and submissive. She was aware these dynamics from her parent's marriage were being re-enacted with her relationship with her

own boyfriend, telling me when she and her boyfriend fought she would cry and "act submissive" as a way to dissipate his anger.

Mary's tears began to flow in our first session together. She described feeling lost and as though she would burst with all the feelings that she felt she was unable to communicate to anyone. I initially felt very protective of Mary and yet sensed her strong ambivalence, mistrust and fear of attaching to me. Many of the early months of our work were spent with Mary hunched over, sobbing into her sodden skirt, leaving me feeling at times just as useless, hopeless and lost as Mary herself felt. Her tears seemed to be the only way she could communicate to me her felt internal experience.

Gradually, I began to notice that my response to Mary's tears changed; at times I felt emotionally unmoved when she cried, like a mother that just cannot bear any more of her child's sobbing. I also noticed with irritation that just when I might try to put into words what I thought might be happening between us she would often blow her nose loudly; it felt in a bid to silence me. Her tears, perhaps as a reflection of her object relations, felt to me to be sadistic and angry and at other times, they felt self-pitying and masochistic. Mostly they seemed to block the process of our work, leaving me feeling blank and unable to think as I struggled to get past the tears and connect with Mary.

Over time a number of insights helped Mary and I in our journey together. The first thing that helped was my realisation that instead of trying to go against the tide of her tears I needed to somehow surrender to them. By this I mean I allowed myself to really be present with Mary and her tears, letting them 'wash' over me. In this respect, I began to think about what they might be communicating that words did not seem to be able too. During this process, I became aware how much her tears also left me feeling not responded to and invisible. Memories of being emotionally missed in my own childhood helped me identify my own wish to protect myself from those uncomfortable feelings resonating in Mary's sobbing. This painful experience helped me gain increased empathy for Mary's experiences and my own.

Secondly, through her crying I began to understand the depth of Mary's vulnerability and terror at engaging and being in relationship with me. In this sense, her tears served the

purpose of protecting her from what might have felt to her like my intrusion into her internal world that no one had ever visited before. I interpreted that her tears often functioned as a kind of test, to see if I could bear her, as many others clearly could not.

It seemed important for Mary to know that I could surrender to the depths of her tears with her yet also withstand the flow of them and give her a solid lifeline that at times threatened to wash our relationship away. Gradually as my awareness grew through use of my own therapy and supervision, so did the clarity and focus in our sessions. As Mary's tears lessened both in intensity and frequency, her language and ability to articulate her feelings, particularly her anger, grew stronger. I noticed how she began to 'stand up for herself' both in and out of our sessions, telling me how a number of people (including her boyfriend) had noticed a new, stronger side to her.

Over time, Mary began to physically appear and seem more mature in our sessions and less like a lost infant. Our relationship also started to feel more robust and able to tolerate the ongoing challenges Mary would present, out of her fear of attaching to me. Mary's crying did return at times but with less of a feeling of overwhelm; as if we had passed through a phase in our work together that had represented something very young in us both.

One of the interesting aspects of my work with Mary is that her crying and the responses evoked in me did not remain static but developed, as did the mutual trust in our relationship. For example, my initial protective counter-transference in our early work is common in response to what Nelson (2005) terms "infantile tears of despair" (p. 121). Later, our work began to feel blocked by her tears that felt simultaneously submissive and aggressive. There may have been an unconscious bid on Mary's part to defend against thinking in our sessions and as Booth (2006) suggests, to keep me at a distance for fear of attaching. Nelson (2005) hypothesises that feeling shut out or pushed away, as I did at that time, could indicate that Mary was in a period of detached inhibited crying, in which she was unable to tolerate any comfort or soothing from me. Then, as my self-awareness and empathy toward Mary increased so did the space for us to talk and process what was occurring. This allowed Mary to trust me enough to stay in the therapy without needing to sabotage our work to the same extent.

Booth (2006) acknowledges the discomfort a therapist may feel when experiencing a less than empathic response to a client's tears. Alexander (2003) provides case examples of this, in relation to the tears of narcissistic clients. She suggests it might be common for a therapist to feel unresponsive and unempathic to narcissistic tears that seem lifeless and shallow; even to the extent of wishing the client would leave therapy. She uses the work of Lowen to describe the situation when a child's cries remain unresponded to, describing the child's sobbing as "unable to rouse the mother" (p. 31). This then becomes played out in the therapeutic setting where the client's lifeless, 'dead' crying, also fails to arouse the therapist's empathy.

Alternatively, Alexander (2003) suggests that the therapist may feel manipulated, exploited and emotionally drained in response to narcissist tears that seem performative, inauthentic and exploitative. This reflects the inner world of the narcissist's own feelings of being "greedily exploited by the mother" (p. 32). Alexander does not reflect on whether the client moves through stages with their tears or if the crying changes over time. However, what she does illuminate is the fact that adult crying in the psychotherapeutic setting can evoke a negative response in the therapist that can be viewed as an opportunity to gain insight into the internal world of the patient. Just as an infant has different cries to signify whether s/he is hungry, cold or in need of attention; so too does adult crying vary in its expression of need, which may impact on how it is received. I propose that this may depend on the quality of the attachment to the therapist and on the therapist's relationship to his or her own needs.

Noticing counter-transference responses may allow the therapist at times to use herself as an internal gauge of the client's emotional world. Alexander's (2003) writing implies some clients crying might induce even a homogenous countertransferential response in the therapist. While in one respect this provides a useful way to think and hypothesise about what might be happening for the client, it also seems to set up the therapist as a kind of 'knower-of-truth' about the client. This risks pathologising the client, rather than compelling the therapist to examine his or her own internal reactions and to reflect on what the tears might be unconsciously conveying. Having a greater focus on their own relationship with tears as a part of their attachment history may enhance therapists' insight

into what they themselves bring to the relationship. This awareness, coupled with what is known about the client may then be used as a cross-referencing system in order to understand more fully, what is being created in the therapeutic relationship.

Summary

Nelson (2005)[12] believes that "crying at its core is a separation behaviour that functions as an appeal for the caregivers presence" (p. 27); while Alexander (2003) describes crying as a "primitive type of verbalization" (p. 28). Yet the literature reviewed in this chapter suggests that crying and what it communicates may be far more sophisticated in adulthood than is largely recognised. Kottler (1996) for example, understands crying as having its own language system within which lies a diverse range of dialects. Perhaps some of these dialects are illustrated in this section on attachment. For example, I have examined how tears can communicate a variety of functions; to avoid or elicit separation, to induce care-giving, to defend against loss, aggressive impulses and potential hurt. I have suggested that the suppression of tears can cause increased 'weeping' of other bodily functions and that adult tears have the power to induce infantile feelings in another adult. I have also explored how the responses felt by the therapist may be less than empathic and that this could be to do with both the client and the therapist's attachment history and character type. I have proposed that by therapists paying greater attention to their client's crying and their own relationship with tears may result in a greater understanding of the client's internal world as well as their own. While this chapter has focused on the interpersonal aspects of crying as an attachment behaviour, the next chapter aims to explore tears in the therapeutic relationship more closely through the lens of intersubjectivity.

[12] One of the challenges to Nelson's (2005) assertion that crying remains an attachment behaviour in adulthood is that it does not account for when individuals cry alone (Levitz, 2006). However, Nelson argues that solitary crying is an adaptive attachment behaviour where the need for the attachment figure may take on an "as if" quality through a process of self-soothing.

Chapter Five – The Intersubjective Nature of Tears

Crying (in the clinical hour) is a particularly delicate visceral, nonverbal experience, one that merges into individual and collective memories, a part of their mutual history that can never be recreated or fully expressed in words. Attempting to capture these particular clinical moments and their meaning is then an exercise in poetry, not science.
(Nelson, 2005, p. 151)

Introduction

This chapter expands previous ideas that focus on what might be needed in the relationship for crying to be cathartic, and how the attachment relationship between the therapist and client might influence crying behaviour. Stern (2004) believes intersubjectivity is separate from, but complementary to, attachment theory. He argues that attachment behaviour negotiates closeness and distance, whereas the system of intersubjectivity focuses on the actual psychological intimacy of the relationship. Nelson (2005) adds that the intricacies of the attachment bond and intersubjectivity are interwoven "crying and care-giving are inseparable: attachment behaviour (the patient's and the therapist's) and care-giving behaviour (the patient's and the therapist's) are a mutually interactive cycle in adult psychotherapy" (p. 153). The intention of this chapter then, is to build on the previous ones, taking a step closer to examine the intersubjective impact of tears (both the clients and the therapists) as thought about in the literature.

Neuro-scientific support for inter-subjectivity

For many years, counter-transference has been used as a basic explanation for all the therapist's feelings toward the client. However, the idea that the interplay between the subjective experiences of the therapist and the client influences the psychotherapy process is becoming more widely accepted (Natterson & Friedman, 1995; Stolorow et al., 1987). Just as the mother and infant dyad influence each other to match the timing and affective direction of behaviour, so too do individuals who empathise and feel attuned to one another (Beebe & Lachmann, 1988). This idea is supported by Pally (1998) who provides evidence from neuro-scientific studies that suggests both the analyst and client may influence one another's body sensations, imagery, thoughts, behaviours and even words by unconsciously processed non-verbal cues of emotion. Pally states, "Emotion connects not only the mind

and body of one individual but minds and bodies *between* individuals" (p. 349). Given these theorists support for the idea of a shared mutuality in the therapeutic relationship, it is not hard to imagine that the therapist may feel tearful alongside the client at times in the therapy. This idea will be explored more fully further on.

Nelson (2005) uses a case example from Bollas (1992) that to an extent illustrates the mutual influence of the therapist and client. Bollas describes a client crying for the first time in their work. The client's tears are in response to an interpretation Bollas (1992) makes regarding an image he held of his patient as a three year old. An image that he felt was created by a kind of "unconscious rapport" (p. 121) between himself and the client. It seems that the client's tears in response to his interpretation were the result of feeling deeply understood by Bollas. This shared experience facilitated progression in the therapy after a long period of frustrating despair on both the analyst's and the client's part. While Bollas devotes just one line to describe his client's tears, Nelson focuses more closely on them, suggesting that the client's tears were a result of an emerging attachment to Bollas. Through this process of attaching, the client was able to allow him to be with her "in her active despair" (Nelson, 2005, p. 164).

Perhaps the strength of the attachment bond formed the basis in which this intersubjective attunement could occur. This is described by Stern as a shared interpenetration of minds that suggests a feeling of "I know that you know that I know" or "I feel that you feel that I feel" that can be very powerful; for in that moment the dyad are sharing the "same mental landscape" (Stern, 2004, p. 75). In fact, Bollas (1992) describes his interpretation as being a turning point in their work, so much so it became the subject of a dream for the client a year later.

It seems as if a sense of synchronicity or 'resolution' (described previously by Cornelius, 2001) may have occurred in this intersubjective moment between Bollas and his client. It follows that this sense of resolution might provide a new experience for the client, offering a sense of hope for change and possibly catharsis. Nelson (2005) agrees that crying in the therapeutic relationship is about hope and not just about grief "because they are triggered and shared within the context of an entirely new caregiving relationship" (p. 154).

In contrast, Forester-Miller (cited in Kottler, 1996) describes a session in which she felt mis-attuned to her client's tears, leaving them both in a state of emotional dissonance. Forester-Miller describes counselling a tearful adolescent boy and reflects on her own feelings of emotional pain in seeing him cry, admitting that her own unresolved feelings around crying were caught unawares. In hindsight, she is aware that she may have unconsciously directed the rest of the session to a cognitive level where she felt comfortable and safe, and where the client soon matched her level of affect.

In this example, it is interesting to note how the idea of an intersubjective mutuality played out. Initially the therapist and client seemed aligned, she certainly experienced a felt sense of the client's pain. It seems however that she was also experiencing her own strong reactions to her client's suffering. This resulted in the in-the-moment experience of her client's tears having a 'too-much' quality that left her having to ensure her own needs were met by diverting the client's attention away from his pain. This example illustrates the layering effect of the intersubjective interplay that exists between client and therapist. Some of the more obvious layers might have to do with power, gender, age, culture, the context and the issue being discussed. Underneath would be the unconscious dynamics at play between Forester-Miller and her young client where her fears around crying would have been interpreted by him at some level that it was unacceptable to cry in that moment. This may have been a re-enactment of his earlier experiences with past attachment figures.

I think this shows the importance of the therapist's self-awareness and understanding of the subtle interplay that occurs in the therapeutic dyad. The literature I have used as evidence suggests that the therapist's beliefs, values and feelings can be picked up by the client and responded to on an unconscious level and vice versa. In this case, the client attuned himself to the therapist, and switched to a cognitive state to match her.

Making sense of the client's tears

Some researchers have noted that crying exists primarily to communicate what words cannot (Hayes, 2006; Kottler, 1996; Nelson, 2005). Nelson (2005) writes "one tear is worth a thousand words" (p. 154). Kottler (1996) describes his work with a female patient whose profuse crying seemed to him to have a vocabulary and grammar of its own:

> I can tell by the quantity and quality of her tearfulness whether she is feeling just a little sad, or downright suicidal… I have seen, heard, and felt her shed tears of loss, grief, disappointment, despondency, frustration, anger, even relief and joy. She has taught me the special meanings that crying holds for her, even though she has been unable to put her feelings into words. (p. 74)

Kottler (1996) implies he has gained an understanding of his client's emotions, communicated to him through her weeping. This may allow him to formulate a hypothesis about what is happening for her intra-psychically. Yet in this case, the therapist's ideas regarding what is happening for the client remains based in the therapist's subjective experience, not in the client's own subjective understanding. In this respect, it seems necessary for the therapist to facilitate a process whereby the client can make sense of his or her tears. For Kottler, this is the therapeutic factor for the client.

> It is only in the act of resolution that crying can become therapeutic. In their analysis of this phenomenon, Jay Efran and Tim Spangler found that it is the recovery from tears, not the act of crying itself, that is experienced as most therapeutic. The implications of this are, then, that helping people to feel comfortable crying is indeed important, but not without also helping them to dry their eyes and make sense of their experience. (Kottler, 1996, p. 195)

The process of 'making sense' is perhaps synonymous with the process of resolution that I described above. In other words, the client's subjective understanding of his or her tears (facilitated by the therapist) both contributes to and is influenced by the mutuality of the therapeutic relationship. From another perspective, Gendlin (1991) suggests that when a client cries in therapy this brings forth all past material contained within the tears, (reminiscent of the condensed layers described by Nelson). From this view, the process of talking about what might be symbolised by or associated with the tears, may bring up previously repressed material as well as consolidating greater trust in the working alliance of the therapeutic relationship.

Therapeutic timing

Stern (2004) believes that the 'present moment' shared between therapist and client needs to be held in precious regard. He argues that too often 'being in the moment' is lost through a process of trying to put words to an experience too soon, which ultimately objectifies it. In this respect, the process of talking about the client's tears and what they mean to them

may be all about therapeutic timing. Shoan-Golan (2003) remembers spending many of her earlier psychotherapy sessions "speechless, but tearful" (p. 2). She acknowledges how important this process was to her personally.

Interestingly, in infancy crying is often described as a pre-verbal behaviour, based on the fact infants have not yet developed the speech to articulate their feelings. Yet in this sense, crying in adulthood may also be thought of as literally pre-verbal. First, the tears acknowledge the subjective emotional experience signalling to the therapist that an affective response is taking place in the client. Then, the process of articulating the felt experience using words can complete the process. For Maroda (1999) the emotional experience necessarily precedes "both the acquisition of genuine insight and the intellectual organizing of that experience…the point of change comes at the point of emotional surrender" (p. 63).

Hayes (2006) supports the premise that crying can communicate something words cannot. Yet in her experience of group work, she found it was also true that when the crying ceases, "the members begin to be able to put into words feelings hitherto unexpressed. The pre-verbal communication opens the possibility of finding a spoken shared language" (p. 45). Hayes (2006), Kottler, (1996) and Stern (2004) therefore suggest that finding the language to talk about tears is necessary at some point in the therapy in order for the client to gain therapeutic insight, which arguably may be intrinsic to feelings of catharsis as earlier suggested. Speech then becomes the tool for facilitating understanding as Lacan suggests, and becomes the means by which the client's view of the past can be altered (Lacan cited in Benvenuto & Kennedy, 1986). This process in turn may lead to an internal change in the client and eventual healing.

For Maroda (1999) the process of surrendering to one's own emotional experience is in itself the "self-altering process" (p. 54). For other theorists, feeling one's affective state is the first step and articulating it is the second. What seems to be needed from the therapist is attunement to where the client might be in relation to these concepts. McCrank (cited in Mills & Wooster, 1987) suggests that in reaction to the tears of another person, a neuro-chemical response is aroused in the observer that has a "quieting effect" (p. 128). This may

enhance the observer's capacity to be with a client's tears without the need to make sense of them too soon, yet this may depend on the anxiety the crying evokes in the therapist.

The therapist's tears – breakthrough or breakdown?

As mentioned previously Beebe and Lachmann (1988) and Pally (1988), suggest that a congruency of feeling states may exist in some therapeutic relationships. This provides a theoretical explanation for the potential of therapists to experience tearfulness alongside their clients in the therapy process. Another explanation along similar lines comes from Sussman (2001) who suggests therapist tears that 'come out of the blue' may be attributable to what is termed as psycho-peristalsis. She describes this as an involuntary, intuitive gut response that is able to pick up affect at an unconscious level in the therapist and client during the therapy. This appears to be congruent with the theories of Pally and Beebe and Lachmann, and suggests that the therapist may not always have control over their tears. Sussman feels it is vital for the therapist to notice the differences in tearful responses with clients. She argues that when tears arise "independently" this may be in reaction to unconscious client material (Sussman, 2001, p. 91).

According to Nelson (2005), the suggestion that therapists cry with their clients is seldom discussed in the literature. Conducting her own informal study, she found that most therapists surveyed indicated that they rarely cried with their patients and that those who did cry believed at times it could help the client and at other times interfere. She noticed that there seemed to be a correlation with how therapists personally felt about and experienced crying, and how they perceived the idea of crying with a client.

Waldman (1995) carried out research in this area to investigate whether therapists that cried with their clients could be considered either a breakthrough or a breakdown in the therapeutic relationship. She interviewed ten doctoral-level, psycho-dynamically orientated and experienced psychologists. Nine of those psychologists interviewed believed their crying enhanced a facilitating process in the patient's work and only one therapist linked his crying to his own personal difficulties. Most described their crying alongside their clients as being emotionally congruent to what was occurring in the moment. One therapist explained her tears as facilitating the client's own grief and another believed to have stifled

her own tears would have been "non-human" (Waldman, 1995, p. 80). A further therapist describes how his client felt his therapist's tears as being "total empathy" (p.81) and that the client would refer back to that session many times. The therapist thought about this experience as being reparative for the client.

In contrast, another therapist felt some shame that his crying could have "created pain" for his client (p. 85). He describes the internal dilemma felt by some therapists. "It is absolutely true for these people that they don't want a therapist who can't feel with them. But… it's frightening to have a therapist who does feel with them" (Waldman, 1995, p. 85). Similarly, Nelson (2005) suggests an anxiously attached person may find the therapist crying to be very unnerving and confusing, whereas as a securely attached adult may feel more empathic toward the therapist. Therapists in Waldman's study were aware of the potential for female patients particularly, to take on the caretaker role when faced with the therapist's tears. They noted that it was important for the client not to experience the therapist's emotional affect as intrusive. It seems possible to conclude that in some cases the different responses of clients to their therapist's tears may be based upon, in part, the attachment between the client and the therapist, the timing and strength of the relationship and the intersubjective experience of both parties relationship with tears.

The therapist's tears may also be influenced by the contextual situation of the therapy. Waldman (1995) suggests there might be an emotional distance for the therapist in dealing with the client's historical grief in contrast to new material, such as a sudden death in the client's life. She argues that by responding tearfully in the moment of a client's loss, the therapist might "be providing the most useful demonstration of their humanity as clinicians" (p. 123). Counselman (1997) whose article focuses on her experience of working with a couple, during which time the wife developed terminal cancer, supports Waldman's view. Counselman reflects that in those sessions she learnt to allow her own tears as a way of being truly emotionally present with the very difficult emotional work needing to be done. Maroda (1999) adds weight to the benefit of the therapist's emotionality when she states:

> being lost momentarily and giving over to deep, even primitive feelings, does not have to translate into losing control of the therapeutic situation. On the contrary,

> an analyst who is not afraid to surrender to her own and her patients' strong emotions, is more likely to transform them both. (p. 64)

For those therapists who work from a more traditional, psychoanalytic framework Maroda's (1999) notion of the therapist surrendering to her feelings with the client may seem extreme. Yet there seems to be support in the literature on crying, for therapists to allow themselves to align with the client on an emotional level. For example in Waldman's (1995) study, all of the participants stated that they thought the idea of neutrality in the relationship needed to be redefined, believing that the notion of therapist crying should be explored in the context of the "interactive influence of both participants in the therapeutic relationship" (Waldman, 1995, p. 89).

In other research, Curtis, Matise and Glass (2003) found that the majority of the counselling students they surveyed thought that the therapist weeping with the client could "facilitate therapeutic change" (p. 300) but that twenty percent were also concerned about doing so. This illustrates the conflict many therapists may feel about wanting to emotionally engage with patients and being seen as unprofessional if one 'tears up' during a session. Part of the discussion in this study focuses on the intentionality of the therapist and the authors argue that a practitioner is able to intentionally hold back tears if it was felt that it might disrupt the therapeutic process.

There appears to be some disagreement in the literature surrounding this issue as previously mentioned, but Nelson (2005) states in her survey that most therapists reported that they would "suppress their tears" (p. 175) when working with clients. Yet Nelson herself suggests that tears can be beyond the control of the crier. While it may be impossible to know the answer, what seems to be vital is for the occurrence of therapist tears to be talked about, just as it seems important for the client's tears to be processed. Waldman (1995) concludes that it would be hazardous not to discuss the reality that tears are shed by both therapist and client. She suggests that it is not particularly useful to categorise tears as either a breakdown or a breakthrough but to see them as "individually powerful moments of the therapy that need to be addressed both in the therapy and by the psychodynamic community at large" (Waldman, 1995, p. 134).

Nelson (2005) and Curtis et al. (2003) may well agree with Waldman and add that there is a definite lack in teaching students how to deal with powerful feelings in the therapy room and use of the therapist's tears as part of the work. Nelson suggests this could be because crying is often experienced as "vaguely shameful" particularly from the stance of psycho-analytical neutrality, as it is essentially "involuntary self-disclosure" (p. 177).

Summary

In this chapter, I have used evidence from neuro-science to provide a context for exploring the emotional intersubjectivity that exists between the therapist and client. I have found that some theorists suggest crying can communicate without words, yet most agree at some point, the crying needs to be talked about in the relationship in order to have a therapeutic and arguably cathartic value for the client.

I have also discussed the experience of the therapist who cries with her clients and have looked at the different meanings writers have attributed to this occurring. What seems to be of the greatest importance is whether or not shedding tears facilitated something therapeutic in the work. The issue of whether therapists' tears are intentional or beyond their control is a matter of controversy in the literature. There is a dearth of writing on therapists' tears and this may have to do with Nelson's (2005) belief that it remains an uncomfortable grey area for therapists to explore, in both theory and practice. In my final chapter that follows, I summarise my discussion thus far and reiterate the clinical implications gained from this work.

Chapter Six - Conclusion

I started this process interested in why there seemed to be an assumption that crying was a positive, yet largely taken-for-granted aspect of the psychotherapeutic process. This interest was sparked by my clinical work with clients, their different ways of expressing tears, and my feelings in response to them. I embarked on this dissertation seeking to find out how crying has been given meaning to in psychoanalytic theory and related disciplines. Following a review of the literature, this chapter summarises my findings in response to my original question and discusses some of the implications for clinical practice. I endeavour to point out the strengths and limitations of this study as well as areas for further research.

Summary of findings

Through exploring the historical context of crying, I have established that religious beliefs that crying can cleanse and make the crier pure and free of aggression may have played an important role in forming the idea that crying can be cathartic. In conjunction, I found that there still exists at a societal level, the ideology that crying promotes emotional, spiritual and physical health and well-being. The process of reviewing psychoanalytic theory, behavioural psychology research, and experiential theories, established that there is evidence to support the notion that intrapsychic change can occur through crying. I also found that in order for catharsis to occur, certain conditions in the therapeutic relationship might be needed, suggesting that catharsis might itself be dependant on the quality of the interpersonal, attachment relationship between the therapist and client.

Specifically, I found that when an optimal environment exists, it is possible clients may allow themselves to ‘surrender’ to their feelings and for the tears to create an emotional release. This emotional surrender combined with the processing of the tears in psychotherapy over time may have therapeutic value and produce healing in the client. This was illustrated by my clinical work with Julie.

In Chapter 4, I introduced the well-researched link between crying and attachment. I explored how infants learn from their attachment figures whether crying is an acceptable and safe behaviour to engage in and how this extends into adulthood to become a much

more sophisticated expression of emotion. I used Nelson's (2005) work to argue that the attachment style and the ensuing beliefs the adult client has about crying may be determinant factors in how, why and if the client cries in the therapy and how he or she is responded to by the therapist. I also discovered that the therapist's own attachment history and relationship with tears requires examining in order to work effectively with clients' tears, particularly when experiencing negative responses to a client's weeping. A relevant example of my work with Mary was used to illustrate this chapter.

I then used evidence from neuro-science research to further explore the idea that the therapeutic relationship has a pivotal role in whether the client's tears might be experienced as therapeutic or not. I provided an intersubjective view of crying, suggesting that the influences of the intrapsychic and interpersonal nuances of both the therapist and the client may invite or hinder tears. Within this framework, I have explored the belief held by a number of theorists that crying needs to not be seen as just a thing-unto-itself but needs to be talked about and processed in order that the client can reach their own subjective understandings. This process may bring forward further layers of unconscious material to be worked through. It has been argued that the insight gained from processing the emotional experience may have therapeutic value.

I also investigated how the therapist's tears might feature in the work and impact on the therapeutic relationship. This provided some contrasting ideas about the intentionality of the therapist's tears and the discomfort that exists amongst therapists in addressing this issue. My findings have revealed a lack of writing from a psychoanalytic perspective and this stresses the need for greater consideration to be given to crying in the therapy room, in training institutes, theory, research and the wider psychotherapy community. As this study has revealed, the simplicity of tears also belies their complexity. These findings provide an evidential base for the development of clinical implications.

Clinical synthesis and implications

The distinct lack of theorising about crying until recently, has meant that in a clinical sense, crying has remained invisible by its obviousness. This current study has opened a space for further dialogue to take place on the subject of tears, how we interpret them, what they

mean to us personally as therapists and how we can work with them in order that the most therapeutic outcome for the client might be achieved.

From a clinical perspective, it appears that the quality of the therapeutic dyad is an essential feature for the possibility of the client to experience their tears as cathartic. In order for the quality of the relationship to be optimal, a number of conditions need to be in place. Firstly, the therapist's own awareness of their attachment history in relation to tears needs to be illuminated, as does the clients. Clients also need to experience the therapy as a safe and confidential setting where they have some trust and hope in the therapist and feel accepted by them. One of the tacit foundations of psychotherapy may be that intrapsychic change in the client can be facilitated in part through the interpersonal relationship between the therapist and client. This work has attested to the importance and relevance of the therapeutic relationship to how clients might experience their own and their therapist's tears.

Secondly, the client's tears may offer useful insights into their representational world, including the client's object relations and attachment history. It follows that, by clinicians paying greater attention to their own responses and by processing the tears with the client, the therapist may learn more about who they represent to the client and how that attachment is being played out in the relationship. Intrinsically linked to this is the therapist's responsibility to closely examine his or her own relationship with tears, an area that seems to have been largely ignored perhaps because it is assumed therapists have sufficient self-awareness through their own therapy and supervision.

Booth (2006) writes that the person who knows best about the tears is the person who is shedding them. I suggest that by the therapist being able to sit however uncomfortably, with the client's tears in his or her own unknowing, is a valuable part of the work. I have discussed the therapist's surrender to the process and the willingness to do so may facilitate for the client the possibility of insight, catharsis and deep healing. As shown in infancy, the mother's instinctual response is to soothe the baby and quieten the tears. Yet in the therapeutic setting, it seems often the therapist's role is to both soothe 'the baby' and allow the tears, before helping the patient make sense of them. Simultaneously, I am aware that in

trying to solicit meanings around crying, we are in fact attempting to define in words something that can be deeply inexplicable.

Strengths and limitations of this study

This study has been limited by the lack of psychoanalytic writing on the subject of crying in general, but particularly from the perspective of therapist crying with the client. This perhaps reflects some discomfort in the psychotherapeutic community about the involuntary self-disclosure associated with crying and is an area that needs further research and theorising. With the move toward more intersubjective paradigms, I believe this discourse can and will be further expanded and that this dissertation has laid some foundations for this to occur. There is perhaps a potential bias of psychoanalytic literature to use case studies (as I did myself) that have positive outcomes. Were therapists to explore their less successful therapeutic experiences and share them in publications, we could be afforded the opportunity for a continued dialogue from multiple perspectives.

The psychoanalytic case material used for this dissertation came primarily from the subjective interpretation of the therapist rather than the client. This reflects the ethical difficulty the paradigm of psychotherapy faces, in making sense of the work we do. I believe my use of psychology research has enhanced this study in that it has provided some literature from the client's perspective, and recognise that this comes with its own bias. I am also aware that by using evidence from non-psychoanalytic theory my research process may be considered to be both enhanced and somewhat diluted.

Further areas for research

As mentioned in the introduction, I chose to exclude crying in relation to gender and culture because of the breadth of these areas. Thus, gender and cultural influences on crying in the therapeutic relationship would be important and interesting directions for future studies of crying; particularly an exploration of gender roles in conjunction with the idea that tears can serve to dissipate aggression.

Further investigation into the neuro-chemical responses between therapist and client via tears would also be of interest particularly from the view of Nathanson (cited in Maroda, 1999) who states, "Nothing becomes an emotion until it travels outside the brain to the musculature and microcirculation of the face, there to be assessed and interpreted as an affective response" (p. 68). Connected to this is the experience of non-crying in the psychotherapeutic setting, an area I have paid little attention to due to the scope of this work.

Concluding thoughts

As a result of engaging in this study, I notice in myself a deeper awareness of the mutual influence that exists between myself and my clients, particularly in relation to tears. I am more aware of the impact of my own losses in relation to my clients in the moment of our intersubjective meeting. On one hand this has given me greater clarity about who might be feeling what and on the other it has helped me recognise the inter-weaving of our diverse yet collective histories. I recognise at times my own discomfort when I feel my own tears beginning to rise in a session but what I know now, is that these moments need to be thought about carefully before deciding the best way to proceed, and this will depend on the context and the attachment of the relationship. Reflecting on how I have developed as a clinician since my work with Mary and Julie makes me feel grateful and humbled by the learning I gained from them both.

My hope is that the psychotherapy community might begin to dialogue about the complex subject of crying more fully and not just accept weeping as a thing-unto-itself. Working towards facilitating an understanding in our clients of the meanings their tears, may provide therapeutic value that has been largely under utilised in the psychotherapy paradigm. Only through engaging in a process of both not knowing and keeping open to an awareness, can we hope to turn what Barbalet (2005) terms the "opaqueness" (p. 136) of tears into something more transparent.

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