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Crying in Psychotherapy: Catalyst, Byproduct, or Resistance? A Qualitative Exploration of Therapists' Working Models Across Theoretical Orientations

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Abstract

The experience, expression, and exploration of emotions are central to the psychotherapeutic process, and crying is a frequent part of it. Yet, its role remains surprisingly under-researched. In the absence of established theories or guidelines on adult crying in psychotherapy, therapists rely on their own working models - likely shaped by factors such as clinical experience, specific training, and personal beliefs. This study explores therapists' assumptions about crying in therapy, its perceived roles and functions within the therapeutic process, and the interventions used in response. We conducted a total of N = 33 interviews with therapists from psychodynamic, cognitive-behavioral, and systemic orientations. Data were analyzed using an iterative qualitative approach based on the principles of Grounded Theory. From this, we developed a consensual, integrative category system that synthesizes therapists' diverse working models and highlights their shared foundation across orientations. This cross-orientation framework captures common assumptions and strategies while also accommodating orientation-specific nuances. Findings indicate that therapists commonly view crying as a marker of pivotal therapeutic moments, often emphasizing its role in relationship building. At the same time, they distinguish between different forms of crying, with varying assessments of whether it supports the process or signals resistance and avoidance. The resulting integrative category system provides a conceptual basis for future research and theory development on crying in psychotherapy.

Keywords: crying, psychotherapy process, emotions in psychotherapy, mechanisms of change, therapeutic interventions, therapists' working models

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Introduction

In recent years, the phenomenon of (adult) crying in psychotherapy has received growing attention in psychotherapy research, as evidenced by an increasing number of publications (e.g., Bylsma et al., 2021; Hill et al., 2025; Katz et al., 2024). Nonetheless, the field remains in its early stages: while promising hypotheses and emerging trends can be recognized, many questions remain unresolved, and the current body of research is limited, with a tendency toward methodologically homogeneous designs.

The Role of Crying in the Therapeutic Process

When considering crying in psychotherapy, a key question concerns its role in the therapeutic process and its relevance for change. Rottenberg et al. (2008) more broadly asked, "Under what conditions and for whom is crying likely beneficial?" (p. 403) – a question that is equally relevant to psychotherapy. Within psychotherapy research, emotional expression has generally been linked to favorable outcomes (Peluso & Freund, 2018; Sønderland et al., 2024), although crying is typically not examined as an explicit factor.

Retrospective studies indicate that therapists and clients often construe crying as important and potentially facilitative for the therapeutic process (Knox et al., 2017;'t Lam et al., 2018). Katz et al. (2024) refer to crying as a "window of opportunity" and – building on and expanding prior research (Genova et al., 2021; Katz et al., 2022) – report positive associations between crying episodes, the therapeutic alliance, and indicators of therapeutic progress. One of the few observational studies in this field found that crying episodes were often preceded by affect-focused and meaning-oriented interventions and were experienced as subjectively challenging, while therapeutic alliance ratings remained unaffected (Capps et al., 2015). Hill et al. (2025), likewise using an observational, process-oriented design, found that inhibited crying was associated with reduced collaboration in therapy, particularly among patients who were anxiously or avoidantly attached.

Taken together, these findings suggest that crying in psychotherapy may be clinically meaningful and, under certain conditions, associated with beneficial relational and process-related outcomes. At the same time, the existing literature remains limited. Much of the available evidence is based on retrospectively reconstructed accounts or cross-sectional self-report designs, offering only limited insight into the situational dynamics and processual unfolding of crying in psychotherapy. Katz et al. (2024) emphasize the need for alternative methodological approaches, such as qualitative methods, to provide a more comprehensive understanding and expand on the current findings.

Forms of Crying and Therapeutic Interventions Around It

In a study by Gutjahr and Benecke (2024), an external, observational perspective – clinically informed yet non-participatory – was adopted, in which videotaped crying episodes from therapy sessions were analyzed with respect to patients' crying and therapists' reactions to it. This resulted in the development of two category systems: one categorizing different forms of emotional crying in patients, and the other classifying various therapeutic interventions in response to crying.

The following forms of crying were identified by Gutjahr and Benecke (2024), several of which closely correspond to Nelson's (2005) earlier categorization: "Protest crying," characterized by an angry and wailing undertone; "Overwhelmed crying," typically accompanied by feelings of despair and helplessness; "Crying in grief," marked by sadness and mourning; and "Positive crying," associated with emotions such as gratitude or relief. These forms differ in their interactive function, while the boundaries between them are fluid, and different qualities of crying may overlap or shift.

Therapists' responses to crying were grouped into three overarching categories: "Addressing," in which emotions are acknowledged and possibly intensified; "Giving space," in which control of the situation is left to the patient; and "Neutralizing," in which emotions are downregulated. These categories are not mutually exclusive but represent distinct types of therapeutic interventions that may co-occur or shift within a crying episode.

While these findings provide a valuable initial insight into the observable interactional dynamics of crying in therapy, they remain descriptive of what can be observed from an external perspective. They leave open the question of how therapists themselves arrive at these responses, how they make sense of their patients' crying, and how such sense-making is embedded within broader therapeutic frameworks and working models. The present study seeks to address this gap.

Therapists' Working Models

Considering the limited evidence, we were interested in how therapists make sense of crying in therapy, including when and for whom it is perceived as helpful within the therapeutic process and when it may be experienced as challenging.

In the absence of established guidelines, therapists rely on a range of explicit and implicit assumptions shaped by their training, theoretical orientation, clinical experience, and personal beliefs. Each therapist thus operates with a working model that guides how patient crying should be interpreted and responded to in clinical practice. The concept of working models is used to describe clinicians' guiding assumptions in clinical action and has been elaborated as a transtheoretical

framework for operationalizing clinicians' concepts for process-outcome research (e.g., Spurling, 2018; Storck et al., 2021).

Storck et al. (2021) distinguish three levels: general, case-specific, and session-specific models. The present study primarily addresses aspects of therapists' general working models – their overarching assumptions about the meaning of crying for the therapeutic process, the alliance, and change. At the same time, these assumptions are understood as dynamically related to case- and session-level considerations and usually reflect a co-creation between therapist and patient.

The Present Study

This study aims to explore psychotherapists' working models of crying in psychotherapy. Therapists from different theoretical orientations – psychodynamic (PDT), cognitive-behavioral (CBT), and systemic (ST) – were included to examine the potential integration of these perspectives into a comprehensive framework. This led to the following research questions:

1. What assumptions do therapists hold about the role of crying in psychotherapy?
2. What interventions do they choose in response to patient crying?
3. Can therapists' working models of crying across different theoretical orientations be integrated into one category system while preserving orientation-specific nuances?

By addressing these questions, we developed an integrative category system of therapists' perspectives on crying. This system serves as a preliminary conceptual and heuristic framework for theory development and future process-outcome research, focusing on shared assumptions and intervention logics across orientations rather than on systematic orientation-based comparisons.

Method

Study Design

Over several years (2014–2023), a total of $N = 33$ expert interviews (Bogner et al., 2009) were conducted with psychotherapists specialized in PDT ($n = 15$), CBT ($n = 11$), and ST ($n = 7$). Interviews were conducted by a total of seven researchers with varying levels of clinical and research experience (including one senior researcher and clinician, licensed psychologists, and advanced graduate students in clinical psychology), all of whom were trained and supervised within the same research team. The extended data collection period reflects the integration of this study within an ongoing, thematically focused research program on crying in

psychotherapy. While interviews were collected over time, the interview focus and core methodological procedures remained consistent.

Analysis was guided by a Grounded Theory framework (Glaser & Strauss, 1999) and followed an iterative analytic design, resulting in an integrative category system that captures a shared conceptual framework underlying therapists' working models of crying in psychotherapy while preserving orientation-specific nuances. Accordingly, theoretical orientation was treated as contextual background information rather than as an analytic comparison variable, with the analysis focusing on recurring patterns of meaning across therapists rather than contrasting orientations or assessing relative frequencies.

Participants and Data Collection

Participants were licensed psychotherapists experienced in their respective orientations, all of whom primarily conducted individual psychotherapy. Licensure in Germany requires extensive postgraduate training following a university degree in psychology or medicine. Participants ranged from early-career therapists who had recently completed their training to highly experienced practitioners with several decades of professional practice. They worked in outpatient care, primarily in private practice, treating a broad range of adult clients rather than a specific clinical population.

PDT, CBT, and ST were included as the three publicly reimbursed and guideline-approved core psychotherapy approaches in Germany, each defined by standardized postgraduate training and broad relevance in outpatient psychotherapeutic practice. Ethical considerations were carefully observed throughout the study. All participants provided informed consent after being fully briefed about the study's aims, procedures, and data handling. The interviews were audio-recorded, promptly transcribed, and pseudonymized; the original recordings were then deleted. Only minimal demographic data (therapeutic orientation and professional experience) were collected to prevent identification.

The interviews incorporated elements of problem-centered (Witzel, 2000) and episodic interviewing (Flick, 1995) in a semi-structured, open format. They relied primarily on open prompts and conversational cues – such as "Can you recall a situation in which a patient cried during therapy that particularly stayed with you?" or "Do you observe different types of crying in therapy?" – to elicit therapists' experiential and process-related knowledge (Bogner et al., 2009). The flexible interview guide ensured coverage of key thematic domains (e.g., forms and functions of crying, therapeutic responses, relational aspects, therapists' own crying, training), while prioritizing the natural conversational flow over standardized questioning.

Data Analysis

The analysis followed an iterative, collaborative process involving multiple researchers. Initially, subsets of the corpus (N = 33 transcripts) were independently analyzed by team members, each focusing on thematic or orientation-related questions within the broad framework of therapists' working models. A pilot phase with a subset of interviews was used to harmonize coding practices and refine initial category definitions. Established approaches from qualitative content analysis (Kuckartz & Rädiker, 2023; Mayring, 2015) guided the development of preliminary category systems.

Primary analyses, conducted under supervision and with reflective feedback from the first author, were subsequently integrated into a comprehensive secondary analysis by the first and second authors. This synthesis yielded a consensual, integrative category system capturing both shared and orientation-specific aspects.

Category definitions were initially specified but remained flexible to accommodate new and emerging meanings. Meaning units – defined as the smallest text segments that still carry a distinct meaning – were grouped into domains aligned with the research questions and clustered according to shared meanings; multiple coding was allowed when a segment addressed more than one theme. Using constant comparison, groups were iteratively merged, subdivided, or retained. This process resulted in a hierarchical structure of main categories and subcategories at different levels of abstraction.

Grounded Theory provided the overarching framework, with the research questions functioning as an open starting point. Deductive and inductive approaches were combined: the category systems developed by Gutjahr and Benecke (2024) served as a deductive framework to explore forms of emotional crying and associated therapeutic interventions, while inductive, material-driven analysis was used for all remaining aspects. MAXQDA 2024 (VERBI Software, 2024) provided support for coding and data management.

To assess the applicability of the finalized category system and further refine it, the system was re-applied to three interviews (one per therapeutic orientation). Interrater reliability (Kappa = .68) indicated sufficient coding alignment, helped clarify category boundaries, and prompted discussion of ambiguous categories, leading to refined definitions. Although this procedure does not provide statistical generalizability, it strengthened the coding scheme's methodological rigor. Consensus was ultimately reached for all coded segments.

To enhance methodological quality, several criteria for trustworthiness were addressed. These included analyst triangulation through independent coding and consensus discussions, reflexivity via supervision and team reflection, transparency through detailed documentation of coding and category development, and credibility through interrater checks and iterative refinement.

Results

All categories identified across the interviews are presented below. Together, they refer to different aspects of what we call a therapist's working model of understanding and responding to crying in psychotherapy. The system is organized around two overarching domains – "Assumptions" and "Interventions" – which further branch into main categories and, in some cases, subcategories. The domains are theoretically interrelated: therapists' assumptions (e.g., about "forms of crying") inform the interventions they choose in practice. While each therapist draws on an individual working model, our category system integrates these into a shared, cross-orientation framework. The categories and subcategories should therefore not be viewed in isolation but as interrelated components of a broader working model, with fluid boundaries and overlapping constellations of assumptions and strategies in practice.

Although the analysis did not aim for a systematic comparison of therapeutic orientations, some orientation-related tendencies emerged and could be mapped onto this overarching system, primarily in terms of emphasis, terminology, and preferred interventions. Selected categories are illustrated with interview excerpts to clarify their meaning and situated use. These excerpts reflect therapists' retrospective accounts of their own experiences and are presented descriptively. The analysis thus focuses on therapists' practices and perspectives on crying rather than on crying itself or clinical recommendations. A graphical overview of the final category system is presented in Figure 1. The complete integrative category system, including definitions and anchor examples, is openly available on the Open Science Framework (https://doi.org/10.17605/OSF.IO/ZEK23).

Assumptions About Forms of Emotional Crying

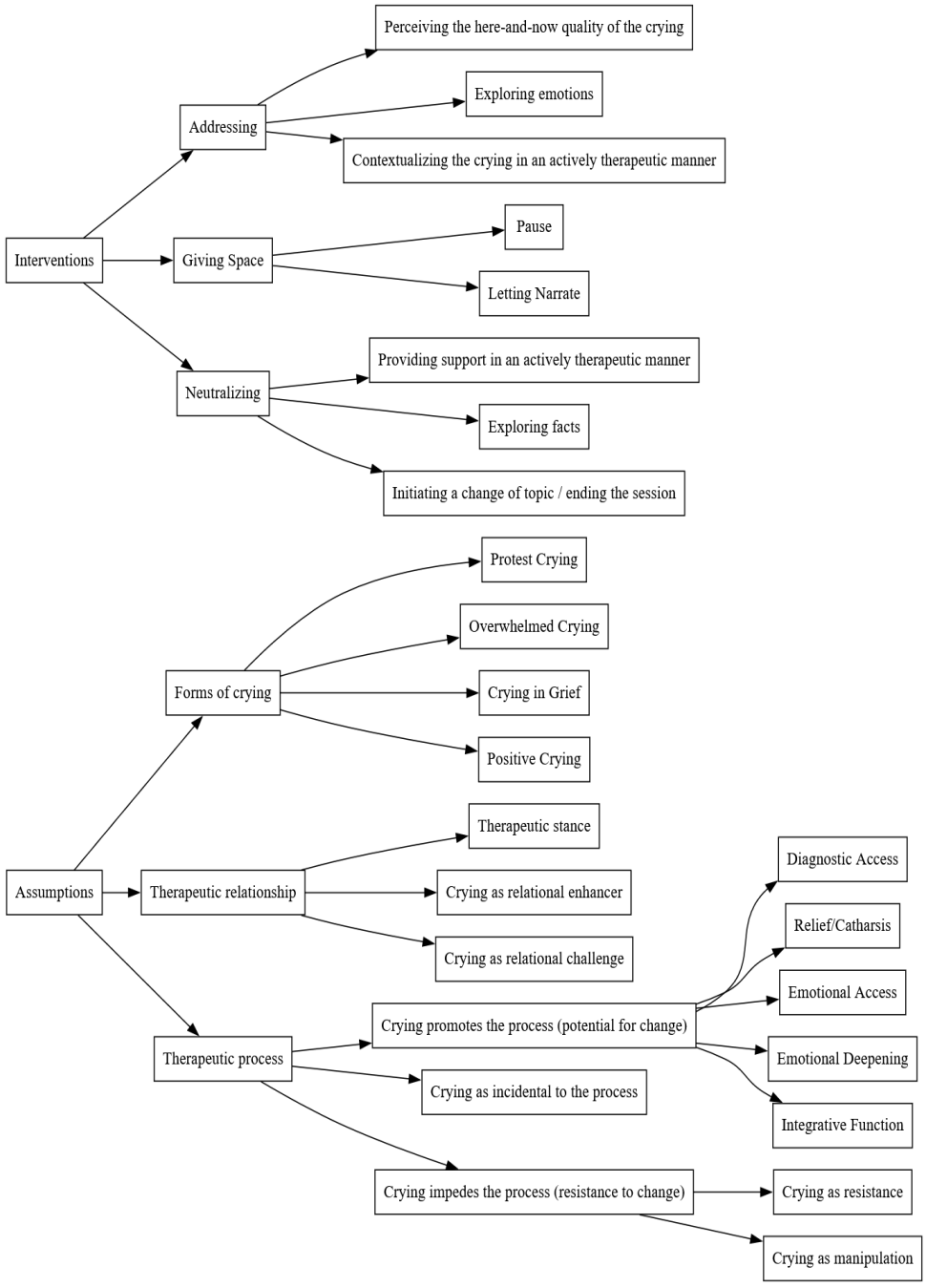
This main category delineates distinct forms of crying, drawing on Gutjahr and Benecke's (2024) typology, which was further differentiated and expanded with material from this study. Each form elicits characteristic countertransference reactions and is dynamically linked with other assumptions, e.g., regarding the therapeutic process. This interplay shapes how challenging a given form of crying is experienced, how empathically it can be engaged with, and which interventions are selected.

Protest Crying

Protest crying typically arises from feelings of anger, injustice, or self-pity, often triggered when a person feels undervalued or unfairly treated. Common themes include relationship conflicts, personal misfortune, or perceived slights, with guilt

Figure 1

Integrative Category System: Overview



and responsibility frequently externalized. This form of crying is described as complaining, defiant, or offended, and can vary in intensity. It appears to serve a strong interactive function, being outwardly directed and validation-seeking, which can evoke frustration or anger in the therapist and sometimes prompt boundary-setting or emotional withdrawal. This form of crying often reflects resistance to the situation and nonacceptance of circumstances. Protest crying was often associated with the categories "Crying as resistance" and "Crying as a relational challenge."

> "That kind of protesting crying triggered something in me – like, 'I need to set a boundary here. I'm not willing to go along with this pity narrative.' It felt like a defense: 'I'm small and helpless, I want to rage, and you're not allowed to say anything.' And I just didn't want to get drawn into that."

Overwhelmed Crying

Overwhelmed crying typically stems from feelings of helplessness, powerlessness, fear, or despair, often triggered by acute situations that evoke a general sense of overload or loss of control. It can occur when a person feels unable to cope or during moments of painful realization, sometimes associated with traumatic memories. This crying is described as insecure, anxious, and desperate in quality, and can vary in intensity. Its interactive function is moderate, suggesting that the therapist may feel compelled to offer help, comfort, or guidance. This form of crying indicates less resistance to the circumstances and an increasing awareness of the (imminent) loss.

> "Then the crying is often more like: 'I can't handle this anymore. I have no idea what to do.'"

Crying in Grief

Crying in grief stems from deep sadness associated with specific losses such as farewells, separations, or death – usually in the past, occasionally ongoing. Patients are emotionally affected but remain composed, often crying silently. Its interactive function is minimal, as it appears at peace and does not seek a response. Therapists perceive this form positively, resonating with empathy and shared sadness. It reflects an inner acceptance of the loss.

> "I had this patient who was always crying […] and she said she really needed a lot of space to process everything she'd been through. A lot of it was about loss and really coming to terms with death and saying goodbye."

Positive Crying

Positive crying is described as stemming from joy, gratitude, or being moved – often when long-awaited events come true after hardship, or in humorous situations. Therapists see it as reflecting relief or catharsis (linked to the "Relief/Catharsis" category). Patients appear deeply moved yet calm, often smiling or laughing through

tears. Its interactive function is minimal, though therapists often resonate with and feel moved themselves.

> "Tears of joy happen too... but the big difference is, suddenly something's there again that's been missing for a long time."

Assumptions in Relation to the Therapeutic Relationship

This main category encompasses assumptions regarding the interplay between crying and the therapeutic relationship. It reflects the bonding and communicative functions of crying, as described in the literature, unfolding within therapy. It includes the "Therapeutic stance" toward crying and the conflicting assumptions of "Crying as a relational enhancer" versus "Crying as a relational challenge."

Therapeutic Stance

Assumptions about the "Therapeutic stance" refer to therapists' understanding of their role, responsibility, and basic attitude toward patients, including their crying. Across orientations, this stance is characterized by professionalism, openness, and a compassionate, accepting attitude that fosters safety:

> "[…] what's important to me is that the other person knows: It's okay to cry here."

Unlike in everyday contexts, crying in therapy is not immediately comforted but is held with presence and containment. It includes empathic presence without enactment and the capacity to tolerate even difficult countertransference reactions without acting on them. This accepting stance forms the basis for further interventions:

> "In that moment, it does make me feel a bit helpless too – but in the end, I kind of take the other person's helplessness into my own 'container,' you know? I just hold it, without snapping, giving advice, or trying to restore order or balance right away. I just sit with the fact that situations like this exist – and that's okay."

Crying as a Relational Enhancer

Crying is often considered beneficial for the therapeutic relationship. Therapists describe this association as bidirectional: a strong alliance can enable or be reflected in crying, while crying can also actively strengthen the relationship.

> "Crying does create a connection… I usually feel closer to the person afterward."

It can serve as a form of communication through which patients convey implicit needs for closeness, care, attention, or comfort. When perceived as authentic, it

promotes trust and connection. Therapists report positive countertransference reactions such as gratitude, joy, or compassion:

> "Because someone who's crying is opening up to me in a completely different, wordless way – and I'm grateful for that trust. When someone can let go and cry, it really shows they trust you."

Crying as a Relational Challenge

While crying is often associated with emotional authenticity and relational closeness, it can also evoke challenging reactions in the therapist, particularly when it appears excessive, dysregulated, theatrical, or emotionally manipulative.

> "The histrionic [crying] doesn't really stir much compassion – it's more like, 'Oh god, this is exhausting, annoying, irritating… does it really have to be happening?'"

Relational messages conveyed through crying may be experienced as highly demanding, pressuring, or even emotionally coercive. Sometimes, crying may feel like a relational test. Therapists may feel inclined to reject the perceived relational offer rather than respond with empathy, experiencing irritation, emotional distancing, or helplessness. Such dynamics can disrupt attunement and the therapist's emotional availability, evoking negative countertransference such as anger, withdrawal, devaluation, or feeling overwhelmed. Depending on how the interaction unfolds, this form of crying may strain or even temporarily rupture the therapeutic alliance. "Crying as a relational challenge" is often associated with "Protest crying" and "Crying as resistance."

Assumptions in Relation to the Therapeutic Process

This main category encompasses assumptions regarding the interplay between crying and the therapeutic process:

> "Crying is either like a gate that closes something off – or it's more like a fluid, like an oil."

It comprises the categories "Crying as incidental to the process," "Crying promotes the process (potential for change)," and "Crying impedes/obstructs the process (resistance to change)," each of which is further divided into subcategories.

Crying as Incidental to the Process

This category reflects the idea that crying does not exert a specific impact on the therapeutic process but is instead seen as a by-product. It is, for example, regarded as just one of many emotional expressions, without any distinct function:

> "Crying, first and foremost, is just one way of expressing a feeling."

Crying Promotes the Process (Potential for Change)

This category reflects the notion that crying may act as a catalyst for therapeutic change and progress. In some cases, crying is even regarded as an indicator of therapeutic success:

"I'd say if people cry, then I've done a good job."

This category includes five subcategories that highlight various aspects of how crying may facilitate therapeutic work. The subcategories are not static or strictly separate but may be interrelated or sequential, reflecting different emphases and levels of conceptual abstraction in understanding the impact of crying. The first subcategory "Diagnostic access" relates to the therapist and concerns the role of crying in providing diagnostic insight. Therapists often describe crying as a "signal function" or "key moment," especially in early sessions, where it can initiate diagnostic hypotheses. This subcategory intersects with "Therapeutic stance," as therapists emphasize observing both the patient's crying and their own countertransference with curiosity, treating these internal reactions as informative for diagnosis:

> "I find it really interesting how I react to crying... Sometimes a patient starts crying and I don't feel anything at all. And then I start wondering – like, 'Am I slipping into the role of the cold mother right now? Or do I feel kind of manipulated, like I'm not supposed to ask something or push further?'"

Therapists reported that, at times, they notice an internal urge to cry or even tears forming before the patient shows any observable emotion. They interpret these early affective reactions as signals that something emotionally relevant may be unfolding and therefore slow down and pay closer attention to the moment.

The second subcategory concerns the "Relief/Catharsis" function of crying. Therapists across orientations commonly described crying as relieving, calming, and even health-promoting, enhancing patients' well-being, and often producing a sense of relief. This effect is particularly evident when crying enables emotional access, brings repressed conflicts into focus, and restores a sense of agency, linking it to subsequent subcategories. Crying was also described as a self-soothing behavior that releases tension, with some therapists suggesting that tear production may help eliminate stress-related substances.

The third subcategory, "Emotional access," represents the patient-side counterpart to "Diagnostic access." Crying can signal to the patient themselves that something significant is emerging, marking a moment of contact with the patient's inner emotional experience while simultaneously expressing it outwardly. It may indicate a shift from cognitive processing to felt experience, facilitating the naming of emotions and underlying issues. The here-and-now quality of crying is central here, reflecting early-stage, surface-level emotional contact. Conceptually, this subcategory is linked to the intervention "Perceiving the here-and-now quality of the crying:"

> "Patients are often surprised by what made them cry, or they draw conclusions like, 'I cried – that's when I realized how much it got to me, or that I haven't really processed it yet, and that I need to take another look at it."

The fourth subcategory, "Emotional deepening," encompasses the idea that crying provides access to deeper emotional layers, serving as a gateway to life history, unconscious material, and the inner world. This subcategory moves beyond initial emotional expression, fostering deeper emotional understanding that enables therapeutic exploration and insight. Conceptually, it is closely linked to the intervention "Exploring emotions." The final subcategory, "Integrative function," captures the assumption that crying can open new perspectives or pathways within the therapeutic process, particularly when linked to cognitions (CBT), (unconscious) conflicts (PD), or relational patterns (ST). It may initiate a process of awareness and reintegration, facilitating emotional processing, meaning-making, and the re-evaluation and new understanding of one's experiences and patterns. This subcategory is conceptually related to the intervention of "Contextualizing the crying in an actively therapeutic manner."

> "And I also think, when people go to some kind of psychological support or whatever, and then say something like, 'Yeah, I cried so much,' – well, from how I see therapy and how it works, what they had was probably more of a release. But that doesn't necessarily lead to healing. I mean, crying a lot doesn't mean healing a lot, right? And if there's no new perspective, no new pathways, no re-linking of the affect, then it's just a re-enactment. And that doesn't really get us anywhere."

Crying Impedes the Process (Resistance to Change)

This category captures the notion that crying can disrupt or interrupt the therapeutic process. Here, crying is viewed not as facilitating therapeutic progress, but as potentially hindering emotional or relational development within the session. Two conceptually distinct but related subcategories were identified within this category, both framing crying as serving a function that maintains the status quo and counteracts therapeutic change. "Crying as manipulation" is characterized by intentionality and conscious use, assumed to serve strategic purposes such as adopting a victim role, gaining attention, or eliciting a desired response. This form of crying is often described as "crocodile tears" or "crying on command" and perceived as manipulative or emotionally coercive. In contrast, "Crying as resistance" is viewed as a more unconscious form, serving to avoid difficult topics or underlying emotions. This may develop into a rigid, automatic response pattern and signal potential ruptures in therapy, with therapists reporting feelings of emotional exhaustion or caution. It can indicate defenses that reflect the patient's unreadiness to engage, requiring an attuned and accepting therapeutic stance.

> "Like, someone starts crying and that kind of changes the whole situation – so that you can't really keep asking questions or continue."

Both subcategories are linked to "Protest crying" and "Crying as a relational challenge," as they often strain the therapeutic relationship. When crying disrupts the process, therapists frequently report negative internal (countertransference) reactions, such as emptiness, distance, irritation, aversion, or even aggression.

Interventions

This domain delineates distinct therapeutic interventions associated with crying, drawing on Gutjahr and Benecke's (2024) typology, which was further differentiated and expanded. Unlike Gutjahr and Benecke (2024), the present investigation did not examine specific triggers of crying.

Addressing

The essential feature of the category "Addressing" is that the therapist explicitly responds to expressed or underlying emotions. The therapeutic aim is to maintain or even intensify the emotional tension, rather than reduce or divert it. Within this category, three subdimensions can be distinguished, reflecting a continuum from attending to immediate affective expression to embedding it in a broader personal context. Although these approaches often overlap in practice, they can be described as three prototypical types. "Perceiving the *here-and-now* quality of the crying" refers to interventions that acknowledge, mirror, and contain emotions as they emerge in the session. Therapists may explicitly encourage the expression of tears and validate their significance. This approach emphasizes presence and emotional contact in the moment and is conceptually linked to the process-related category "Emotional access." Second, "Exploring emotions" shifts the focus toward the *there-and-then*, as therapists examine the triggers, motives, wishes, and conflicts underlying crying episodes. By verbalizing and elaborating on these experiences, patients are supported in organizing and differentiating their emotional world. This approach is closely linked to the process-related category of "Emotional deepening." Finally, "Contextualizing the crying in an actively therapeutic manner" involves linking immediate affect to broader biographical, relational, or diagnostic perspectives. Therapists may point out contradictions, highlight underlying relational patterns, or offer interpretations connecting present affect with past experiences. This approach is linked to the process-related category "Integrative function," situating current emotions within a larger therapeutic framework.

Giving Space

The category "Giving space" differs from other response types in that it involves no explicit therapeutic intervention. Its defining feature is that the therapist refrains

from directing the interaction, allowing the patient to set the course and pace. Although the two subdimensions look very different from the outside – one involving mostly silence and the other mostly speech – both share the essential feature of therapeutic restraint, creating space for processes to unfold. Therapists maintain a holding, containing presence while intentionally giving the patient space to feel and express emotion. The first subdimension, "Pause," refers to deliberate therapeutic silences that interrupt verbal exchange and slow the interaction, fostering present-moment awareness. These pauses can support emotional reflection or help regulate potentially overwhelming affect. In clinical practice, they may be accompanied by subtle non-verbal expressions of empathy and affect attunement (e.g., facial expressions, posture, nodding, or other embodied signals). The second subdimension, "Letting narrate," is characterized by the patient holding the (almost) exclusive speaking role, while the therapist adopts a markedly non-directive stance. The therapist allows the patient to set the pace and direction of the narration, tolerates pauses and topic shifts, and intervenes minimally to support the patient's flow. Central to this subdimension is that the narrative unfolds primarily in a self-guided manner, with the therapist responding receptively rather than structuring or directing the process.

Neutralizing

"Neutralizing" refers to therapeutic behaviors and interventions aimed at deliberately reducing the emotional intensity of crying or downregulating patient arousal. Unlike "Addressing" or "Giving space," this category is defined by its goal of de-escalation. Three subdimensions can be distinguished. The first, "Providing support in an actively therapeutic manner," encompasses a range of comforting and supportive interventions that directly aim to ease emotional tension. Therapists may reframe or normalize emotions, validate the patient, or propose alternative perspectives and solutions. Calming techniques such as grounding, body-based relaxation exercises, or guided imagery for emotional self-regulation (e.g., inner child work, screen technique) are also used. In some instances, therapists report offering tissues as a gesture of comfort, though others deliberately avoid this practice for fear it may implicitly influence (encourage or discourage) the continuation of crying – a concern sometimes associated with traditional notions of therapeutic neutrality.

> "And then I said, 'Can you feel compassion for this little girl?' – and she started crying really intensely. But if I had just left her in that state, I wouldn't have seen it as a successful intervention… just because she cried. So, I asked, 'What does this little girl need right now?' And she said, 'She needs to be held and put to bed.' And then I said, 'Okay, then please go ahead and do that now.' And after that, she stopped crying."

This intervention is particularly interesting as it illustrates how the therapist actively elicits crying by targeting emotional content, then provides support by

guiding the patient toward self-soothing through imagination. The second subdimension, "Exploring facts," involves shifting the focus to a rational or factual level of the patient's narrative. Clarifying and comprehension questions, as well as requests for more detailed description of a triggering situation, are typical. These interventions remain tied to the emotion-eliciting topic and thus differ from the third subdimension. Therapists noted using these interventions particularly with patients who show structural impairments, where cognitive structuring provides stabilization. The third subdimension, "Initiating a change of topic/ending the session," represents the only intervention in which the therapist explicitly redirects attention away from the emotion and its trigger. This may include ignoring the crying, introducing a new topic, lightening the mood, or formally closing the session. Therapists report using this approach when crying is seen as disrupting the therapeutic process, such as in cases of maladaptive, persistent, or inauthentic crying. By definition, this subdimension does not apply when the patient initiates the distraction and the therapist merely follows.

Discussion

This study aimed to develop an integrative category system that synthesizes therapists' working models guiding the interpretation and response to patient crying in clinical practice across orientations, and provides a conceptual framework for future research. Rather than a mere collection of categories, the system captures therapists' guiding assumptions and strategies, highlighting their interrelations and clinical relevance for addressing crying in psychotherapy. It is organized into two domains: "Assumptions" and "Interventions," which are theoretically connected insofar as interventions are grounded in underlying assumptions. These assumptions likely inform therapists' situational decisions about whether to allow, encourage, or limit crying. At the same time, much of this decision-making may draw on "implicit relational knowing" (Lyons-Ruth et al., 1998), which guides intuitive responses in the moment and only becomes partially accessible in later verbal accounts. Therapists' verbal explanations of their interventions may therefore sometimes appear as post hoc rationalizations (Ajzen, 1985; Cushman, 2020), but can also be understood as retrospective, language-based approximations of complex implicit processes. Against this background, moments of crying in psychotherapy may thus coincide with heightened relational intensity and what Stern (1998) has described as "now moments" or "moments of meeting." This is an important avenue for future research: examining how explicit and implicit assumptions relate to observable interventions, and how situational or client factors shape therapeutic decision-making. While Gutjahr and Benecke (2024) provide evidence that reported interventions are applied in practice, it remains an open question to what extent these interventions are directly assumption-driven. Within the domain of "Assumptions," we identified three main categories: "Forms of crying," "The therapeutic

relationship," and "The therapeutic process". These should not be seen as separate entities but as interdependent elements of therapists' working models. However, for analytical purposes, their separate consideration remains useful. For both the domain of "Interventions" and the category "Forms of crying," the taxonomy by Gutjahr and Benecke (2024) provided a coherent, deductive framework that closely aligned with our data. This congruence suggests that their taxonomy provided a compatible deductive framework that also reflected recurring constellations of assumptions and strategies in our material. The present category system, therefore, extends their taxonomy into a broader transtheoretical framework of therapists' working models, integrating assumptions and interventions into a conceptual model that is both clinically meaningful and suitable for research.

Clinically Relevant Patterns and Implications

In the following, we highlight several clinically relevant issues, while recognizing that only a subset of findings can be discussed here.

Crying as Relational Challenge and Resistance

A striking observation was the frequent co-occurrence of "Protest crying," "Crying as a relational challenge," and "Crying as resistance." The latter, together with "Crying as manipulation," formed part of the broader category "Crying impedes the process (resistance to change)." Notably, "Crying as manipulation" was mentioned less often, suggesting that therapists rarely attribute deliberate intent to patients' tears, focusing instead on their functional significance. This points to a clinically important distinction between resistance as a processual phenomenon and attributions of intentional manipulation. Future research could examine whether differentiating resistance from manipulation holds practical value. The frequent co-occurrence of "Protest crying," "Crying as resistance," and "Crying as a relational challenge" appears theoretically coherent. However, further research is needed to clarify whether these labels capture the same or distinct but related constructs. When crying is experienced as confusing or excessive, it may strain the therapists' empathic attunement. At the same time, such moments do not necessarily undermine the therapeutic relationship. If constructively engaged, they may even foster productive rupture-repair processes – a particularly promising lens for future research on crying in psychotherapy. Crying is never inherently dysfunctional simply because it challenges the therapist. Rather, it underscores the therapist's responsibility to respond in a therapeutically meaningful way. For example, "Protest crying," as conceptualized by Gutjahr and Benecke (2024), is not necessarily a "disruptive" factor, but can be a normal part of the patient's emotional processing. It may reflect a stage in which certain difficult feelings are not yet fully tolerated, prompting self-protective or externalizing behaviors. Consistent with this, Hill et al. (2025) found that clients with avoidant attachment styles are more likely to exhibit protest crying,

possibly as a means of diverting attention and maintaining distance. Similarly, "Crying as a relational challenge" was often associated with what therapists called "histrionic" crying, suggesting another pattern of challenging yet potentially meaningful expressions of affect. Recognizing these patterns highlights the nuanced role of crying in therapy and the importance of therapists' working models in navigating such episodes.

Crying as a Therapeutic Opening: Patterns of Understanding and Response

A second clinically relevant pattern concerns the close alignment between therapists' assumptions about the function of crying and their corresponding interventions. Specifically, the three subdimensions of "Crying promotes the process," i.e., "Emotional access," "Emotional deepening," and "Integrative function" – can be understood as interrelated aspects of an emotional process that crying may foster, opening possibilities for change. These process qualities closely parallel the three subdimensions of "Addressing" interventions, which appear to facilitate precisely these processes. "Emotional access" and "Perceiving the here-and-now quality of the crying" both indicate an initial, surface-level engagement with affect in the moment. "Emotional deepening" and "Exploring emotions" move toward linking current experiences with past material. Finally, "Integrative function" and "Contextualizing the crying in an actively therapeutic manner" reflect a synthesis of here-and-now, there-and-then, and potentially new perspectives. This interpretation remains preliminary, but it highlights crying as a potential opening in the therapeutic process that can be actively engaged through specific types of responses. From the perspective of therapists' working models, these findings point to a coherent set of assumptions and strategies that guide clinical action during moments when patients cry. While this alignment appeared across orientations, therapists described orientation-specific emphases in how interventions were implemented in practice: PDT therapists emphasized working with countertransference, CBT therapists leaned toward confrontation, and ST therapists focused on relational patterns and alternative courses of action. Future research could examine these differences in greater detail, as well as extend this line of inquiry to additional approaches, particularly body-oriented psychotherapies, which explicitly focus on bodily signals, emotional relief, and regulation.

Crying as Opportunity and Challenge

Summarizing these findings and returning to Rottenberg et al.'s (2008) question – "Under what conditions and for whom is crying likely beneficial?" – our results add further nuance. Crying was described as helpful when it enabled diagnostic or emotional access, created shared understanding, or supported integrative processes, but less helpful when it hindered confrontation or recurred as a resistant pattern. Consistent with Katz et al.'s (2024) notion of crying as a "window of opportunity," therapists described such episodes as key moments and potential catalysts for

meaningful change. This supports earlier evidence from patients' retrospective self-reports by confirming the relevance of crying for relationship and progress, while also offering insight into possible underlying mechanisms. At the same time, our findings emphasize the flipside: under certain conditions, crying may also constitute a relational challenge that requires careful clinical navigation rather than automatic validation.

Limitations

Several limitations of the present study should be noted. As an exploratory qualitative study, no generalizable conclusions can be drawn and hypotheses were not tested; the focus was on generating practice-based insights to inform future research. We prioritized an integrative, cross-orientation perspective rather than a systematic comparison of therapeutic approaches. Our analysis remained at the explicit level of therapists' general working models, leaving implicit assumptions, nonverbal processes, and the fine-grained dynamics of individual sessions unexplored. In-depth or hermeneutic approaches, as well as single-case studies, could address these dimensions and examine the unfolding of assumptions and interventions over time, aligning with a process-research perspective. To enhance applicability across clinical contexts, the study focused on broader therapeutic functions of crying rather than on specific diagnoses, personality organization, or attachment styles. Therapists did, however, note differential aspects – e.g., "histrionic crying," a shift to factual-level processing ("exploring facts") in structurally impaired patients, or limited "emotional access" in patients with somatic complaints – suggesting targets for future research. Given the study design, these observations cannot be considered statistically reliable and warrant systematic quantitative investigation. Other limitations include unexamined inhibited or non-crying behaviors, the small and potentially non-representative sample, the subjective nature of qualitative data, and researcher interpretive influence. Finally, integrating diverse therapeutic orientations into a single framework risks oversimplifying or overlooking orientation-specific nuances. Future research could therefore build on the proposed framework by explicitly examining orientation-specific patterns using suitable comparative designs.

Conclusion

From a meta-level perspective, our findings highlight the multifaceted role of crying in psychotherapy and its relation to change. Crying may facilitate change by fostering shared relational experiences, enabling deeper emotional understanding, or signaling resistance that creates opportunities for reflection. While these mechanisms require further empirical investigation, they underscore crying as a dynamic element within therapists' working models. Returning to the question posed in our title – Is

crying a catalyst, a byproduct, or resistance? – our findings suggest that it can be all of these, reflecting the complexity of crying in therapeutic practice.

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Ethics Statement. The study was conducted in accordance with ethical standards for research involving human participants and adhered to the principles of the Declaration of Helsinki.

Data Availability Statement. The integrative category system developed in this study, including definitions and anchor examples, is openly available on the Open Science Framework (OSF) at https://doi.org/10.17605/OSF.IO/ZEK23. Supplemental material is also available on the journal's website (https://pt.ffri.hr/pt/issue/view/52). The interview data are not publicly available due to privacy and confidentiality restrictions. De-identified excerpts supporting the findings are included in the article.

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