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Patients' Experiences of Clinicians' Crying during Psychotherapy for Eating Disorders

Ashley Tritt

McGill University and Project HEAL, Canada

Jonathan Kelly

BEAT (Eating Disorders Association), UK

Glenn Waller

University of Sheffield

Author Note

Ashley Tritt, McGill University, Montreal, and Project Heal, Canada.

Jonathan Kelly, BEAT (Eating Disorders Association), Norwich, UK

Glenn Waller, Clinical Psychology Unit, Department of Psychology, University of Sheffield, Sheffield, UK

Correspondence concerning this article should be addressed to: Glenn Waller, Clinical Psychology Unit, Department of Psychology, University of Sheffield, Western Bank, Sheffield S10 2NT, UK. email: g.waller@sheffield.ac.uk

Patients' Experiences of Clinicians' Crying during Psychotherapy for Eating Disorders**Abstract**

Many psychotherapists cry in therapy sessions. Those clinicians who do cry see it as likely to have a positive impact on the therapy or to have no impact, and therapist personality characteristics have not shown reliable associations to crying in therapy. However, it is not known how patients experience therapists' crying, or whether the patient's view of the therapist's characteristics is related to that experience. This study used an online survey, recruiting 202 patients with eating disorders, 188 of whom had received therapy for an eating disorder, and 105 of whom had experienced a therapist crying. Retrospective data from those 105 individuals indicated that therapists' crying tended to be seen positively, but that perception was influenced by the patients' perceptions of the demeanor of their therapist and their understanding of the meaning of the crying. While they need to be extended to other disorders, these findings suggest that therapists' crying needs to be understood in the context of the therapist's perceived characteristics and demeanor, rather than being assumed by therapists to be positive or to have no impact on the therapy.

Keywords: Psychotherapy; therapist; patient; crying

Patients' Experiences of Clinicians' Crying during Psychotherapy for Eating Disorders

Psychotherapy has a tradition of focusing on the inner world of the patient. However, the inner world of the therapist is also important, as it interacts with that of the patient. Such interaction appears in many forms in the literature, including constructs such as transference/countertransference and the therapeutic alliance. Therefore, regardless of therapeutic orientation, it is important to consider the therapist's reactions to the client during the session (e.g., Gelso & Hayes, 2007; Gilbert & Leahy, 2007; Summers & Barber, 2010). This study addresses one specific reaction – the therapist crying in the session, and the impact of that experience on the patient.

Emotional experience in the therapy session and how it can disrupt therapy if unattended are key elements of therapists' reactions. This concept is not limited to the psychodynamic construct of countertransference. For example, Waller (2009) has hypothesised that cognitive-behavioral therapists who experience higher levels of anxiety are less likely to implement core behavioral techniques, making them less effective. Following a series of small-scale reports in the literature, Blume-Marcovici, Stolberg and Khademi (2013) surveyed a large number of psychologists and trainees ($N = 684$) regarding one specific emotional marker – the therapist crying in therapy. In this relatively diverse group of clinicians, using a variety of therapeutic approaches with a wide range of patients, they reported that over 70% of the therapists reported ever having cried in therapy (with 30% having done so in the past four weeks). Pope, Tabachnick and Keith-Spiegel (1987) found a slightly lower lifetime rate for therapists' crying (56.5%), but these findings represent a relatively high proportion of clinicians. Blume-Marcovici et al. (2013) found little evidence that the act of crying was associated with the general personality characteristics, empathy levels or gender of the therapists, but crying was more common among therapists who were dynamically-oriented and those who cried more in everyday life. The age of the clinician qualified that last finding - older therapists were less likely to cry in everyday life, but more likely to cry in therapy sessions. A key finding was that therapists who cried almost

universally saw the experience as either positive for the therapy (53.5%) or neutral (45.7%), with only 0.8% believing that their own crying led to a poorer therapeutic relationship thereafter. A positive interpretation was more prevalent among dynamically-oriented therapists. When asking the whole sample (including those who had not cried) about likely positive and negative impacts of therapists' crying, there was still a preponderance of perceived positive outcomes (e.g., patient feels cared about). However, there was a small set of perceived negative outcomes (e.g., client feeling burdened with the therapist's emotions). This contrast suggests that those who had not cried might see the experience more negatively than those who had (though no analysis was presented to test this hypothesis).

To summarise, clinicians who cry during sessions tend to see it as a positive event in psychotherapy. However, as has been outlined above, the interaction between the therapist and the patient is critical, and the evidence to date is only one side of the story. What is not known is the patient's experience of the therapist's crying – how often patients have seen their therapist cry; whether they see that crying as good or bad for therapy; their understanding of why therapists cry; and whether patients see the therapist's own characteristics as relevant to the impact of the crying on the therapy and the working alliance. Without such an understanding, there is the danger that therapists' own positive interpretations of their experience of crying in therapy are self-serving, allowing the clinician to feel that their emotional reaction is positive when patients might see it as having a negative impact on the therapy.

This study investigates the experiences of patients who have undertaken psychotherapy for eating disorders, and whose therapists cried during the sessions. This clinical group was selected for this initial study because the authors are active in working with the eating disorders (working with patient support organisation groups and clinically). It was important at this stage to limit any variance due to asking too wide a range of patients. Those with eating disorders are a patient group where therapists can experience a range of emotions. For example, Zerbe (1998) stresses the need for therapists to be aware of

countertransference reactions such as anger, the need to change or 'repair' the patient, and pride. There is some evidence that those clinicians' emotional states can have a negative impact on the delivery of evidence-based therapies for the eating disorders (Waller, Stringer, & Meyer, 2012). However, there is no evidence regarding how often therapists cry when treating such cases, and no knowledge of patients' perspectives on the effect of such emotions in therapy.

Aims

This study determined the frequency with which patients with eating disorders recalled their therapists having cried in therapy, considering different intensities of crying. It then determined whether the patients saw their therapists' crying as a positive or negative influence on the experience of therapy. Finally, it considered the ways that patients made sense of their therapists' crying, and whether that interpretation was associated with their perception of the therapists' positive or negative emotional demeanor.

Method

Design and Ethical Issues

The study employed a survey design, asking individuals with eating disorders retrospectively to detail their experiences in a previous, completed episode of psychotherapy for their eating disorder. The survey was completed online. The Research Ethics Board of the Department of Psychology, University of Sheffield, UK approved the study.

Participants

Participants for the study were a sample of convenience, drawn from two patient representative groups (Project HEAL [Help to Eat, Accept and Live] and Beat, which provide support for individuals with eating disorders in the USA and Canada and in the UK, respectively). Men and women were invited to take part, and 236 individuals undertook the online survey. Inclusion criteria were that individuals: were 18+ years at the time of completing the survey; and had experienced a previous therapy for an eating disorder (whether successful or otherwise). Any individuals who failed to meet these criteria were screened out early in the process of the online survey.

Measures

The authors generated the survey items, to address the aims of the study. The survey was accompanied by an explanation that it examined the views of individuals with eating disorders who had ever experienced a therapist crying in therapy. However, it was also stated that it would be helpful if all who had received therapy would complete it, to enable comparison between those who had and had not experienced a therapist crying. The survey initially asked questions that would exclude participants who were not eligible for the study (underage; no history of eating disorder; no history of any psychotherapy). Subsequent questions addressed other demographic factors among those who had experienced a therapist crying, related to their most recent experience of this event (own age at the start of the therapy; therapist's perceived age group; description by therapist of type of therapy concerned; stated diagnosis at the time). The options for 'diagnosis' were anorexia nervosa, bulimia nervosa, binge eating disorder, eating disorder not otherwise specified, simple obesity, and 'other' (no participants reported either of the last two diagnoses). The options for the therapy concerned were cognitive-behavior therapy, family-based therapy, dialectical behaviour therapy, interpersonal psychotherapy, psychodynamic therapy, other, not stated, and unable to recall. Apart from diagnosis and type of therapy, no other question on the survey allowed a response of 'other' or a write-in response. There were two reasons for focusing on the most recent experience of a therapist crying - to minimise biases in recall by making the event as recent as possible, and to reduce the likelihood that patients would remember the 'worst possible case', thus making the pattern of findings less representative.

Thereafter, questions addressed: the frequency of different types of therapist crying during the index course of therapy (the total number of times in that course of therapy that the therapist had appeared or sounded close to tears; overtly cried; cried and had to pause the session; cried and had to end the session); the degree to which the therapist crying had a positive or negative effect on different aspects of the therapy (listed in Table 2: rated 1 = very negative; 5 = very positive); and individuals' understanding of the reasons that the therapists cried (listed in Table 3: rated 1 = Not at all; 5 = Completely).

The final six questions asked the respondent to rate the relevant therapist on six characteristics across the course of the therapy. The researchers chose therapist characteristics that they had heard patients describe as influencing whether or not they could work on their eating disorder – happiness, firmness, consistency, anxiety, boredom and anger. Respondents rated each of these characteristics on a 1-5 scale, with a higher score indicating a greater level of that feature. The first three were summed to create a measure of perceived 'positive therapist demeanor', while the final three formed a measure of perceived 'negative therapist demeanor'.

Procedure

The participants were initially approached by email (if they had given prior consent to be approached in that way) or via the websites and social media accounts of Beat, Project HEAL, and affiliate organisations. No payment was offered for participation. The survey ran on Survey Monkey software, accessed via an enclosed web link. Participants gave consent within the survey, having previously read the information sheet. They also had opt-out points throughout the survey, in case the material was distressing (though these were used on only three occasions). If the respondent had to be excluded (e.g., below 18 years), that was done as soon as the fact was identified (at the start of the survey). At the end of the survey, a summary of the findings was offered to participants (when available).

Data Analysis

The frequency of patient experiences of therapists' crying, ratings of the impact on therapy of the therapist crying, and ratings of understanding of the reasons that the therapist cried were all presented as descriptive statistics. After that, correlations (Spearman's *rho*) were calculated between the therapists' two demeanor scores and the patients' perception of the impact of therapists' crying on therapy, and between the demeanor scores and the patients' understanding of the reasons for the therapists' crying. Non-parametric correlations were used because several of the scores were not sufficiently normally distributed. Because a large number of correlations were carried out ($N = 32$), the acceptable *alpha* level adopted was 1%, to reduce the risk of type 1 errors. Effect sizes (*d*)

were calculated for each correlation.

Results

Patients Who Have Experienced Therapists' Crying

Table 1 shows the transition from the 236 individuals who began the online survey to the 105 patients with eating disorders who met all criteria (e.g., age, completion of different stages in the survey; had experience of therapy, and had experienced a therapist crying in at least one such therapy). It also shows the characteristics of the sample at different stages in the transition process. Considering the transition from the 188 participants who had therapy to the 107 who had experienced a therapist crying in that therapy, there was no association between self-reported diagnosis (anorexia nervosa, bulimia nervosa, EDNOS) and having had a therapist cry ($\chi^2 = 2.86$, $df = 2$, $P = 0.24$).

Insert Table 1 about here

Considering the final sample of 105 participants, 103 were female and two were male – a gender imbalance that is typical of such samples, though prevalence figures would suggest that males are underrepresented here. Sixty-three patients (60%) reported that the index therapy had been one with a strong evidence base for the eating disorders - cognitive-behavior therapy (41 patients); family-based therapy (two); dialectical behavior therapy (ten); or interpersonal psychotherapy (ten). The remaining patients reported that they had received a psychodynamic therapy (seven patients), that the therapy had a label that was not among those specified (six), that the therapy had not been given any label by the therapist (22), or that they could not remember the type of therapy (seven). Where individuals did not complete all subsequent items, this is reflected in the N reported.

Patients' Ratings of Intensity and Frequency of Therapists' Crying

Patients who had experienced their therapist crying at least once reported the

following frequencies of different types of crying: looked or sounded close to tears ($M = 4.24$ times across the index course of therapy, $SD = 10.6$); cried openly, but was able to carry on ($M = 1.64$ times, $SD = 5.06$); cried openly and had to pause the session as a result ($M = 0.30$ times, $SD = 1.31$); and cried and had to end the session ($M = 0.46$ times, $SD = 0.60$).

There were no differences in reported total frequency of therapists' crying by perceived age group of therapist ($P > .20$ in all cases). There was also no significant difference in reported crying (unequal variance $t = 1.47$, $P = .15$) between therapists who stated that they were delivering evidence-based therapies ($M = 4.35$, $SD = 3.52$) versus non-evidence-based approaches ($M = 10.4$, $SD = 25.0$), though the pattern suggested a trend toward more crying by those delivering non-evidence-based psychotherapies.

Of the 77 respondents who identified the gender of the therapist in the index episode of treatment, only five had male therapists. Therefore, comparison of patterns of crying across male and female therapists should be treated with caution. Two-tailed Mann-Whitney tests showed no gender differences in frequency of 'looked or sounded close to tears' ($Z = 1.37$, NS) or 'cried openly and had to pause the session' ($Z = 0.46$, NS). However, there were differences in the other forms of crying. Female therapists ($M = 2.10$; $SD = 5.77$) were more likely than men ($M = 0.20$; $SD = 0.45$) to 'cry openly but carry on' ($Z = 2.21$, $P < .05$). In contrast, male therapists ($M = 0.80$; $SD = 0.45$) were more likely to be reported as having 'cried and had to end the session' than the females ($M = 0.24$; $SD = 0.46$) ($Z = 2.74$, $P < .05$). However, these differences require further investigation with a larger samples of male therapists.

Association of Perceived Therapist Demeanor with Frequency of Therapists' Crying

The association of patients' recall of the frequency of different forms of therapist crying with their perception of the therapists' demeanor was tested using Spearman's correlations. Stated effect sizes (d) were medium to large (Cohen, 1988). The perceived rating of 'positive demeanor' (i.e., happiness, firmness, consistency) was positively associated with frequencies of the therapist looking close to tears and of crying openly ($\rho = .271$, $d = 0.56$, $P < .05$; $\rho = .246$, $d = 0.51$, $P < .05$, respectively), but negatively with the

frequency of crying and ending the session ($\rho = -.628$, $d = 1.61$, $P < .001$). In contrast, the perceived rating of 'negative demeanor' (i.e., anxiety, boredom, anger) was negatively associated with the frequency of crying openly ($\rho = -.268$, $d = 0.56$, $P < .05$) but positively with the frequency of crying and ending the session ($\rho = .697$, $d = 1.94$, $P < .001$). Thus, there was a positive perception of the demeanor of those therapists who cried moderately, but negative perception of those who cried more extremely. Of course, no causal direction can be assumed from these correlations.

Again, the small number of male therapists identified means that gender differences in therapist demeanor should be treated as suggestive rather than conclusive. Mann-Whitney tests showed no gender difference in the 'negative demeanor' rating ($Z = 1.28$, *NS*). However, there was a higher positive demeanor rating for female therapists ($M = 3.94$; $SD = 0.76$) than for males ($M = 2.94$; $SD = 0.34$) ($Z = 2.26$, $P < .05$). This finding suggests that female therapists were seen as happier, firmer and more consistent, though it requires a larger-scale replication.

Patients' Perceptions of the Impact of Therapists' Crying

Table 2 shows that patients saw the therapists' crying as having a generally positive impact on the therapy (i.e., scores above the mean of 3.0), both short- and long-term. It also shows the correlations between the patient's view of the impact of the therapists' crying and their perception of the therapists' positive and negative demeanor. An alpha of .01 was adopted, to reduce the risk of type 1 errors. The therapists' crying had a positive impact on therapy if the therapist was seen as having a positive demeanor, with the greatest impact (largest effect sizes) on the patients' respect for the therapist, willingness to express emotions, and willingness to undertake therapy in the future. However, there was a converse effect on if the therapists' demeanor was seen as negative, when the experience of therapy was rated as poorer. In particular, if the therapist who cried had perceived negative characteristics, the patient reported being less willing to express emotions in therapy or to undertake therapy in future.

Insert Table 2 about here

In order to understand which aspects of the therapist's perceived demeanor might be contributing to these patterns, Spearman's correlations¹ were carried out on the three individual items that contributed to each significant correlation in Table 2. Two or three of the items contributed in all cases. The only exception was 'Willingness to undertake therapy in the future', which was correlated positively correlated only with perceived therapist firmness. There was no consistent pattern of individual items that contributed to the significant associations of overall negative demeanor with perceived impact on therapy. Two or three individual items were correlated with each element of impact. Thus, none of the individual elements of therapist demeanor proved to be central or negligible.

Patients' Understanding of the Reasons for Therapists' Crying

Table 3 shows the patients' mean ratings for the different possible reasons for their therapist crying. A Friedman's test showed that there was a significant overall difference between the five mean scores ($Q = 28.0$; $P < .001$). Post hoc tests showed that this overall effect was explained by two pairwise differences - between 'on the same page about my experiences' and both 'I was a problem' ($P < .001$) and 'something I had done to upset my therapist' ($P < .004$). Other pairwise differences were non-significant. Thus, overall, patients were unlikely to see themselves as responsible for the therapist crying. Rather, they saw the tears as being based more in a positive aspect of therapy – the therapist understanding their experience.

Insert Table 3 about here

Table 3 also shows correlations between the patients' view of the reasons for the

¹ Full details of these correlations available on request from the corresponding author.

therapist crying and their perception of the therapists' positive and negative demeanor. Again, an alpha of .01 was adopted, to reduce the risk of type 1 errors. The effect sizes were generally large. If the therapist was perceived as having a positive demeanor, their crying was not seen as indicating that the patient was a concern, and was not attributed to a problem in the therapist's own life. Rather, it was taken as a positive indicator of therapist and patient being on the same page. In contrast, therapists' negative demeanor was associated with the patient being more self-blaming, as well as assuming that there was something wrong in the therapist's own life and that therapist and patient did not have a shared perspective.

Again, the role of individual items was tested (Spearman's *rho*) to determine which items might contribute most consistently to the significant correlations in Table 2². Among the positive demeanor items, only 'firmness' was associated with the three variables where there was an overall correlation. For each item where there was an overall effect of perceived negative demeanor, there were correlations with perceived therapist anxiety and boredom.

Discussion

This study examined the experiences of patients with eating disorders regarding their psychotherapist crying in therapy. It considered patients' understanding of the impact of that experience on the therapy and of the reason for the therapist crying. Finally, it considered whether the patient's view of the therapist's demeanor was related to the impact of crying and to understanding why it occurred.

Considering the prevalence of therapists' crying, over half of patients with eating disorders reported that they had experienced a therapist crying at least once. If the therapist cried at all during a course of therapy, the mean number of such experiences during that course of therapy was four episodes of the therapist being close to tears and approximately two episodes of the therapist actively crying. These figures cannot be directly compared to the self-reported prevalence of crying among therapists (different time frames, professional

² Full details of these correlations available on request from the corresponding author.

backgrounds, patient group, and definition of 'crying'). However, they do not represent a surprisingly high prevalence, given Blume-Marcovici et al.'s (2013) finding that nearly three-quarters of therapists report ever having cried in a session. It is also very close to Pope et al.'s (1987) prevalence figure for therapists who had ever cried in the presence of a client. The nature of the eating disorder and the type of therapy did not have significant impacts on the likelihood of therapists' crying, though there was a non-significant trend for the provision of evidence-based therapies to be associated with a lower likelihood of that experience. That trend indicates a need for further investigation to determine whether such a distinction exists between different therapy types. One possibility is that any such difference is not about the therapy type, but due to the duration of the therapies under consideration. For example, if the more evidence-based therapies consist of fewer sessions, then the difference in experience of therapists' crying might simply be due to having had less time when it could have occurred.

It is important to understand the impact of the therapists' crying on the therapy. Taken as a whole, the findings support therapists' opinions (Blume-Marcovici et al., 2013) that their crying tends to have a positive impact on the relationship with the patient. However, the perceived characteristics of the therapist played a substantial role. Considering the patients' perception of the impact of therapists' crying, a therapist with a positive demeanor (i.e., happiness, firmness, consistency) can cry and be seen to have a positive impact (e.g., the patient has greater respect for the therapist, is more likely to express emotions, and is more likely to undertake therapy in the future). In contrast, if a therapist is seen as having a more negative demeanor (i.e., bored, anxious, angry), then their crying is seen as having a deleterious effect on treatment (e.g., the patient is less likely to express emotions, to continue therapy, or to undertake therapy again in the future). Clearly, this finding is not directly comparable with Blume-Marcovici et al.'s (2013) conclusion that therapists' personality characteristics have no relationship to their crying in therapy. However, taken together, the findings indicate that therapists' characteristics (as perceived by the patient) are important moderators of the impact of therapists' crying on their patients.

In short, contrary to the general opinion of the clinicians who were surveyed by Blume-Marcovici et al. (2013), therapists' crying cannot be assumed to be an almost universally positive or neutral event – it depends on how patients see the therapist as a person.

When considering perceived reasons for the therapists' crying, the overall picture was again a positive one, with the patients reporting seeing the tears as an indication that their therapist understood them. However, there was a clear moderating influence of the therapist's perceived characteristics upon this association. In particular, if the therapist is seen as firm, the patient is more likely to interpret the crying as being for positive reasons (being on the same page). In contrast, the patient sees the reasons for such tears as being more negative (the patient being the problem; the therapist having something bad in their own life) if the therapist is perceived as having a more negative demeanor (particularly if they are seen as anxious and bored). Again, these findings augment those of Blume-Marcovici et al. (2013), stressing that therapists who are seen by their patients as more anxious, bored or angry cannot assume that the patient will see their tears as being positive for or irrelevant to the therapy.

Overall, these findings contribute to our understanding of patients' perceptions of therapists' emotional states, which is an under-researched area. Therapists' emotional states are a widely discussed element of treatment, with consideration of features such as anxiety (e.g., Harned, Dimeff, Woodcock, & Contreras, 2013), boredom and burnout (Morrant, 1984), insecurity (e.g., Hoffart, Hedley, Thornes, Larsen, & Friis, 2006), and dissatisfaction in working with some patient groups (e.g., Bourke & Greyner, 2010). Countertransference has been shown to be multi-faceted (e.g., Tishby & Wiseman, 2014), but there is evidence that it is at least partly based in the therapist's own emotional patterns as well as being related to what the patient brings to therapy (e.g., Holmqvist, Hansjons-Gustafsson, & Gustafsson, 2002). However, there is far less empirical consideration of how patients experience their therapists' emotions. In contrast, patients' emotional experiences are commonly explained in terms of external factors (e.g., life stress), attributed to the disorder itself (e.g., the impact of starvation on emotions in the eating disorders), or seen as

reactions to events in therapy (e.g., termination of treatment). An example is the study of the reasons that patients themselves cry during sessions (Capps, Mullin, & Hilsenroth, in press). It is not yet known whether patients and therapists will agree about the emotions that therapists experience in treatment, or which is the more clinically important perspective. For example, in a parallel domain, research on the elements of the therapeutic alliance suggests that these partners in therapy do not share a common view of the emotional elements behind therapeutic relationships, and that therapists should seek the perspective of their clients (e.g., Bachelor, 2013).

These findings of links between perceived therapist characteristics and patients' perceived treatment experiences augment the small evidence base regarding the impact of therapist emotions on the delivery of therapy. For example, in the eating disorders, therapists' own anxiety features have been associated with a greater concern about delivering some elements of cognitive-behavioral therapy (Turner, Tatham, Lant, Mountford, & Waller, 2014), while their mood is related to attitudes towards manualised treatments (Waller, Mountford, Tatham, Turner, Gabriel, & Webber, 2013). Similarly, across disorders, therapists' anxiety is associated with being less likely to implement specific techniques. This association is found in the implementation of structured eating and behavioural experiments for eating disorders (e.g., Waller et al., 2012) and the use of exposure techniques for anxiety disorders (Harned et al., 2013). Therapist anxiety is also associated with poorer outcomes during treatment for panic disorder with agoraphobia (Hoffart et al., 2006).

Limitations and Future Research

A key issue is that this study has only considered experiences of therapy for the eating disorders. Further research is needed to determine the impact of therapists' emotional expression on treatment delivery and quality of the therapy across the wide spectrum of psychological disorders. Such research should consider further therapy details that were not collected here (e.g., duration of treatment), to determine their relevance to therapists' crying and its perceived impact on the patient. The use of an online survey means that it is not possible to be sure of the participants' origins, whether they had an eating disorder at the

time of the survey, or whether they completed the task more than once (though no repeated computer addresses were noted in the database). Again, these are issues to address in future research.

These findings need to be understood in conjunction with those of Blume-Marcovici et al. (2013). For example, clinicians' self-rated personality characteristics are not strongly related to their likelihood of crying (Blume-Marcovici et al., 2013). However, this study shows that patients' perceptions of therapist qualities are relevant, and should be considered in future research regarding the impact of therapists' emotional expression. It is a limitation of this research that it focused on a set of clinician characteristics generated by the authors from their own clinical experience. Future research should consider alternative elements of therapist demeanor, based on other clinicians' experiences or on specific therapeutic models. It would also be valuable to consider the use of an empirically-validated measure of therapist demeanor that can be completed in parallel by patient and therapist, allowing for direct comparison of perspectives.

Due to the lack of comparable research in the literature, this study is limited by the use of unvalidated questions. Therefore, it will be important to treat the current findings with caution until there is evidence to support the method and the specific questions used. For example, the range of therapist characteristics chosen will need to be extended, to determine whether other perceived features are also important in determining the likelihood and impact of therapists' crying (e.g., empathy, warmth, openness). Obviously, Blume-Marcovici et al.'s (2013) clinician sample and the present patient group represent different perspectives on the same experience. An alternative approach would be to observe or record sessions, to determine which of these perspectives has more objective reality. Such an approach would help to address concerns about the retrospective nature of these findings, reducing the potential impact of recall and reporting biases. Any such research will also need to adopt a more purposive sampling strategy, considering the ways in which these different findings might apply to different patient groups, to the expression of different emotional states, to outcomes of treatment, and to different forms of psychotherapy. Such

studies should also consider methodological issues, including whether online surveys yield comparable data to other survey or interview methods, the inclusion of validity checks, and whether the method of questioning biased responses (e.g., by not allowing 'other' responses).

A further limitation of this study is that it did not consider whether therapists' crying was seen by patients as having a positive or negative impact on the outcome of therapy, and that issue should be addressed in future. While it was not possible to do so here, due to the use of non-parametric correlations, future research should compare the patterns of association for statistical difference, to determine whether some characteristics (e.g., of crying or of the clinician) are significantly more powerful influences on the experience of therapy. It was also assumed that the forms of crying addressed here represented an ordinal progression in terms of intensity, but that might not be the case. In particular, the three types of experience where the clinician was reported to have cried overtly might not be about intensity of crying, but simply different ways in which therapists chose to cope with similar levels of emotional experience. In turn, those patterns of coping on the part of the therapists might play a part in the way that the patient interprets their demeanor. Further research might investigate this as a reciprocal interactive process between clinician and patient.

Another important consideration for future research is whether intra-individual factors (e.g., mood, pessimism) might influence the patient's perception of the therapist's demeanor, thus making it more likely that the patient will feel helpless in the light of the therapist crying. Finally, while this study focused on patient's most recent experience of a therapist crying in therapy, it would be equally interesting to consider different sampling strategies. For example, the patient might be asked about the most intense experience of a therapist crying, or might be asked to compare and contrast the impact of both more and less intense experiences over different times or episodes of therapy.

Clinical Implications

This study raises many clinical questions about the impact of the therapist's own emotions in therapy for an eating disorder, and their clinical importance. While it is widely

agreed that an awareness of the role of therapist's own emotions is necessary for the delivery of psychological treatments (e.g., Summers & Barber, 2010; Gilbert & Leahy, 2007), the display of those emotions is not universally positive or negative in its impact. This lack of universality cannot simply be attributed to the patient, as the therapist's own demeanor (at least, as perceived by the patient) appears to be a key moderator of any effect of showing emotions. Understanding whether the therapist crying diminishes or enhances the dynamic between patient and therapist appears to be dependent on knowing how the therapist is perceived. Clearly, it would be inappropriate to assume that crying reflects the only emotional state to be considered, as other emotional traits seem to require attention (e.g., therapist anxiety – Harned et al., 2013; Waller et al., 2012). The potentially diverse impact of therapists' emotions is clearly an issue that needs to be discussed widely in training and in supervision, in order that clinicians who cry in therapy do not assume that it is likely to be a positive or simply neutral event. Clinicians are invited to use their clinical experience to identify and investigate the wider range of their own characteristics that might moderate the impact of their emotional states upon patients, and whether those features interact with patients' own characteristics (e.g., diagnosis, personality).

While these data do not allow us to reach firm conclusions about the impact of crying on the therapeutic alliance and process, it is possible to speculate as to how clinicians might handle matters when they have cried in therapy or know that they are prone to doing so (as this seems to be an event that repeats within individual clinicians – Blume-Marcovici et al., 2013). Whether one works to a model that considers crying to be a countertransference experience or one that treats crying as a more straightforward reaction to an emotive situation that arises in therapy, these findings suggest that the clinician can use the experience in a way that is positive for the patient. First, before the crying has taken place, it is important that therapists should beware of showing (or being perceived to show) any anxiety, boredom or anger in sessions. Instead, displaying firmness, happiness and consistency seems to allow the therapist to derive a positive outcome from crying if it should happen. As with all emotional reactions in therapy for the eating disorders (e.g., Zerbe,

1998), these are matters that should be addressed in supervision for all clinicians, given that so many do cry in sessions (Blume-Marcovici et al., 2013; Pope et al., 1987). Second, when the therapist has cried in the session in response to material that is emerging, that event should be discussed openly with the patient. Such frank conversation on the matter allows therapists to attribute distress to the nature of the patients' experiences, rather than leaving patients to see themselves as somehow 'toxic' to others. Such an approach has the potential to validate the patient's experience of negative events, allowing therapy to continue with an enhanced attachment bond element to the working alliance (Bordin, 1979).

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Table 1

Transition between numbers recruited and final set of participants, including characteristics of the sample at different stages

Stage in transition	<i>N</i>	Exclusions (and <i>N</i>)	Characteristics of sample
Participated in the online survey	236	<ul style="list-style-type: none"> • Under 18 years (<i>N</i> = 31) • Did not complete survey at all (<i>N</i> = 3) 	
Completed the survey	202	<ul style="list-style-type: none"> • No past experience of face-to-face therapy for an eating disorder (<i>N</i> = 14) 	<ul style="list-style-type: none"> • 199 female • 185 white Caucasian • Mean age = 26.2 (<i>SD</i> = 7.65, range = 18-54)
Had therapy for an eating disorder in past	188	<ul style="list-style-type: none"> • No experience of a therapist crying during therapy (<i>N</i> = 81) 	
Had experience of a therapist crying during therapy	107	<ul style="list-style-type: none"> • Did not complete core elements of the survey (<i>N</i> = 2) 	
Completed survey fully	105		<ul style="list-style-type: none"> • Self-reported disorder when receiving treatment: <ul style="list-style-type: none"> • Anorexia nervosa = 65 • Bulimia nervosa = 11 • Binge eating disorder = 1 • Eating disorder not otherwise specified = 28 • Mean age at start of therapy = 22.7 years (<i>SD</i> = 8.90; range = 8-53) • Female <i>N</i> = 103

Table 2 – Patients' experiences of therapy at the time of their therapist crying and thereafter, and association (Spearman's *rho*) with patient perception of the therapist's demeanor

Experience of therapy related to the therapist crying	Group characteristics			Association with perceived therapist characteristics			
	N	M	(SD)	Positive demeanor		Negative demeanor	
				<i>rho</i>	<i>d</i>	<i>rho</i>	<i>d</i>
Your relationship with the therapist at the time	92	3.83	(1.07)	.378*	0.82	-.301	0.63
Your relationship with the therapist for the rest of therapy	92	3.92	(1.07)	.296	0.62	-.146	0.30
Your respect for your therapist	92	3.79	(1.12)	.455**	1.02	-.347*	0.74
Your feeling of being comfortable in the therapy sessions	92	3.77	(1.04)	.253	0.52	-.129	0.26
Your feeling of safety in the therapy	92	3.66	(1.07)	.365*	0.78	-.243	0.50
Your active participation in therapy	92	3.66	(1.17)	.374*	0.81	-.263	0.55
Your own willingness to express emotions in therapy sessions	92	3.43	(1.20)	.624**	1.60	-.535**	1.27
Your feeling of being the one who was being looked after in therapy	92	3.48	(1.11)	.206	0.42	-.204	0.42
The benefit of therapy for you	92	3.64	(1.05)	.370*	0.80	-.274	0.57
Your willingness to keep attending therapy	92	3.62	(0.97)	.315*	0.66	-.345*	0.74
Your willingness to undertake therapy in the future if needed	90	2.70	(1.52)	.650**	1.71	-.674**	1.82

* $P < .01$; ** $P < .001$

Table 3 – Patients' understanding of the reasons for therapists' crying, and association (Spearman's *rho*) with patient perception of the therapist's demeanor

Understanding of the reason for the therapist crying	Group characteristics			Association with therapist characteristics			
	N	M	(SD)	Positive demeanor		Negative demeanor	
				<i>rho</i>	<i>d</i>	<i>rho</i>	<i>d</i>
Something that I had done to upset my therapist	92	1.51	(0.92)	-.048	0.10	.197	0.40
An indication that I was a problem	92	1.61	(1.10)	-.337*	0.72	.574**	1.40
A good thing, showing that I had done something positive	92	1.93	(1.32)	.264	0.55	-.426**	0.94
Something bad that was going on in her or his own life	92	2.25	(1.59)	-.384**	0.83	.517**	1.21
A positive indicator that we were on the same page about my experiences	92	2.42	(1.54)	.529**	1.25	-.536**	1.27

* $P < .01$; ** $P < .001$