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Emotional Displays by Mental Health Professionals:

A Survey Study of Therapists' and Clients' Opinions and Experiences

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An abstract of

A dissertation submitted to the Faculty of the

James T. Laney School of Graduate Studies of Emory University

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in Clinical Psychology

2012

Abstract

Emotional Displays by Mental Health Professionals:

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By Marcia L. Caron-Besch

The topic of therapists' emotions is often discussed in practice settings, occasionally explored in theoretical writings, but rarely subjected to empirical investigation (Najavits, 2000). The current study used electronic survey methodology to explore the opinions and experiences of both mental health professionals/therapists and mental health consumers/clients with regard to three emotional displays by therapists: crying, laughing, and shouting/yelling. The obtained sample of 106 therapists was 76.4% female and 85.8% European American/White, with a mean age of 37.8 years and 10.3 years of clinical experience. The obtained sample of 87 clients was 85.1% female and 94.3% European American/White, with a mean age of 38.9 years and 4.3 years in therapy. Among therapists, 33.0% reported having cried in session, 91.0% having laughed in session, and 17.6% having shouted/yelled in session. Female therapists reported crying more in both their personal and professional lives, while male therapists were more likely to raise their voices in sessions, but not in their personal lives. In general, men and women and therapists and clients endorsed comparable opinions of the different emotional displays. However, male clients reported expecting to react less negatively to their therapists shouting/yelling than did female clients. Overall, respondents held much more favorable opinions of therapists laughing in session as compared to crying and more favorable opinions of therapists crying in session as compared to shouting/yelling. Clients were more comfortable with higher levels of laughing and lower levels of shouting/yelling, while both clients and therapists reported that higher levels of crying had more positive effects on treatment. Therapists' levels of emotional expressivity in session, but not in their personal lives, were positively related to their opinions of the emotional displays. More years in therapy, experiences with having therapists be emotionally expressive, and (to a lesser degree) stronger working alliances were all related to clients expressing more favorable opinions of therapists' emotional displays. Potential beneficial and harmful effects of, reasons for, and outcomes from the emotional displays are summarized as described by therapist and client respondents. Implications for clinical practice guidelines, therapist training, and clinical supervision; study limitations; and future directions in research on therapist emotionality are discussed.

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Acknowledgments

I would like to thank the following individuals...

…Marshall for his wisdom and guidance.

…Ellie for her reassurance and encouragement.

…my committee members for their contributions to this research.

…John for his love and patience.

…my parents for all their sacrifices and pride.

…my sister for being such a great role model.

…all my in-laws for all their support.

…my nephews for being a source of inspiration.

…the makers of Kleenex for their fine product.

…Krauser (1989) for her brave admissions which spoke directly to my heart.

…and lastly, my participants for their valuable time.

Table of Contents

List of Appendices

List of Tables

List of Figures

Emotional Displays by Mental Health Professionals:
A Survey Study of Therapists' and Clients' Opinions and Experiences

Picture a typical individual psychotherapy session. Now imagine that someone is expressing strong emotions in your scene. Given such instructions, most people will envision the client sobbing, cowering in fear, laughing hysterically, or yelling angrily in the therapy room. But what about the mental health professional in the room? Everyday around the world, thousands of therapists see clients for treatment, and at times, many of these therapists experience strong emotions and are thus faced with the decision to either express or suppress their feelings. Given this context, what is the "right" thing to do?

Ethical Considerations

In considering right and wrong therapeutic actions, one can turn to relevant professional ethics codes (i.e., American Counseling Association, 2005; American Psychiatric Association, 2010; American Psychological Association, 2002, 2010; National Association of Social Workers, 2008). The tenets of beneficence and nonmaleficence (i.e., to do good and avoid harm) are central to the provision of all mental health services and are explicit general principles for psychologists (American Psychological Association, 2002, 2010). In striving for beneficence and nonmaleficence, therapists must rely on both clinical judgment and scientific knowledge. Unfortunately, minimal research exists on potential client outcomes when a therapist displays emotions. Nonetheless, the existing theoretical arguments, anecdotal reports, and empirical data (i.e., the scientific literature) will be reviewed below.

Another ethical tenet listed among psychologists' general principles is that of integrity, or acting honestly. Integrity is also found among the core values of social

workers (National Association of Social Workers, 2008), as a professional responsibility for counselors to "aspire to open, honest, and accurate communication" (American Counseling Association, 2005), and as the second ethical principle for psychiatrists, which requires one to "uphold the standards of professionalism" and "be honest in all professional interactions" (American Psychiatric Association, 2010). One could argue that acting with integrity includes expressing one's genuine emotions to clients (e.g., crying if one genuinely feels like crying rather than inhibiting this honest expression), though matters of beneficence and nonmaleficence would still need to be taken into consideration. In contrast, one might argue that emotional expressivity is a form a self-disclosure by a therapist (Bishop & Lane, 2001; Frank, 1997), which would again be subject to analysis for beneficence and nonmaleficence.

The final ethical tenet to be considered is that of impaired professionals, which would be relevant when personal issues are the cause for a therapist's emotional expression. Psychologists' Standard 2.06 on Personal Problems and Conflicts requires that impairment must not interfere with professional competence (American Psychological Association, 2002, 2010). Social workers' Standard 4.05 on Impairment states that "personal problems" or "psychosocial distress" also should not interfere with "professional performance" (National Association of Social Workers, 2008). Finally, counselors' Mandate C.2.g on Impairment based on "physical, mental, or emotional problems" requires that counselors "refrain from offering or providing professional services when such impairment is likely to harm a client or others" (American Counseling Association, 2005). Thus, the tenet of nonmaleficence clearly provides the rationale behind codes on impaired therapists and will be revisited accordingly in the

discussion of what is known about client outcomes (i.e., the potential for harm) when a therapist displays strong emotions in session. The discussion now turns to an overview of the general scientific literature on emotional experience and expression.

Scientific Literature on Emotional Experience and Expression

Function of emotions. The functional perspective of emotions as adaptively useful currently dominates the psychological field (Frijda, 2000). Evolutionary hypotheses abound speculating on the origin and utility of various emotional experiences and expressions. In both everyday life and the therapy room, emotions motivate and shape behaviors (Frijda, 2000), aid in memory and learning (Miceli & Castelfranchi, 2003), and help establish and deepen relationships (Kemper, 2000). Emotional expressivity is an individual difference variable that can affect successful interpersonal functioning, including in the therapeutic relationship. Clark and Finkel (2004) contend that expressing emotions is adaptive and beneficial when one is in the company of others who care about one's welfare, but unwise with companions who do not care about one's well-being. Different clients will fall into each of these categories.

Gender differences in emotionality. In their extensive review on gender differences in emotional expressivity, Brody and Hall (2000) concluded that "gender stereotypes have frequently been borne out by data on actual patterns of behavior" (p. 346). Thus, women show sadness and cry more than men (to be reviewed below), while men show direct aggression and yell more than women (Archer, 2004; Sharkin, 1993). Women also tend to experience and show more empathy than men (Eisenberg & Fabes, 1998; though research methodology is an important consideration). Interestingly, men

and women tend to experience anger with equal frequency, and the gender difference only arises at the level of emotional expression (Archer, 2004).

When and why do these gender differences in emotionality emerge? The simplest answer of during puberty because of hormones (Buck, 1999) does not tell the full story, but does add relevant details. The male hormone testosterone and aggressive behavior seem to be weakly linked in humans (Archer, Graham-Kevan, & Davies, 2005), while the female hormone prolactin is believed to lower crying threshold (Bekker & Vingerhoets, 2001). The catchphrase 'gender socialization' reveals most of the rest of the story. Society as a whole and parents in particular treat boys and girls differently for a variety of reasons which are beyond the scope of this review (see Brody & Hall, 2010; Golombok & Fivush, 1994). Nonetheless, the end result is that "boys increasingly inhibit the expression and attribution of most emotions, whereas girls increasingly inhibit the expression and recognition of socially unacceptable emotions, e.g., anger" (Brody, 1985, p. 102).

Consequences of emotional expression vs. inhibition. In general, either excessive or unnatural/forced expression or inhibition of emotion can be unhealthy (Lewis & Haviland-Jones, 2000). Research on the link between excessive anger/hostility and coronary risk is well-known though under constant debate and refinement (e.g., Friedman & Rosenman, 1974; Williams, 1993). In an interesting demonstration of another risk, Labott and Teleha (1996) randomly assigned 50 undergraduate women to either express or inhibit their tears while watching a sad film. These researchers found higher self-reported and physiologically-measured stress levels among women assigned to the condition that conflicted with their natural crying propensity (i.e., women in the

inhibit condition who cry frequently in real life were highly stressed by the forced emotional inhibition, and women in the express condition who cry rarely in real life were highly stressed by the forced emotional expression).

Given that unnatural emotional expression or inhibition can be detrimental to one's self, what is a therapist to do? One might argue that a therapist should take care of him/herself first if he or she is expected to be able to take care of another (i.e., the client). This logic would lead to a recommendation for authentic emotional expression rather than suppression among therapists. In support of this recommendation, one finds that emotional expressivity can be cathartic, thereby reducing tension and providing relief or improved mood, as in the case of crying (Cornelius, 2001), laughing (Goldstein, 1987), and screaming (Janov, 1970, 1991). However, these self-benefits do not give therapists a carte-blanche excuse to display every emotion they might feel. Professional obligations to one's client override matters of temporary, personal discomfort in most situations. Sociologist Hochschild (1979, 1983, 1990) coined the term "emotional labor" to describe such efforts to change one's emotions to meet job requirements. She also discusses the broader concept of "emotion work" to manage one's emotions in accordance with the "feeling rules" and "expression rules" for one's social identity, including gender and occupational roles (reviewed by Kemper, 2000). Unfortunately, the expression rules for therapists remain largely unknown, though Mann (2004) argued that emotional labor is both a vital skill and a source of significant work stress for individuals in the counseling and guidance professions.

Theoretical Views of Therapists' Emotions

Given the overview above on emotional experience and expression in the general population, the focus now turns to the emotional experiences and expressions of mental health professionals during service delivery. The current study will focus on therapists' crying, laughing, and shouting/yelling as three examples of "strong feelings" (Mahrer, Fairweather, Passey, Gingras, & Boulet, 1999) or behaviorally-based emotional displays. Notably, these three displays all have easily recognized facial and vocal expressions (Russell, Bachorowski, & Fernández-Dols, 2003). Before turning to these three emotions in a particular, a general overview of emotionality by therapists is presented next.

Countertransference. Therapists' emotions are often considered synonymous with the concept of countertransference (Najavits, 2000). Waldman (1995) gives a detailed overview of the historical interpretations of the term countertransference, beginning with the classical psychoanalytic view that all countertransference is burdensome to clients; that it necessarily interferes with treatment; and that it impairs the therapist's desirable positions of neutrality, anonymity, and rationality (i.e., the one-person model). Waldman then reviews more modern conceptualizations of countertransference (and the judicious disclosure thereof) as possibly useful in treatment; as quite powerful in healing; and as contributing to the therapist's desirable positions of participation, genuineness, and authenticity (i.e., the two-person model or relational approach). For the purposes of both Waldman's study and the current one, "Countertransference will be understood to mean the psychotherapist's particular affective responses as they relate to individual patients" (p. 19). Notably, this definition excludes therapists' emotions that relate to a therapist's personal issues or idiographic

reactions. Interpersonal psychotherapy draws strongly on this distinction in deciding which affective responses to share with clients in the hope of providing useful feedback that other individuals in a client's life would not usually be willing to disclose (Frank & Levenson, 2010).

Whether under the umbrella of countertransference or not, a therapist's affective responses may be suppressed or expressed, sometimes under conscious control (a form of intentional self-disclosure or non-disclosure), and other times involuntarily (a form of inadvertent self-disclosure; Frank, 1997). One researcher has gone so far as to suggest that the inability to keep one's emotions under conscious control (i.e., an absence of strong emotion regulation skills) would predict candidates who are unsuitable for training in the mental health field (Cook, 2009). Yet, in Waldman's (1995) interview study of 10 successful therapists discussing their experiences with crying in session, "The respondents uniformly agreed that they had no control, nor did they choose their physiological response of tears. However from their reports, they were able to quickly, almost automatically, shift to a position of conscious decision making with regard to whether they would continue crying during the session" (p. 104). Accordingly, crying and by extension laughing and shouting/yelling in the current study will be understood as either intentional or inadvertent emotional displays, and as sometimes within the realm of countertransference and sometimes not.

Najavits (2000) describes the "well-known" twofold nature of countertransference "as both harmful to treatment (when too intense) and helpful to treatment (when used as a guide to the patient's internal world)" (p. 322). In reference to the former interpretation of countertransference as potentially harmful, overly strong affective responses can indeed

cause experiential avoidance by therapists (Hahn, 2000), meaning that they act "in ways that prioritize not feeling bad instead of dealing with the issue at hand" (Alves de Oliviera & Vandenberghe, 2009, p. 238). Alternatively, countertransference responses that are suppressed (as advocated in the classical view) risk being perceived by clients as "withholding, hostile, or brooding….as covertly manipulative" (Bishop & Lane, 2001, p. 249). Maroda (1998) similarly comments that "Failure to show emotion qualifies as abandonment in the patient's eyes, and may also be perceived as cowardice, lack of interest, or even betrayal" (p. 128).

In reference to the latter interpretation of countertransference as potentially helpful, Colson and colleagues (1986) comment that therapists should "view [their] emotions as an important technical instrument" (p. 928). Their research involved having 44 psychiatric hospital staff members rate their emotional reactions to 127 patients on long-term units; one finding was that patients with severe character pathology tend to evoke strong countertransference reactions of anger. Based on this finding, Colson et al. remarked that therapists may use their own experience of anger to better understand their patients' experience, "thereby aiding empathy" (p. 927).

This study by Colson and colleagues (1986) revealed five distinct dimensions of countertransference: angry-provoked, positive engagement, fearful, helpless-confused, and protective. More recent research has revealed five similar dimensions (hostile-mistreated, positive-satisfying, overwhelmed-disorganized, helpless-inadequate, and parental-protective) but three additional ones as well: special-overinvolved, sexualized, and disengaged (Betan, Heim, Zittel, & Westen, 2005; Betan & Westen, 2009). Now that the various categories of countertransference reactions seem fairly well understood, the

next step is conducting applied research with the goal of providing clinical guidelines for how best to work with different clients eliciting different reactions.

Different theoretical orientations. The different perspectives on countertransference tend to emerge from within the psychoanalytic/psychodynamic tradition. However, practitioners from different theoretical orientations also take a stand on the issue of how best to deal with emotions in therapy. At the two extremes, one might find emotion-focused and experiential therapists pitted against behavioral and cognitive-behavioral therapists. Working within an emotion-focused or experiential framework, therapists encourage emotional experiences and work to evoke emotional expressivity from clients (Grant, 2006; Greenberg, 2010; Mahrer, 1996). Indeed, these therapists view strong affect as essential to productive work in therapy (Mahrer et al., 1999). In contrast, behavioral or cognitive-behavioral therapists will tolerate emotional expressions but work to minimize maladaptive emotional experiences such as depression and anxiety (Antony & Roemer, 2011; Craske, 2009). These therapists view strong affect as interfering with productive work in therapy (Beck, Rush, Shaw, & Emory, 1979). Regardless of whether one's theoretical orientation encourages or prohibits affective displays, we now turn to a discussion of the scientific literature on emotional displays by mental health professionals.

Scientific Literature on Crying

Crying by therapists. Mostly anecdotal evidence exists to describe clients' reactions to their therapists crying in session. Interestingly, all of these anecdotes have been provided by clients who are themselves therapists or therapists-in-training (reporting on their personal therapy with other therapists who cried). Two counseling students

described such experiences as “a positive turning point” and “one of the most therapeutic moments of [his/her] own personal counseling” in offering additional comments on a survey concerning therapists crying (Curtis, Matise, & Glass, 2003, p. 303). In an informal online survey conducted by a colleague (Nelson, 2005), one therapist-client reported that when her therapist cried, it “increased [her] sense of a close bond between” the dyad (p. 180), and another reported that “it was very validating for me….very healing” (p. 181). Lastly, in a theoretical paper, another therapist-client described gaining a new perspective on his therapist when the therapist cried during their final session together: “I saw the warm heart of this man with a fine mind and a shy nature” (Guntrip, 1975/1986, p. 454, cited in Waldman, 1995). These brief quotations convey all the information contained in these publications reporting on clients’ reactions to their therapist crying in session.

In the one exception to collecting client reactions via anecdote, Sussman (2001) conducted a “heuristic inquiry” (p. 92) into her own therapy clients’ experiences of her crying in session with them. Based on her semi-structured interviews with four, high-functioning, 30-something, female clients, Sussman concluded that “All participants considered [her] own tears to have been very important to their therapy” (p. 96). Sussman’s clients specifically remarked that their therapist’s tears made the first client “feel that [her] feelings were acknowledged,” were “an important part of the sharing that helped [the second client] move through the pain,” and were interpreted as “a wonderful feeling of empathy” and “beyond empathy, beyond support” by the third and fourth clients, respectively (p. 96).

Additional anecdotes about the presumed impact of the therapist's tears on the client have been provided second-hand by the crying therapists. First, in a detailed psychoanalytic case study, Kafka (2008) wrote that her tears allowed her elderly male client to understand that she "cared enough to know his pain" (p. 161) and to "transform loss and grief into compassion and hope" (p. 157). Second, in describing an initially "classic case for couples treatment" (p. 233) during which the wife then experienced a terminal remission of cancer, Counselman (1997) reflected on her own crying with the couple and concluded that "they connected to [her] as well as they did because [she] decided to be open and real with them, which encouraged them to be open and real with each other" (p. 237). Lastly, Waldman (1995) interviewed five male and five female, psychodynamically-oriented, licensed psychologists who volunteered with a "general willingness" (p. 59) to share their experiences of having cried with clients. Nine out of the ten therapist-participants described beneficial effects of their tears, including one participant who stated that his tears were caused by personal issues (i.e., acute grief). Specific comments on the presumed impact of the therapists' tears are as follows: they "facilitated [the client's] ability to own her sadness" (p. 78); they were "transformative" for the client (p. 79); "the therapeutic relationship was strengthened" (p. 79); the client was "appreciative" and the dyad turned a "huge corner…together" (p. 80); one client experienced "total empathy" and another "the most trust in the entire therapy" (p. 81); and the client felt "really happy….like an achievement kind of experience" (p. 82).

Despite these favorable reports, not all interpretations of clinical outcomes when a therapist cries have been positive. One therapist in Waldman's (1995) interview study believed that his tears were disruptive to his client, and he said he felt badly about having

possibly caused his client pain and anxiety. Next, in describing the reactions of three adolescents clients with whom she cried during their termination sessions, Nelson (2005) reported that two of the clients seemed to understand her tears as a sign of caring and a way for her to convey that she will miss them, while the third client seemed to interpret Nelson's crying as "behaving like her needy…parent" (p. 185). Nelson (2009) also offers anecdotal third-hand reports of therapists' interpretations of the effect of their tears on their clients. Among her "numerous examples" gathered, Nelson summarized that half of the incidents of therapists crying were "effective and meaningful" for clients, while the other half "resulted in a rupture in treatment," usually because the client interpreted the therapist's tears "as an appeal for caregiving" (p. 343) or as a sign of "hypersensitivity" (p. 344). Among the positive examples, Nelson (2005) reported that one therapist's tears "helped to soothe and regulate a woman's sense of loss and failure" (p. 183), while another's "assisted in normalizing [his] client's grief" (p. 188).

Aside from its impact on clients and their clinical outcomes, another aspect of crying by therapists that is important to assess is its prevalence (i.e., how many therapists cry) and frequency (i.e., how often therapists cry). In a detailed self-study of herself as a therapist, Sussman (2001) reported that she cried during 25% of her therapy sessions during one year. On the other extreme, existential psychotherapist McGinley (2008) alludes to but never admits to ever having cried during a therapy session. Similarly, doctoral candidate Waldman (1995) admits to but does not elaborate upon having cried in therapy. In an informal online survey of 19 colleagues, Nelson (2009) found that two-thirds of her respondents had cried with a client, though for most it was a rare event (e.g., occurring 3 to 5 times over the course of 9 to 40 years in practice; Nelson, 2005).

Frequent crying was noted by one therapist as crying in session one to two times per week (Nelson, 2005).

The relative rarity of the event does little to assuage therapists' fears about the possibility of crying in front of a client. Indeed, the author's personal communications and the literature suggest that these fears are very real and fairly common. In a survey study of 159 counseling students, 21% reported feeling somewhat to very worried about crying in front of a client (Curtis et al., 2003). The authors (i.e., the students' clinical supervisors) commented that "these students' concerns caused them to question their future as counsellors [sic]" (p. 301). The authors of another paper (also clinical supervisors) similarly commented on their students' intrapersonal conflict, shame, and confusion with regard to crying during their psychology training (Hoover-Dempsey, Plas, & Wallston, 1986). Waldman (1995) observed that "There still seems to be a prohibition against any behavior on the clinician's part that cannot be intellectually understood in that moment as a conscious intervention. Affective displays are referred to in passing; and it seems, with some fear" (p. 42).

Given these negative internalized attitudes, what beliefs about therapists crying have been given voice? Matise (2006) developed and validated a 23-item questionnaire (i.e., the Tears Inventory) to assess counselors' attitudes towards crying (both in and out of counseling sessions) for his dissertation research. Survey respondents were 279 counselors and counseling trainees (79.6% female, 89.2% Caucasian). This sample was generally undecided or neutral about the therapeutic effectiveness of a counselor crying in session with a client and about how individuals who cry are subjectively perceived. On average, the sample disagreed that a counselor who cries in session is unethical or

unprofessional, it somewhat disagreed that crying is socially unacceptable, and it largely agreed that crying has health benefits. In this study, counselor's attitudes towards crying were not related to their emotional intelligence, age, or ethnicity. However, female counselors generally reported more positive attitudes towards crying than did male counselors.

Other studies have provided additional information about therapists' attitudes towards crying. Though the majority of the 159 counseling students surveyed by Curtis and colleagues (2003) were ambivalent as to whether crying with clients is "unprofessional," 61% reported that doing so could facilitate the therapeutic relationship. In Nelson's (2005, 2009) informal online survey of 19 therapists, 21% reported believing that therapists' tears always interfere with client treatment. McGinley (2008) notes that "the euphemisms that we use [for crying] tell us a lot about our attitude in general," citing the examples of 'breaking down,' 'losing control,' "being reduced to tears," and 'becoming hysterical' (p. 215). One clinical psychologist summarized the prevailing beliefs as follows: "For the ethos dictates that control and constraint is of the essence, and regardless of situation, *professionals don't cry* [emphasis in original]" (Ussher, 2001, p. 284). This raises the questions of prevalence rates and attitudes towards crying among other professionals, namely those in medicine.

Crying by medical professionals. Several nurses and doctors have published anecdotes 'confessing' to having cried in hospitals for a variety of reasons: empathy and compassion (Angloff, 2001), helplessness and anger (Clark, 1993), sympathy and shock (Hallock, 1995), frustration and sadness (Krauser, 1989), and grief and fear (Schultz, 1994). In these and other reports of crying in medical settings, it seems an effort is made

to normalize or even encourage the (modulated) expression of emotion through tears (Mander, 2008; McGreevy & Heukelem, 1976; Pongruengphant & Tyson, 2000). Emerging research suggests that the experience of crying by medical professionals is indeed the norm. In an informal survey of her clinical supervisees, Angloff (2001) reported that 73% (133 of 182 third-year medical students) cried at least once during their clinical rotations. More formal survey research reveals prevalence rates for crying at work among 31% of medical students, 57% of doctors, and 76% of nurses (Wagner, Hexel, Bauer, & Kropiunigg, 1997; total sample size of 252 participants in Australia); 32% of medical students and 53% of nursing students (Kukulu & Keser, 2006; total sample size of 130 participants in Turkey); and 69% of medical students and 74% of medical interns (Sung et al., 2009; total sample size of 311 participants in the United States). It is important to note, however, that these surveys refer to crying anytime while on the job, and not just crying in front of patients (which would create the most direct point of comparison for therapists crying in session).

These same survey studies also explored attitudes towards crying in the medical profession. Angloff (2001) stated simply that "Medical students worry about crying" (p. 1017). Wagner and colleagues (1997) found that crying in hospitals was viewed as more "acceptable" for nurses and students than for doctors, though all ratings were above the midpoint from never to always. Sung and colleagues (2009) found that 89% of respondents considered it "unprofessional" to cry in front of patients out of stress, compared to 37% for crying out of sadness. Finally, in the survey by Kukulu and Keser (2006), almost all nursing students indicated that the subject of crying should be included in their curriculum, whereas only half of the medical students shared this belief, and half

of these indicated that crying was simply not important enough to include in the curriculum. The broader literature on how medical students are socialized to become professionals (e.g., Hafferty, 1988; Pitkala & Mantyranta, 2003), including how they learn to cope with their emotional responses without explicit curricular instruction as suggested above, is also relevant to the training of mental health professionals.

Crying by men vs. women. Each of the three formal survey studies on crying by medical professionals (Kukulu & Keser, 2006; Sung et al., 2009; Wagner et al., 1997) found significant gender differences which are consistent with research from the general population (i.e., that women cry more than men). For example, Bekker and Vingerhoets (2001) reviewed 14 empirical studies which all found significant gender differences in the expected direction for crying frequency, intensity, duration, and/or proneness. In addition, across five non-clinical, adult samples, Hastrup, Kraemer, Bornstein, and Trezza (2001) obtained an average gender ratio in crying frequency of approximately 6:1, meaning that women cry approximately 6 times as often as men. However, both sets of reviewers cautioned against making individual inferences on the basis of group means, due to the wide variability in crying behavior within each gender (Bekker & Vingerhoets, 2001; Hastrup et al., 2001).

Interestingly, the traditional gender differences in crying frequency (across all life situations, not just in therapy) were not upheld in one sample of 219 clinical psychology practitioners (Trezza, Hastrup, & Kim, 1998). Hastrup and colleagues (2001) speculate that "…it is possible that self-selection into this kind of emotionally draining work may have increased the number of men who are more emotionally expressive and androgynous; alternatively or in addition, the work itself may increase the likelihood of

crying" (p. 60). Nonetheless, the traditional gender differences did hold strong in one study of 66 school psychologists and 215 psychology faculty members (Hastrup, Phillips, Scheiner, McAfee, & Kraemer, 1986).

Reasons for Therapists' Emotional Displays

In general, it seems that crying can be triggered by and express a great variety of emotional states (i.e., empathy, sadness/grief, fear, shame, anger, or even joy), whereas laughing and shouting/yelling tend to occur with and convey more specific emotional states (i.e., laughing out of joy/amusement or nervousness and shouting/yelling out of anger/frustration or surprise). While acknowledging that therapists emote for the same reasons as other people, discussions of the specific reasons that therapists might cry, laugh, or shout/yell in session now follow. The smaller scientific literatures on laughing and shouting/yelling by therapists are also incorporated in the following sections.

Reasons for crying. Empathy was the most common reason for crying offered in the informal online survey of 19 therapists by Nelson (2005, 2009). Other therapists have provided equivalent explanations of their tears as stemming from compassion (Sussman, 2001) or the desire to show care/support (Waldman, 1995). Similarly, therapists have reported not inhibiting their tears in order to remain genuine (Waldman, 1995), to be emotionally present with clients (Counselman, 1997), to model emotional expressivity (commented on by one therapist participant in Curtis et al., 2003 and one in Waldman, 1995), and to strengthen the therapeutic relationship (Nelson, 2005, 2009; Waldman, 1995). Other positive reasons for crying cited by therapists include gratitude (Nelson, 2005, 2009), joy (Waldman, 1995), and relief (Waldman, 1995).

Some negative emotions that have provoked therapists' tears are feelings of shame (Hahn, 2000), inadequacy (Waldman, 1995), powerlessness (Ussher, 2001), and helplessness (Miceli & Castelfranchi, 2003). Ussher (2001) commented that therapy is "a painful and difficult job" in which burnout and/or secondary traumatization are prevalent and can result in excessive emotionality or emotional numbing (p. 293). Indeed, crying due to death-related (client) issues was the most common reason offered in Waldman's (1995) interviews with 10 therapists (reason also cited by Counselman, 1997 and Ussher, 2001). Death-related issues in the therapists' own lives (i.e., working during acute grief) were also acknowledged as a source of in-session tears by Kafka (2008), by one therapist interviewed by Waldman (1995), and by an unspecified number of therapists surveyed by Nelson (2005, 2009). Finally, saying goodbye during termination sessions has also been reported to elicit therapists' tears (Guntrip, 1975/1986; Nelson, 2005, 2009).

Reasons for laughing. The most obvious reason a therapist might laugh in session is "because something is funny" (Waldman, 1995, p. 98), thereby showing appreciation for a client's sense of humor. In general, laughter serves to release tension, foster insight, facilitate social interactions, induce cooperation, and promote social intimacy (Chapman, 1976; Nelson, 2008b; Russell et al., 2003), and thus could be used by therapists to establish or strengthen the therapeutic relationship (Franzini, 2000). A therapist might laugh to model emotional expressivity for an inhibited or anxious client (VanFleet, 2001), to affectionately tease an overly serious client (Ehrenberg, 1991), or to attempt to lift the mood of a sad or depressed client via the contagious nature of laughter (Labott, Martin, Eason, & Berkey, 1991; Provine, 1992). However, therapists might also

laugh out of personal nervousness or worse yet, out of disparagement towards or mockery of a client (Mindess, 1976; Zillmann, 1983).

The astute reader might have noticed the conjectural nature of the statements above. This is because, despite a large literature on the use of humor in therapy (see next paragraph), there is little mention of therapists actually laughing in session. Six anecdotes below are noted as exceptions. First, Ehrenberg (1991) described playfully engaging with an adult male client who took "to delight in getting [her, the therapist] to laugh" (p. 231). She described their shared laughter as validating and affirming for the client. Second, Gladding (1995) described joking and then laughing with a new adult male client in a reportedly successful effort to reduce tension in the therapy room. Third, Carlberg (1997) reported on a child therapist who laughed "heartily" with her young female client in what became a "turning point" for both treatment and the therapeutic relationship (p. 332). Fourth, Corbett (2004) discussed laughing with an adult male client to show affection and alleviate despair. Fifth, Siebold (2006) described working with an adult female client with whom she "shared the experience of knowledge about female sexuality by laughing together as [the client] talked about what felt really good to her" (p. 12). Finally, Nelson (2008b) reported having laughed spontaneously when a young adult female client described an unusual scene that had been very irritating to her: "Fortunately, [the therapist] read the situation correctly and [the client] was able to lighten up as well" (p. 47). Interesting, all six of these anecdotes report on laughter shared by both therapist and client.

While not discussing therapist laughter in particular, there are entire books on the use of humor in therapy (Buckman, 1994; Fry & Salameh, 1987; Strean, 1994), and an

Association for Applied and Therapeutic Humor (formerly the American Association for Therapeutic Humor) exists. There are guidelines for using humor within different theoretical orientations (e.g., psychoanalysis [Ehrenberg, 1991], behavioral therapy [Franzini, 2000], and Gestalt therapy [Jacobs, 2009]) and with specific client populations (children [VanFleet, 2001], adolescents and young adults [Saper, 1990], college students [Vereen, Butler, Williams, Darg, & Downing, 2006; Warner & Studwell, 1991], groups of adults [Kennedy, 1991; Lewis, 1987], older adults [Richman, 2006], and individuals with schizophrenia [Witztum, Briskin, & Lerner, 1999]). Kubie (1971) provides the most commonly cited overview of the "destructive potential" of humor in therapy and concludes that it should mostly be avoided. Mindess (1976) concisely reviews these dangers (albeit tongue-in-cheek) of using humor in therapy: "An inhibiting, confusing type of communication, a defence [sic] against anxiety, a form of masked hostility, an obstacle in the path of taking illness seriously, an exhibitionistic display, a seductive ploy, and dangerous weapon" (p. 333).

Given the potential pitfalls, efforts have been made to clarify with which clients and in which situations therapists might consider or should avoid using humor (Fabian, 2002). Unfortunately, little research exists to support such recommendations, as noted in reviews by Saper (1987) and Shaughnessy and Wadsworth (1992). To date, still no controlled outcome studies exist. However, Marci, Moran, and Orr (2004) conducted an interesting study in which they coded for the presence of laughter by both therapist and client in 10 videorecorded therapy sessions with clinically-stable, adult clients. On average, clients laughed 12 times and therapists 5 times per 45-minute session (a significant difference), suggesting that "therapists tend to withhold or suppress their

expressions of affect in a therapeutic setting" (p. 693). Interestingly, about three-quarter of client laughs were while speaking (rather than listening), compared to only one-tenth of therapist laughs. Through physiological recordings associated with the laughter episodes, Marci and colleagues concluded that laughter is a consistently arousing experience which communicates information about dominant vs. submissive roles in the therapeutic dyad.

Reasons for shouting/yelling. Waldman (1995) commented that "A growing number of authors speak generally to their emotional responses within treatment; however, they seem reluctant to provide specific examples of what occurs during the clinical hour" (p. 26). The current author notes that a parallel seems to exist between the frequent discussion of humor but not laughter in therapy, and the frequent discussion of anger but not shouting in therapy. Thus, therapists admit to feelings of anger/frustration (Bishop & Lane, 2001; Colson et al., 1986; Hahn, 1995; Jacobs, 1997; Sharkin & Gelso, 1993), hostility/rage (Alves de Oliveira & Vandenberghe, 2009; Searles, 1979), and even hatred (Epstein, 1977/1979; Winnicott, 1949) towards their clients, but they do not discuss their actual behaviors or emotional expressions resulting from such feelings. Two anecdotes, one case study, and one piece of information from a national survey are discussed next as exceptions.

In the first anecdote, Frank (1997) describes how he conveyed his frustration to a help-rejecting, adult male client: "Impulsively, exasperatedly, I exclaimed, 'Why do you always have to do that?!' My statement, blurted out before I could reflect on it, clearly revealed a lapse in my usual composure" (p. 296). Though exclaiming might not be as strong as shouting or yelling, Frank wrote on to describe his client's non-defensive

reaction and the useful clinical dialogue that ensued. In the second anecdote, Alves de Oliveira and Vandenberghe (2009) relay information obtained from in-depth interviews with four female clinical psychologists reporting on "upsetting experiences" in therapy. The researchers recount that two of the four therapists reported having "retaliated with hostile remarks of their own" when faced with hostile clients (p. 237). Unfortunately, the loudness of their remarks and their clients' reactions were not reported.

In the one case study, Malekoff (1999) discusses an incident in which he expressed his anger towards a group of five adolescent male clients. The clients "had all been referred to a mental health center for various destructive acts," and "They had all experienced disruption in their family lives – separation, divorce, death and dislocation" (p. 72). Malekoff's "mistake, as [he] perceived at the time, was ending a group early by angrily throwing all five boys out of [his] office" (p. 73). Before Malekoff shouted at the boys to leave, they had "lost control of themselves" (p. 74), cursing, shouting, shoving, and humping one another. Malekoff described his reasons for shouting as stemming from his "growing irritation, embarrassment, and helplessness" (p. 78), as well as "a protective drive, bordering on controlling" because he "feared losing control" (p. 79). Yet, he still reports a vaguely positive result of his shouting, in that his clients learned he "was tolerant within limits, flexible to a point, determined to ensure physical and emotional safety and capable of losing [his] temper without abusing them or abandoning the group," (p. 79) which are arguably important lessons for a group of troubled teenage boys.

Lastly, in the national study, Pope and Tabachnick (1993) surveyed 285 psychologists about several different feelings towards clients, including anger and hate. In response to the item assessing the frequency with which therapists raise their voice at

clients out of anger, 45.6% of respondents indicated never, 44.9% rarely, 6.8% sometimes, 0.4% often, and 0.4% with most clients (1.9% of therapists did not answer this question). Reports did not vary with client gender, and no additional information was collected on incidents of shouting.

For what reasons other than anger towards a client might a therapist shout in session? In general, a raised voice signals the use of power in a social relationship (Kemper, 2000). Despite its name, therapists are not encouraged to shout in primal scream therapy (Janov, 1970, 1991). Perhaps some therapists might shout on a client's behalf in order to model appropriate emotional expressivity (i.e., in dealing with grief or mistreatment). An emotionally present therapist might shout out of surprise at something said or done by a client. An expressive therapist might shout to try to make a point clear or get through to a client. However, one cannot ignore those instances in which a therapist's shouting might represent professional impairment due to personal or unresolved issues somehow triggered (or not) by a client. These instances would represent malpractice and/or verbal/emotional abuse. As perhaps expected, none of these instances have been reported in the literature.

Clients' Reactions to Therapists' Emotional Displays

Given the wide variety of situations which may prompt a therapist's tears, laughter, or raised voice, it is safe to assume there are as many different possible client reactions to such displays. In the anecdotes reviewed above, both tears and laughter have been experienced by clients as therapeutic, validating, and supportive with the effects of providing a positive turning point and/or increasing the sense of connection with the therapist. Laughter also served to relax and uplift clients, while even shouting/yelling was

reported to provide insight, interpersonal connection, and a sense of safety. These positive reactions to therapists' emotional expressivity are predicted in a videotape simulation study by DiMatteo and colleagues (1985) in which medical patients attached a low value to emotional neutrality by doctors and preferred affective behaviors instead.

Negative client reactions have been more frequently discussed in the hypothetical. McGreevey and Heukelem (1976) speculated that tears may elicit any of the following emotions from observers: concern, pity, no response, helplessness/hopelessness, cruelty, insensitivity, or a sense of being manipulated. Hoover-Dempsey and colleagues (1986) also commented on the manipulative potential of crying and further stated that "Older children and adults are at best uncomfortable when others cry…and commonly they may attempt to suppress or ignore the crying" (p. 24). Indeed, adults' tears are commonly understood to serve a help-soliciting function which may be ignored, reinforced, or punished (Hendriks, Croon, & Vingerhoets, 2008). One therapist in Waldman's (1995) interview study speculated that a therapist's tears might make a client worry "…does this mean that you're not going to be able to take care of me? Does this mean that you're going to be overwhelmed by your own feelings and therefore won't be helpful to me? Do I have to protect you from my feelings?" (p. 85). Other therapists in this study also mentioned the potential role reversal of client as caretaker, especially with female clients, a concern also expressed by Nelson (2005, 2009). A survey of medical students and interns provides evidence for this possibility: In reaction to 16 self-reported instances of doctors crying in front of patients, the patients responded by attempting to comfort their doctor approximately one-third of the time (A. Sung, personal communication, June 6, 2011).

Negative client reactions to a therapist's laughter might include hurt feelings or a sense of rejection, shame, anger, indignation, or confusion. Shouting/yelling might also hurt, shame, offend, confuse, or even scare a client. In reaction, clients might withdraw (e.g., fall silent or stop attending therapy), aggress directly (e.g., shout back/yell at therapist), or aggress indirectly (e.g., file a complaint). Shouting/yelling might also affect client compliance, as demonstrated in an interesting study by Milmoe and colleagues (1967). These researchers found based on audiotaped recordings and ratings of doctor-patient interactions, that the more anger and anxiety in doctors' voices during an initial interview, the fewer number of patients followed through on treatment (in this case, for alcohol abuse/dependence). With other client populations (e.g., anxious children or adults with dependent personalities), however, compliance may be increased by the therapist shouting. Client reactions to being shouted/yelled at might also depend on the therapist's gender, as suggested by Brescoll and Uhlmann's (2008) vignette study in which men who expressed anger in professional settings were conferred higher status and viewed as more competent than female professionals expressing anger.

In contrast to the anecdotal or hypothetical outcomes reviewed above, one psychotherapy process study did code in-session therapist behaviors and use them to differentiate more and less effective therapists based on a variety of client outcomes (Najavits & Strupp, 1994). These researchers found that more effective therapists displayed more positive behaviors and fewer negative behaviors than less effective therapists. They defined positive behaviors as ones conveying warmth, affirmation, and understanding, and so this likely would have included laughing. They defined negative

behaviors as ones conveying hostility either passively (e.g., ignoring) or actively (e.g., attacking, blaming), and so this likely would have included shouting/yelling.

Another interesting, relevant study coded the facial expressions of both therapists and clients (11 pairs) based on videotaped sessions (Merten, Anstadt, Ullrich, Krause, & Buchheim, 1996). Researchers found a strong negative correlation between high affective reciprocity in the first session (i.e., therapist and client expressing the same predominant emotion, either happiness, anger, contempt, disgust, fear, sadness, surprise, or no affect) and treatment success as reported by both therapist and client. Unfortunately, because "coding of facial behavior is very time consuming" (p. 203), Merten and colleagues only provide detailed analysis of the most and least successful therapy dyads rather than offering normative information on the facial expressions of their full sample. They concluded that complementary (e.g., a therapist displaying no affect while a client displays contempt) rather than reciprocal/matched affective behavior is preferable in treatment.

Statement of Problem

The topic of therapists' emotions is often discussed in practice settings, occasionally explored in theoretical writings, but rarely subjected to empirical investigation (Najavits, 2000). Yet, this is a valuable area of inquiry, given the many implications for therapist training, clinical practice guidelines, and clinical supervision. According to one researcher, "the study of therapist emotions … has the potential to help address a number of current issues in psychotherapy, including topics such as identifying effective versus less effective therapists, how manualized treatments are differentially

implemented, ability to learn and respond to training, burnout, selection of therapists for jobs, and other realities of current clinical practice" (Najavits, 2000, p. 327).

There seems to be a presumption that strong emotional displays by mental health professionals are rare events in therapy, but their actual prevalence and frequency (and predictors thereof) remain unknown. Of more pressing concern is the lack of knowledge regarding clinical outcomes from such emotional displays, including lower-intensity expressions. Extrapolating from a handful of anecdotes and a stack of theoretical arguments is insufficient to guide true scientist practitioners toward evidence-based practices (see APA Presidential Task Force on Evidence-Based Practice, 2006). Focused research is needed on clients' reactions to emotional displays by mental health professionals before guidelines can be put forth on acceptable/unacceptable or beneficial/harmful emotional expressivity with clients.

In an effort to bridge the existent gap in the field's knowledge, the current study aimed to explore the opinions and experiences of both mental health professionals/ therapists and mental health consumers/clients with regard to three emotional displays by therapists (namely crying, laughing, and shouting/yelling). Researchers used electronic survey methodology in the hopes of determining prevalence rates and frequencies of the emotional displays in personal and professional settings, attitudes towards the emotional displays in therapy, and clinical outcomes resulting from the emotional displays. In doing so, the current study aimed to determine societal "expression rules" for the occupational role of therapist (Hochschild, 1979, 1983, 1990). Therapist and client characteristics (in particular gender, experience in therapy, and presenting problems/clinical issues) were

tested as predictors of the above. Accordingly, the following hypotheses were tested (see Figure 1 for hypotheses in diagram form):

1. Female gender will predict (a) therapists' opinions that are more accepting of therapists crying in session, (b) clients' opinions that are more accepting of therapists crying in session, (c) clients' expectations of more positive outcomes from their own therapist crying in session, (d) greater likelihood of therapists crying in session, and (e) therapists' reports of greater crying propensity in their personal lives. Hypothesis 1a is consistent with the findings from Matise (2006), while hypotheses 1a through 1c are consistent with the literature on gender socialization of emotionality presented above, namely that women are more comfortable with sadness and crying. Hypotheses 1d and 1e are consistent with gender differences in crying frequency, while making the assumption that therapists' gender roles will be more salient than their occupational role.
2. Male gender will predict (a) therapists' opinions that are more accepting of therapists shouting/yelling in session, (b) clients' opinions that are more accepting of therapists shouting/yelling in session, (c) clients' expectations of more positive outcomes from their own therapist shouting/yelling in session, (d) greater likelihood of therapists shouting/yelling in session, and (e) therapists' reports of greater shouting/yelling propensity in their personal lives. Hypotheses 1a through 1c are consistent with the literature on gender socialization of emotionality presented above, namely that men are more comfortable with anger, and therefore shouting/yelling. Hypotheses 1d and 1e are consistent with gender differences in

expression of anger, while making the assumption that therapists' gender roles will be more salient than their occupational role.

3. Therapists' (a) greater emotional propensities out-of-session and (b) their in-session emotional expressivity ratings will predict therapists' opinions that are more accepting of therapists displaying emotions in session. These hypotheses are consistent with cognitive dissonance theory (Festinger, 1957), such that an association between therapists' actions (i.e., their emotional expressivity in their personal and professional lives) and their attitudes (i.e., their acceptance of emotional displays in session) might represent efforts to reduce intrapersonal discomfort if these two aspects were previously in conflict. In addition, it is hypothesized that therapists' greater emotional propensities in their personal lives will themselves predict (c) therapists' ratings of more intense emotions in session. This hypothesis is illustrative of cross-situational consistency in behavior (Bem & Allen, 1974), specifically with regard to therapists' emotional displays across their personal and professional lives. Such cross-situational consistency would represent therapists striving to be genuine and to act with integrity.
4. Clients' perceptions of the working alliance with their therapist will predict (a) clients' opinions that are more accepting of therapists displaying emotions in session and (b) clients' expectations of more positive outcomes from their own therapist displaying emotions in session. These hypotheses suggest that a good therapeutic relationship would buffer a client from the potential negative effects of a therapist displaying emotions in session.

5. Clients' experiences of having a therapist (a, c) cry or (b, d) laugh in session will predict (a, b) clients' opinions that are more accepting of therapists displaying emotion in session and (c, d) clients' expectations of more positive outcomes from their own therapist displaying emotions in session. With respect to crying, these hypotheses are consistent with the mostly positive anecdotal reports in the literature on client reactions to therapists crying. The hypotheses on laughing stem from the assumption that laughing is usually a display of positive affect and so should be met with a positive response; there is also evidence that hearing laughter is generally a pleasant experience (Bachorowski & Owren, 2001). Both hypotheses are consistent with the mere exposure effect in social psychology in which repeated exposure to novel stimuli (in this case, tears or laughter by therapists) increases liking of them (Bornstein, 1989; Zajonc, 1968). In contrast, it is hypothesized that clients' experiences of having a therapist shout/yell in session with them will predict (e) clients' opinions that are less accepting of therapists displaying emotions in session and (f) clients' expectations of less positive outcomes from their own therapist displaying emotions in session. The hypotheses on shouting/yelling stem from the assumption that being shouted/yelled at is generally a negative experience which can sometimes be considered (or be reminiscent of other) verbal or emotional abuse (Keashley, 1998).

To summarize, the first set of hypotheses associates female gender and crying, while the second set associates male gender and shouting/yelling. The third set of hypotheses associates therapists' emotionality in their personal and professional lives,

while the fourth set associates the working alliance with clients' impressions of therapists' in-session emotional displays. The fifth and final set predicts favorable client responses to therapists' tears and laughter but unfavorable client responses to therapists' shouting/yelling.

In addition to testing the hypotheses above, the current study explored the following questions of interest. Explicit hypotheses were not made due to a lack of existing data or strong theoretical rationales.

1. What percentage of clients has ever had a therapist cry, laugh, or shout/yell in session with them? What percentage of therapists has ever cried, laughed, or shouted/yell in session with a client (i.e., what are the prevalence rates for these emotional displays)?
2. Do therapist age and/or years of experience conducting therapy predict differences in therapists' opinions of therapists displaying emotions in session? This question may shed some light on shifts in the culture of the mental health field towards or away from an acceptance of emotionality.
3. Do client age and/or years in therapy predict clients' opinions of therapists displaying emotions in session? Do certain presenting problems/client issues? These questions have important implications for best practices and clinical training.
4. Do therapists and clients report differing opinions of therapists displaying emotions in session? Presumably, it would be desirable for the opinions of the different parties to be in agreement.

5. When therapists and clients are reflecting on memorable incidents of therapists' emotional displays, is the level of emotional expressivity related to comfort levels in the room or reported effects on treatment? These questions also have important implications for best practices and clinical training.
6. In what ways do therapists believe that crying, laughing, or shouting/yelling in session with a client might either benefit or harm the client? Important themes may emerge from these open-ended questions to help shape practice guidelines.
7. What reasons do therapists give for their emotional expressivity in session? What reasons do clients give for their therapists' emotionality? Differences here may point to needs for more discussion in session to avoid misunderstandings.
8. What clinical outcomes have therapists actually observed from their crying, laughing, or shouting/yelling in session? What clinical outcomes do clients report from their therapist crying, laughing, or shouting/yelling with them in session? Again, themes and differences will be important to highlight.

Method

Participants

Therapist participants were required to be at least 18 years of age, be able to read English, have internet access, and currently be providing mental health services. Therapist participants were first recruited from four sites. The first, the Aurora Mental Health Center in the Denver metropolitan area, is a full-service community mental health center which employs professional counselors, social workers, psychologists, and psychiatrists. The second, the Emory University Psychological Center, is a university-affiliated departmental clinic in the Atlanta metropolitan area which trains clinical

psychology graduate students who are supervised by licensed psychologists in the department. The third, the Emory University Student Counseling Center is a comprehensive university counseling center staffed by social workers, psychologists, and psychiatrists. The fourth, the University of Colorado Aging Center, is another university-affiliated departmental training clinic in the Colorado Springs metropolitan area serving a geriatric population. Therapist response rates were determined by total therapist counts at each site as provided by the team managers (site 1) and clinic directors (sites 2, 3, and 4).

After the initial phase of site-specific recruitment, therapist participants were recruited through professional associations. The principal investigator contacted the listserv managers for the Colorado and Georgia state associations for counselors, social workers, psychologists, and psychiatrists and requested that the research invitations be forwarded to listserv recipients. Due to a lack of response by most listserv managers, therapist response rates could not be determined for this phase of recruitment but were roughly estimated.

Client participants were required to be at least 18 years of age, be able to read English, have internet access, and not be an inpatient in a psychiatric hospital at present. Therapist participants had the option of inviting during the week following their own participation as many clients on their schedule who were eligible to participate to do so. Front desk staff at study sites 2, 3, and one location of site 1 also distributed client invitations to every client who checked-in during different three-week periods. Client response rates were determined by asking front desk staff how many invitations were distributed and by asking therapists to indicate how many client invitations they intended to distribute as the final question of the therapist survey.

As with the therapist sample, after the initial phase of site-specific recruitment, client participants were recruited online. The principal investigator contacted the website managers for sites targeting mental health consumers and requested that the research invitation be posted on the site (generally as part of a blog or open forum). Due to the inability to track how many eligible participants viewed these postings, client response rates could not be determined for this phase of recruitment but were roughly estimated. Table 1 provides an overview of response rates in this study.

Sample characteristics. Of the 119 therapists who consented to participate in this study, only 106 did so by responding to at least one question beyond the consent form (89.1%). Among the 106 therapist participants, 25 were men (23.6%) and 81 were women (76.4%). Most therapist participants self-identified as European American/White (n = 91, 85.8%), while three self-identified as Asian American/Pacific Islander (2.9%), three as Hispanic/Latino/Latina (2.9%), two as African American/Black (1.9%), four as an other racial background (3.8%), and three did not respond to this item (2.8%). Most therapist participants self-identified as married or partnered (n = 60, 56.6%), while 25 self-identified as single or dating casually (23.6%), 19 as dating seriously or engaged (17.9%), and two did not respond to this item (1.8%). Therapists' ages ranged from 23 to 73 years old, with a mean age of 37.8 years (SD = 12.5). Therapists' years of experience treating clients (including training years) ranged from 0.5 to 40.0 years, with a mean of 10.3 years of experience (SD = 10.1). Male and female therapists differed significantly in age ($U(105) = 687.00$, $Z = -2.36$, $p = .02$), at 42.2 years for men (SD = 12.7) and 36.5 years for women (SD = 12.2). Accordingly, there was a statistical trend for male and

female therapists to differ in years of experience treating clients ($U(101) = 706.00$, $Z = -1.92$, $p = .06$), with 13.4 years for men ($SD = 11.7$) and 9.3 years for women ($SD = 9.4$).

Approximately half of the therapist participants reported that they work mostly with adults ($n = 51$, 48.1%), whereas 27 reported working mostly with children/adolescents (25.5%), 26 with all ages (24.5%), and two did not respond to this item (1.9%). Approximately half of the therapist participants reported that they are licensed in their field ($n = 51$, 48.1%), whereas 36 reported that they are trainees (34.0%), 17 that they are unlicensed (16.0%), and two did not respond to this item (1.9%). Most therapist participants endorsed having a master's degree ($n = 61$, 57.5%), while 30 endorsed having a doctoral degree (28.3%), 12 having a bachelor's degree (11.3%), two having some college (1.9%), and one did not respond to this item (0.9%).

Of the 105 clients who consented to participate in this study, only 87 did so by responding to at least one question beyond the consent form (82.9%). Among the 87 client participants, 13 were men (14.9%) and 74 were women (85.1%). Most client participants self-identified as European American/White ($n = 82$, 94.3%), while two self-identified as Asian American/Pacific Islander (2.3%), two as an other racial background (2.3%), and one did not respond to this item (1.1%). Most client participants self-identified as married or partnered ($n = 50$, 57.5%), while 26 self-identified as single or dating casually (29.9%), nine as dating seriously or engaged (10.3%), and two did not respond to this item (2.3%). Clients' ages ranged from 18 to 79 years old, with a mean age of 38.9 years ($SD = 14.6$). Clients' total years in therapy across their lifetimes ranged from 0.1 to 50.0 years, with a median of 2.0 years in therapy (interquartile range from 0.5 to 5.0 years). Clients' numbers of sessions with their current therapists ranged from one

to 100 sessions, with a mean of 21.0 (*SD* = 24.2). Male and female clients did not differ significantly in age ($U(87) = 391.00$, $Z = -1.07$, $p = .28$) or in lifetime years in therapy ($U(86) = 408.50$, $Z = -0.80$, $p = .42$). There was a statistical trend for male and female clients to differ in the number of sessions with their current therapists ($U(81) = 243.5$, $Z = -1.96$, $p = .05$), with 27.9 sessions for men (*SD* = 18.9) and 19.9 sessions for women (*SD* = 24.8). Therapist and client participants did not differ significantly in age ($U(192) = 4535.00$, $Z = -0.09$, $p = .93$).

Client participants endorsed the following educational levels: 27 with a master's degree (31.0%), 22 with a bachelor's degree (25.3%), 15 with some college (17.2%), 10 with a doctoral degree (11.5%), eight with an associate's degree (9.2%), four with a high school diploma or equivalent (4.6%), and one with some high school (1.1%). They endorsed the following presenting problems/current issues: 45 with family/relationship problems (51.7%), 43 with stress (49.4%), 43 with anxiety/panic (49.4%), 39 with depression (44.8%), 14 with grief/loss issues (16.1%), 11 with educational/occupational problems (12.6%), eight with anger problems (9.2%), four with alcohol/drug problems (4.6%), four with mania/bipolar disorder (4.6%), two with psychosis/paranoia (2.3%), and 10 with other problems (11.5%, including five of which were specified as eating disorders, 5.7%).

Overall, these samples are not representative of the general adult population. The prototypical therapist respondent was a 30-something, married, White woman with a master's degree, professional license, and nine years of clinical experience. The prototypical client respondent was also a 30-something, married, White woman with a master's degree. She would have attended four years of therapy across her lifetime and

20 sessions with her current therapist working on interpersonal issues and stress reduction.

Procedure

This study was approval by the Emory University Institutional Review Board. Data were collected between September and December 2011. Therapist participants were recruited via mailbox flyers and emails forwarded from their team manager (site 1), the clinic director (sites 2, 3, and 4), or their listserv manager. Therapist participants and front desk staff distributed printed client invitations to participate. Clients recruited online viewed the invitations as posted on mental health websites. Invitations directed participants to the appropriate Survey Monkey link, where they completed a one-time, online survey. Sample invitations to participate in this research for therapists and for clients are contained in Appendices A and B, respectively.

Page 1 of the survey asked participants to provide informed consent (form contained in Appendix C). Page 2 asked for demographic information (Appendices D and E). Page 3 provided operational definitions (Appendix F). The order of pages 4 through 7 was randomly counterbalanced to ask participants separately about their opinions of therapists crying, laughing, and shouting in session (Appendices G and H). The order of pages 8 through 10 was randomly counterbalanced to ask participants separately about their experiences with therapists crying, laughing, and shouting/yelling in session (Appendices I and J). A final question on page 11 was asked only of therapists to help determine client response rate (Appendix K). Clients were instead asked to complete the Working Alliance Inventory, Short Form, Client Version (WAI-S, Tracy & Kokotovic, 1989; see Measures section below and Appendix L).

The design of the survey allowed participants to skip any question they did not wish to answer and to stop taking the survey at any time. Table 2 provides details about levels of survey completion for therapist and client samples. Therapist participants spent a median of 18.7 minutes taking the survey (interquartile range from 11.5 to 30.2); client participants spent a median of 15.1 minutes taking the survey (interquartile range from 9.2 to 26.1). The links to the survey were deactivated once the desired number of both therapist and client participants had been reached and the institutional approval for the study had expired.

Measures

The demographics questions asked of therapists and of clients; operational definitions; the opinion questions asked of therapists and of clients; the experience questions asked of therapists and of clients; the final survey question for therapists; and the WAI-S are contained in Appendices D through L, respectively. The proposed measures are not formatted as they appeared in the online survey. Items were presented in a variety of formats: single-response multiple-choice, multi-response multiple-choice, numerical entry, response grid, and open-ended text. Many items were assessed using 5-point ordinal scales. Operational definitions of therapist, client, session, crying, laughing, and shouting/yelling were provided for clarity. For the purposes of this study, crying was defined as "the visible trickling down of tears as the result of an emotional response" (Sung et al., 2009). To be consistent, laughing was defined as "the audible emission of laughter as the result of an emotional response," and shouting/yelling was defined as "the significant raising of one's voice as the result of an emotional response."

With the exception of the WAI-S, the proposed measures were original, as no existing measures assessed all areas of interest. The first experience question for both therapists and clients was presented in a grid requiring one response per row. Columns supplied frequency ratings (0 = Never and 4 = Very often), and rows supplied gradients/intensities of emotional expression (e.g., 0 = Do not feel like crying to 4 = Sob/cry heavily). These data were coded to ascertain the highest level of emotional expression ever reached by therapists in session (i.e., endorsed at a frequency of at least rarely). A median split was performed to distinguish (1) therapists who have or have not ever cried, laughed loudly, or raised their voice in session and (2) clients who have ever experienced a therapist tear up, laugh loudly, or raise his/her voice in session.

Summative measures. Four summative measures were calculated from survey responses for use as predictors and outcome measures: therapists' emotional propensity, therapists' opinions, clients' opinions, and clients' expected reactions. Each of these measures was calculated once per emotional display of interest (i.e., crying, laughing, and shouting/yelling) for a total of 12 measures. A therapist's emotional propensity was calculated by averaging how often the therapist cries, laughs, or shouts/yells in his/her personal life (0 = Never/Almost never to 4 = Daily); the estimated number of times the therapist cried, laughed, or shouted/yelled during the past month (0 = numeric response falling in lowest quintile to 4 = numeric response falling in the highest quintile); and the last time the therapist cried, laughed, or shouted/yelled (0 = Longer than one year ago to 4 = Within the last 24 hours). Thus, scores for *therapists' emotional propensity* could range from 0 to 4, with higher scores representing greater propensity to display each

emotion in one's personal life. The order in which the nine items in these summative measures were presented to therapists was randomized for each respondent.

Therapists' and clients' opinions were calculated by averaging how often the respondent considered it to be acceptable (0 = Never to 4 = Always), unprofessional (0 = Always to 4 = Never), unethical (0 = Always to 4 = Never), and desirable (0 = Never to 4 = Always) for a therapist to cry, laugh, or shout/yell during a session with a client. Thus, scores for *therapists' opinions* and *clients' opinions* could range from 0 to 4, with higher scores representing greater acceptance of a therapist displaying each emotion in session. The order in which the four items in these summative measures were presented to therapists and clients was randomized for each respondent for each emotional display of interest.

Clients' expected reactions were calculated by averaging how likely the respondent stated he/she would be to return for a second session if his/her therapist cried, laughed, or shouted/yelled during the first session (0 = Very unlikely to 4 = Very Likely); how the respondent would feel if his/her current therapist cried, laughed, or shouted/yelled in a subsequent session (0 = Very uncomfortable to 4 = Very comfortable); how the therapeutic relationship would be affected (0 = Very negatively to 4 = Very positively); how the respondent's opinion of his/her therapist would be affected (0 = Very negatively to 4 = Very positively); and how the respondent's work in therapy and/or personal mental health would be affected (0 = Very negatively to 4 = Very positively). Thus, scores for *clients' expected reactions* could range from 0 to 4, with higher scores representing expectations of more positive outcomes from their therapist displaying each emotion in session. The order in which the last four of the five items in

these summative measures were presented to clients was randomized for each respondent for each emotional display of interest.

Working Alliance Inventory, Short Form, Client Version (WAI-S). Bordin (1979) defined working alliance as the combination of (a) client and therapist agreement on goals, (b) client and therapist agreement on how to achieve those goals (i.e., the tasks of therapy), and (c) the development of a personal bond between therapist and client. In separate meta-analytic reviews of psychotherapy outcome studies, Horvath and Symonds (1991) and Martin, Garske, and Davis (2000) found a moderate but reliable association between good working alliance and positive therapy outcome. Horvath and Greenberg (1986, 1989) developed and validated the 36-item Working Alliance Inventory (WAI) to assess the three elements of Bordin's definition. Tracey and Kokotovic (1989) conducted a factor analytic study of the WAI and selected the 12 items most indicative of the goals, tasks, and bond factors to create a short version, the WAI-S. They obtained high internal consistency estimates for the WAI-S subscale and total scores (i.e., Cronbach's alphas ranging from .83 to .98). Busseri and Tyler (2003) conducted a validation study of the WAI-S and concluded that it can be used interchangeably with the WAI. They also obtained high internal consistency estimates for the WAI-S subscale and total scores (i.e., Cronbach's alphas ranging from .73 to .91).

The WAI-S asks respondents to rate 12 items on 7-point, Likert-type scales from 1 = Never to 7 = Always (see Appendix L). Items 4 and 10 are reverse-scored. Total scores are average scores with higher scores reflecting stronger alliances. Busseri and Tyler reported average total scores of 5.87 (*SD* = 0.88) when assessed mid-treatment.

Analyses

All data from the online survey were uploaded into an SPSS database, and summative measures were calculated as detailed above. Some ordinal and ratio-level variables were recoded as categorical variables for analysis. Mean imputation was used to replace missing data when only one response was missing when calculating summative measures; this was necessary for between zero and six cases per summative measure (i.e., for approximately 3% of summative data). An alpha-level of $p < .05$ was used to determine statistical significance.

Frequency reports and descriptive statistics were used to describe sample characteristics of both therapists and clients. Kolmogorov-Smirnov tests were used to determine if any of the dependent measures violated the assumption of normality. Results of these tests are shown in Table 3. Results indicated non-normal distributions for 18 out of the 24 dependent measures across therapist and client samples (75.0%). Standard data transformations (e.g., square-root, logarithmic) are generally useful in bringing skewed distributions into normality, but 15 out of 18 of the non-normal distributions (83.3%) had little skew (i.e., had skewness values between positive and negative 1.5; see Table 3), and so nonparametric tests were instead selected for data analysis. The six research hypotheses and the first five questions of interest from above were thus addressed using Mann-Whitney *U* tests, Spearman correlations, chi-square tests of independence, and one Friedman test with post-hoc Wilcoxon signed-ranks tests.

The last three questions of interest from above were addressed using qualitative data (i.e., respondents' free-text responses to open-ended questions). Survey questions which allowed for free-text responses were as follows: ways to benefit and harm clients

by each of the emotional displays (asked of therapists only), reasons for memorable incidents of each of the emotional displays (asked of both therapists and clients), client responses to each memorable incident (asked of both therapists and clients), clinical outcomes from each memorable incident (asked of both therapists and clients), and other final comments (asked of both therapists and clients). Responses to these questions were evaluated for emergent themes and compared across respondents (therapists vs. clients). Free-text responses were first analyzed electronically for frequencies of word usage, from which tentative response categories were developed. Due to the brevity and similarly of responses to the client response and clinical outcome questions, these questions were combined for analysis (i.e., as if only one text-box had been provided) and coded based on valence (i.e., positive, neutral/mixed, or negative). Other response categories were not mutually exclusive and were refined during the first round of coding by adding new categories and combining prior categories as appropriate. Responses were coded for a second time using the final response categories after a 48-hour delay.

Results

Frequency Reports and Descriptive Statistics

Descriptive statistics for therapists' emotional propensities, therapists' opinions, clients' opinions, clients' expected reactions, and total WAI-S scores are provided in Table 4. These mean scores can be interpreted to suggest that the average therapist cries on a monthly basis, laughs on an almost daily basis, and shouts/yells on a less than monthly basis. They also indicate that the average therapist views crying in session to be acceptable/professional/ethical/desirable sometimes, laughing to be acceptable/ professional/ethical/desirable often, and yelling to be acceptable/professional/ethical/

desirable rarely. Comparably, the average client views therapists crying in session to be acceptable/professional/ethical/desirable occasionally, laughing to be acceptable/ professional/ethical/desirable often, and shouting/yelling to be acceptable/professional/ ethical/desirable quite rarely. In addition, the average client expected to be affected minimally negatively by a therapist crying, somewhat positively by a therapist laughing, and mostly negatively by a therapist shouting/yelling. The average client has a strong working alliance with his/her therapist, and male and female clients did not differ in total WAI-S scores, $U(57) = 151.00$, $Z = -1.04$, $p = .30$.

Figure 2 contains bar graphs of the percentages of therapists who endorsed each frequency (i.e., never, rarely, sometimes, often, and very often) of each level of emotional expression in their therapy sessions (i.e., do not feel like expressing, feel like expressing but do not, express at low level, express at moderate level, and express at high level). The distributions for crying and shouting/yelling are quite similar and reveal that these expressions by therapists are much less common occurrences in therapy sessions than is laughing.

Figure 3 contains bar graphs of percentages of clients who endorsed each frequency (i.e., never, rarely, sometimes, often, and very often) of each level of emotional expression that their therapist displays in sessions (i.e., does not express, expresses at low level, expresses at moderate level, and expresses at high level). Again, the distributions for crying and shouting/yelling are quite similar and reveal that these expressions by therapists are much less common occurrences in therapy sessions compared to laughing.

Figure 4 contains bar graphs of the percentages of therapists (top panel) and clients (bottom panel) who endorsed each relative level of emotionality (i.e., client was

less emotional than therapist, client was equally emotional as therapist, or client was more emotional than therapist) for memorable incidents of each emotional display. These percentages collapse across different levels of therapist emotionality and thus convey general differences in emotional expressivity between therapists and clients in sessions. When comparing levels of crying, therapists and clients both indicated that usually clients are more emotional, sometimes they are equally emotional, and rarely therapists are more emotional. When comparing levels of laughing, therapists and clients both indicated that usually they are equally emotional, sometimes clients are more emotional, and rarely therapists are more emotional. When comparing levels of shouting/yelling, clients indicated that usually clients are more emotional, sometimes they are equally emotional, and rarely therapists are more emotional, whereas therapists indicated that often clients are more emotional, sometimes they are equally emotionally, and sometimes therapists are more emotional.

Research Hypotheses

This opening section provides a review of the research hypotheses and a preview of the results of the analyses by which they were tested. The evidence was mixed for the first set of hypotheses concerning the relationship between female gender and crying. Predictions about gendered therapist opinions, client opinions, and client expected reactions were not supported, but predictions about gendered crying in therapists' personal and professional lives were mostly supported. The evidence was also mixed for the second set of hypotheses concerning the relationship between male gender and shouting/yelling. Predictions about gendered therapist opinions, client opinions, and shouting/yelling in therapists' personal lives were not supported, but predictions about

clients' expected reactions and shouting/yelling in therapists' professional lives were supported.

Again, the evidence was mixed for the third set of hypotheses concerning the relationships among therapists' opinions and their emotionality in their personal and professional lives. The prediction of an association between therapists' emotionality in their personal lives and their opinions was not supported, but the prediction of an association between therapists' emotionality in their professional lives and their opinions was supported. The prediction of an association between therapists' emotionality in their personal and professional lives was partially supported.

The fourth set of hypotheses concerned the relationships between clients' perceptions of their working alliance and their opinions and expected reactions; both predictions were partially supported. Finally, the evidence was mixed for the fifth and final set of hypotheses concerning the relationships between clients' experiences with emoting therapists and their opinions and expected reactions. Predictions concerning crying and laughing were supported, but predictions concerning shouting/yelling were not.

Gender differences. Research hypotheses 1a through 2d were assessed with Mann-Whitney *U* tests and chi-square tests of independence as appropriate. Contrary to hypothesis 1a, male and female therapists did not differ in their opinions of therapists crying in session, $U(89) = 642.00$, $Z = -0.23$, $p = .82$. Contrary to hypothesis 1b, male and female clients also did not differ in their opinions of therapists crying in session, $U(70) = 292.00$, $Z = -0.14$, $p = .89$. Similarly contradicting hypothesis 1c, male and female clients

did not differ in their expected reactions to their own therapist crying in session, $U(65) = 254.00$, $Z = -0.38$, $p = .70$.

Consistent with hypothesis 1d, female therapists (82.4%) were more likely at the trend level to have ever teared up in a session compared to male therapists (65.0%), $\chi^2(1) = 2.75$, $p = .10$, Cramer's $V = .18$ (a small to medium effect size). However, according to client reports, there was no association between therapist gender and the likelihood of ever having teared up in a session, $\chi^2(1) = 0.74$, $p = .39$.

As predicted in hypothesis 1e, female therapists ($M = 2.16$, $SD = 1.00$) reported a higher crying propensity in their personal lives than did male therapists ($M = 1.49$, $SD = 0.76$), $U(98) = 535.00$, $Z = -2.93$, $p = .00$, $r = .30$ (a medium effect size). The average female therapist reported that she cries on average monthly, that she cried three times in the last month, and that she most recently cried within the last two weeks. In contrast, the average male therapist reported that he cries on average yearly, that he cried one time in the last month, and that he most recently cried within the last month.

Contrary to hypothesis 2a, male and female therapists did not differ in their opinions of therapists shouting/yelling in session, $U(91) = 685.50$, $Z = -0.48$, $p = .64$. Contrary to hypothesis 2b, male and female clients also did not differ in their opinions of therapists shouting/yelling in session, $U(68) = 232.50$, $Z = -1.02$, $p = .31$. However, consistent with hypothesis 2c, male clients ($M = 1.03$, $SD = 0.62$) reported expectations of less negative outcomes from their own therapist shouting/yelling in session than did female clients ($M = 0.65$, $SD = 0.75$), $U(64) = 172.5$, $Z = -1.86$, $p = .05$, $r = .23$ (a medium effect size). The average male client reported that he would be somewhat unlikely to return if his therapist shouted/yelled in session, that he would feel somewhat

uncomfortable, that his relationship with his therapist would be somewhat negatively affected, that his opinion of his therapist would be minimally affected, and that his personal mental health would be somewhat negatively affected. In contrast, the average female client reported that she would be very unlikely to return if her therapist shouted/yelled in session, that she would feel mostly uncomfortable, that her relationship with her therapist would be mostly negatively affected, that her opinion of her therapist would be mostly negatively affected, and that her personal mental health would be mostly negatively affected.

Consistent with hypothesis 2d, male therapists (90.0%) were more likely to have ever raised their voice in a session compared to female therapists (64.8%), $\chi^2(1) = 4.75$, $p = .03$, Cramer's $V = .23$ (a medium effect size). The same associations held true according to client reports, $\chi^2(1) = 5.08$, $p = .02$, Cramer's $V = .28$ (a medium effect size), with clients observing 71.4% of male therapists having raised their voice compared to only 37.7% of female therapists. However, contrary to hypothesis 2e, male and female therapists did not differ in their shouting/yelling propensity in their personal lives, $U(97) = 710.00$, $Z = -1.21$, $p = .23$.

Other predictors. Hypotheses 3a through 3c were assessed with Spearman correlations as shown in Table 5. Contrary to hypothesis 3a, therapists' greater emotional propensities out-of-session were not associated with therapists' opinions of displaying emotions in session. Consistent with hypothesis 3b, therapists' in-session emotional expressivity ratings were associated with therapists' opinions of displaying emotions in session for both crying ($\rho = .54$, $p = .00$) and shouting/yelling ($\rho = .30$, $p = .01$), with laughing nearing the trend level ($\rho = .17$, $p = .12$). Thus, therapists who have reached

higher levels of emotional expressivity in session have higher opinions of doing so, or therapists with higher opinions of therapeutic emotional expressivity are more likely to be expressive in session. Finally, consistent with hypothesis 3c, therapists' emotional propensities out-of-session were associated with therapists' in-session emotional expressivity ratings for both crying ($\rho = .34$, $p = .00$) and shouting/yelling ($\rho = .35$, $p = .00$), but not laughing ($\rho = -.03$, $p = .80$). Thus, therapists who are more likely to cry in their personal lives are more likely to cry in their professional lives, and therapists who are more likely to shout/yell in their personal lives are more likely to shout/yell in their professional lives.

Hypotheses 4a and 4b were assessed with Spearman correlations as shown in Table 6. In partial support of hypothesis 4a, clients' perceptions of the working alliance with their therapist were associated with clients' opinions of therapists laughing in session ($\rho = .27$, $p = .04$), but not with their opinions of therapists crying ($\rho = .19$, $p = .16$) or shouting/yelling ($\rho = -.13$, $p = .18$) in session. Thus, clients with stronger working alliances have more positive opinions of therapists laughing in session. In partial support of hypothesis 4b, clients' perceptions of the working alliance with their therapist were associated with clients' expected reactions to their own therapist crying ($\rho = .33$, $p = .01$) and laughing ($\rho = .42$, $p = .00$), but not shouting/yelling ($\rho = .06$, $p = .67$) in session. Thus, clients with stronger working alliances expect more positive outcomes from their therapist crying or laughing in session.

Hypotheses 5a through 5f were assessed with Mann-Whitney *U* tests after a median spilt on highest level of therapist emotional expression grouped clients into those who have and those who have not ever experienced their therapist tear up, laugh loudly,

or raise his/her voice. Consistent with hypothesis 5a, clients who ever experienced a therapist tear up (M = 1.91, SD = 0.72) had more positive opinions of therapists crying in session than did clients who never experienced a therapist tear up (M = 1.33, SD = 0.74), $U(62) = 249.00$, $Z = -2.60$, $p = .01$, $r = .33$ (a medium effect size). Consistent with hypothesis 5b, clients who ever experienced a therapist laugh loudly (M = 2.73, SD = 0.63) had more positive opinions of therapists laughing in session than did clients who never experienced a therapist laugh loudly (M = 2.35, SD = 0.48), $U(62) = 284.50$, $Z = -2.34$, $p = .02$, $r = .29$ (a medium effect size). Consistent with hypothesis 5c, clients who ever experienced a therapist tear up (M = 1.80, SD = 0.83) expected more positive outcomes from their therapists crying in session than did clients who never experienced a therapist tear up (M = 1.39, SD = 0.75), $U(62) = 304.00$, $Z = -1.89$, $p = .05$, $r = .24$ (a medium effect size). Finally, consistent with hypothesis 5d, clients who ever experienced a therapist laugh loudly (M = 2.95, SD = 0.77) expected more positive outcomes from their therapist laughing in session than did clients who never experienced a therapist laugh loudly (M = 2.58, SD = 0.70), $U(60) = 255.50$, $Z = -2.40$, $p = .02$, $r = .31$ (a medium effect size).

Contrary to hypothesis 5e, clients who ever and who never experienced a therapist raise his/her voice in session did not differ in their opinions of therapists shouting/yelling in session, $U(66) = 443.50$, $Z = -1.28$, $p = .20$. In addition and in direct contradiction to hypothesis 5f, clients who ever experienced a therapist raise his/her voice (M = 0.93, SD = 0.81) expected less negative outcomes from their therapist shouting/yelling in session than did clients who never experienced a therapist raise his/her voice (M = 0.49, SD = 0.60), $U(63) = 331.50$, $Z = -2.30$, $p = .02$, $r = .29$ (a medium effect size).

Quantitative Questions of Interest

Five questions of interest were explored quantitatively. The first offers prevalence rates for the emotional displays of interest according to both therapists and clients. The second found no association between therapists' ages or years of clinical experience and their opinions. The third found that clients' opinions are related to their age, years in therapy, and certain presenting problems/current issues. The fourth found that therapists and clients do not differ in their opinions, but that both sets of respondents view laughing more favorably than crying and, in turn, crying more favorably than shouting/yelling. The fifth found multiple associations between therapists' emotional expressivity and clients' comfort levels in the room and reported effects on treatment.

The first question of interest explores the prevalence rates of the emotional displays of interest. Table 7 provides the numbers and percentages within the therapist and clients samples who endorsed ever reaching or experiencing a therapist reach the varying levels of emotional expressivity. In the therapist sample, 33.0% reported having cried in a session, and 4.5% having cried heavily. In the client sample, 4.7% reported having a therapist cry, and 1.6% having a therapist cry heavily. In the therapist sample, 91.0% reported having laughed quietly in a session, while 69.7% reported having laughed loudly. In the client sample, 89.0% reported having a therapist laugh quietly, while 35.9% reported having a therapist laugh loudly. Finally, in the therapist sample, 17.6% reported having shouted/yelled in a session, and 5.5% having shouted/yelled loudly. In the client sample, 5.9% reported having a therapist shout/yell, and 1.5% having a therapist shout/yell loudly.

The second and third questions of interest explore predictors of therapists' and clients' opinions of therapists' emotional displays. Table 8 contains the relevant Spearman correlations, and Table 9 contains the relevant Mann-Whitney *U* tests. Therapist age and years of experiencing treating clients were not related to therapists' opinions. Younger clients had more favorable opinions of therapists laughing ($\rho = -.28$, $p = .02$) and of therapists shouting/yelling ($\rho = -.29$, $p = .02$). Clients with more years in therapy had more favorable opinions of therapists crying ($\rho = .27$, $p = .03$), laughing ($\rho = .34$, $p = .01$), and shouting/yelling ($\rho = .27$, $p = .03$). When considering presenting problems/current issues as potential predictors of clients' opinions, grief/loss, anxiety/panic, and anger were selected for testing their potentially unique opinions of therapists crying, laughing, and shouting/yelling, respectively. Anxiety/panic was not related to any client opinions, and none of these presenting problems were related to clients' opinions of therapists laughing. Interestingly, clients who identified anger as a presenting problem had more favorable opinions of therapists crying ($M = 2.18$, $SD = .83$) compared to clients who did not identify anger as a presenting problem ($M = 1.48$, $SD = .78$), but these groups did not differ in their opinions of therapists shouting/yelling. In addition, clients who identified grief/loss as a presenting problem had more negative opinions of therapists shouting/yelling ($M = 0.39$, $SD = .64$) compared to clients who did not identify grief/loss as a presenting problem ($M = 0.59$, $SD = .67$), but these groups did not differ in their opinions of therapists crying.

The fourth question of interest explores potential differences in therapists' and clients' opinions of the different emotional displays, while also comparing the displays directly. Therapists and clients did not differ in their opinions of therapists crying

($U(161) = 2959.00$, $Z = -0.94$, $p = .35$), laughing ($U(157) = 2844.50$, $Z = -0.81$, $p = .42$), or shouting/yelling ($U(154) = 2862.50$, $Z = -0.33$, $p = .74$). Across samples, a Friedman test revealed a significant main effect for type of emotional display, $\chi^2(2, 149) = 201.60$, $p = .00$. A post-hoc Wilcoxon signed-ranks test showed that participants viewed laughing ($M = 2.41$, $SD = 0.71$) as a more favorable display than crying ($M = 1.48$, $SD = 0.79$), $Z(151) = -9.06$, $p = .00$, $r = .73$ (a very large effect size). An additional post-hoc Wilcoxon signed-ranks test showed that, in turn, participants viewed crying as a more favorable display than shouting/yelling ($M = 0.79$, $SD = 0.70$), $Z(151) = -7.62$, $p = .00$, $r = .62$ (a large effect size).

The fifth question of interest explores therapists' and clients' reflections on memorable incidents of therapists' emotional displays. Table 10 provides Spearman correlations between therapists' levels of emotional expressivity and respondents' comfort levels in the room and reported effects on treatment. There were no associations between therapists' levels of emotionality and their own comfort levels, but clients indicated being more comfortable with higher levels of laughing ($\rho = .32$, $p = .01$) and with lower levels of shouting/yelling ($\rho = -.27$, $p = .05$). Both therapists and clients endorsed more positive effects on treatment with higher levels of crying ($\rho = .30$, $p = .01$ and $\rho = .32$, $p = .02$, respectively), and clients endorsed more positive effects on treatment with higher levels of laughing ($\rho = .33$, $p = .01$).

Qualitative Questions of Interest

Three questions of interest were explored qualitatively. First, therapists provided free-text responses about the potential beneficial and harmful effects of crying, laughing, and shouting/yelling in session. Next, therapist and client respondents offered reasons for

and outcomes from the emotional displays when reporting on memorable incidents from sessions. Key themes are summarized below.

Benefit and harm. The sixth question of interest explores therapists' beliefs about the potentially beneficial and potentially harmful effects of therapists' emotional expressions in session. Key themes are summarized in Table 11. Among the 77 therapists who provided a textual response to the question about potential benefits of a therapist crying, 29 (37.7%) emphasized that crying conveys empathy or compassion. In addition, 29 therapists (37.7%) indicated that crying conveys validation, support, care, or understanding. Twenty-one therapists (27.3%) suggested that crying could be used to normalize, model, or mirror emotional expression or otherwise show that the therapist is "human." Nineteen therapists (24.7%) commented that crying could improve the therapeutic relationship or alliance, often via sharing, joining, or connecting. Finally, eight therapists (10.4%) indicated that crying could convey that the therapist is authentic, genuine, or present in the room.

Among the 75 therapists who provided a textual response to the question about potential harm from a therapist crying, 26 (34.7%) commented that it would interfere with the therapeutic process by either changing the focus away from the client and onto the therapist or by inhibiting the client from revealing additional personal information. Twenty therapists (26.7%) mentioned that the client would feel a need to comfort, rescue, or take care of the crying therapist, thus representing an unhelpful role reversal. Eighteen therapists (24.0%) interpreted the potential harm as a boundary violation in which the therapist is bringing his or her personal issues into the session. Seventeen therapists (22.7%) commented that clients would perceive the crying therapist as unstable, weak,

overwhelmed, or unable to handle their problems. Twelve therapists (16.0%) mentioned the potential harm as instilling a negative emotion in the client, such as guilt, fear, or embarrassment. Finally, 11 therapists (14.7%) indicated that crying would interfere with the therapist's ability to do his/her job or cause him/her to lose control of the session.

Among the 80 therapists who provided a textual response to the question about potential benefits of a therapist laughing, 40 (50.0%) commented that laughing could improve rapport or the therapeutic alliance, often via bonding, joining, or connecting. Twenty-seven therapists (33.8%) indicated that laughing could be used to normalize or model emotional expressivity, demonstrate social skills, or otherwise show that the therapist is "human." Fifteen therapists (18.8%) reported that laughing conveys validation, support, or understanding. In addition, 15 therapists (18.8%) suggested that laughing helps diffuse tension, lighten up the situation, relax clients, or make them feel comfortable or at ease. Twelve therapists (15.0%) mentioned that laughing could be used to reframe a situation or provide a client with feedback, insight, or a new perspective. Finally, 10 therapists (12.5%) commented that laughing demonstrates for clients an important coping mechanism or a healthy or adaptive behavior.

Among the 78 therapists who provided a textual response to the question about potential harm from a therapist laughing, 44 (56.4%) indicated that laughing is harmful when a therapist is laughing at or making fun of or mocking a client. Seventeen therapists (21.8%) commented that laughing is harmful when it is done at an inappropriate time or in an incongruent situation. Fifteen therapists (19.2%) reported that laughing could make a client feel unsupported, invalidated, or misunderstood. Fourteen therapists (17.9%) mentioned the potential harm as instilling a negative emotion in the client, such as shame,

belittlement, or humiliation. Thirteen therapists (16.7%) suggested that laughing could damage the therapeutic relationship or rapport or violate the client's trust in his/her therapist. Finally, eight therapists (10.3%) commented that laughing could be used to reinforce a client's maladaptive behaviors or to collude with a client in masking their true feelings or mocking others.

Among the 76 therapists who provided a textual response to the question about potential benefits of a therapist shouting/yelling, 16 (21.1%) indicated that they do not believe shouting/yelling is ever beneficial to a client. Eighteen therapists (23.7%) suggested that shouting/yelling could be useful normalization by modeling emotional expressivity, demonstrating assertiveness, or role playing a situation. Seventeen therapists (22.4%) mentioned that shouting/yelling could be used to get a client's attention, to confront them, or to make a point. Fourteen therapists (18.4%) reported that shouting/yelling could be used to communicate urgency or deter a dangerous behavior. Nine therapists (11.8%) commented that shouting/yelling could be useful for validation via mirroring, matching, or enhancing a client's affect. Eight therapists (10.5%) expressed that shouting/yelling conveys empathy, commitment, or protection. Finally, seven therapists (9.2%) indicated that shouting/yelling could be used to increase a client's insight into the impact he/she has on others or to allow that client to experience that impact.

Lastly, among the 74 therapists who provided a textual response to the question about potential harm from a therapist shouting/yelling, 13 (17.6%) indicated that shouting/yelling is harmful when a therapist is yelling at or scolding a client. Twenty-four therapists (32.4%) mentioned the potential harm as instilling a negative emotion in the

client, such as fear/intimidation, guilt, or rejection. Twenty-three therapists (31.1%) commented that shouting/yelling could be abusive or retraumatize a client. Seventeen therapists (23.0%) suggested that shouting/yelling could damage the therapeutic relationship or rapport or violate the client's trust in his/her therapist. Fourteen therapists (18.9%) reported that shouting/yelling could make a client feel disrespected, invalidated, or demeaned. In addition, 14 therapists (18.9%) interpreted the potential harm as a boundary violation or evidence for the therapist's incompetence. Seven therapists (9.5%) suggested that shouting/yelling would cause a client to drop out of treatment. Finally, six therapists (8.1%) indicated that shouting/yelling represented poor modeling and reinforcement of inappropriate behavior.

Reasons for emotional displays. The seventh question of interest explores the reasons offered by therapists and by clients for therapists' emotional expressions in session. Among the 69 therapists who reported having teared up or cried in a therapy session, eight (11.6%) did not provide a reason. Nineteen therapists (27.5%) indicated that they teared up or cried because their client was disclosing an incident of trauma or abuse. Ten therapists (14.5%) reported that they teared up or cried because their client was discussing death. Three therapists (4.3%) teared up or cried when discussing termination, and 29 therapists (42.0%) offered a variety of other reasons for having teared up or cried. Among the 21 clients who reported having experienced a therapist tear up or cry in session, six (28.6%) did not provide a reason. Four clients (19.0%) indicated that their therapist cried when they were discussing death, and two clients (9.5%) indicated that their therapist cried when they were discussing termination. Nine clients (42.9%) offered a variety of other reasons for their therapists' tears.

Among the 62 therapists who reported having laughed loudly in a therapy session, 16 (25.8%) did not provide a reason. Four therapists (6.5%) mentioned that they laughed loudly while their clients were discussing dating, while the remaining 40 therapists (64.5%) offered a variety of other reasons for their laughter (none of which involved laughing at a client). Among the 23 clients who reported having experienced a therapist laugh loudly in session, eight (34.8%) did not provide a reason. Two clients (8.7%) mentioned that their therapists laughed loudly while they were discussing their children, while the remaining 13 clients (56.5%) offered a variety of other reasons for their therapists' laughter (none of which involved laughing at a client).

Among the 64 therapists who reported having raised their voiced or shouted/yelled in a therapy session, 12 (18.8%) did not provide a reason. Thirteen therapists (20.3%) indicated that their clients were argumentative, disrespectful, or noncompliant when they raised their voice or shouted/yelled. Eight therapists (12.5%) reported having raised their voice or shouted/yelled due to safety concerns for their clients. Six therapists (9.4%) indicated that they raised their voice or shouted/yelled out of frustration, and six therapists (9.4%) reported having done so to engage their clients or get their attention. Sixteen therapists (25.0%) offered a variety of other reasons for their raised voices. Among the 30 clients who reported having experienced a therapist raise his/her voice or shout/yell in a session, eight (26.7%) did not provide a reason. Five clients (16.7%) indicated that their therapists raised their voices or shouted/yelled in order to confront them on something, and two clients (6.7%) indicated that their therapists did so to encourage them. The remaining 10 clients (33.3%) offered a variety of other reasons for their therapists' raised voice.

Clinical outcomes. Lastly, the eighth question of interest explores clinical outcomes noted by therapists and by clients after incidents of therapists expressing emotions in session. Table 12 provides percentages of responses as coded by valence (i.e., positive, neutral, negative) for each emotional display for each sample. Among the 69 therapists who reported having teared up or cried in a therapy session, 11 (15.9%) did not provide information about their client's response or the impact on his/her treatment. Of the remaining 58 therapists, 31 (53.4%) conveyed positive responses to their emotional display (e.g., the client felt heard, touched, or grateful/appreciative). Twenty-six therapists (44.8%) conveyed neutral responses, predominantly reporting that their client had not noticed their tears. One therapist (1.7%) conveyed a negative response (i.e., the client was apologetic). Among the 21 clients who reported having experienced a therapist tear up or cry in session, seven (33.3%) did not provide information about their response or the impact on their treatment. Of the 14 remaining clients, nine (64.3%) conveyed positive responses to their therapists' emotional display (e.g., feeling connected, validated, or "honored"). Two clients (14.3%) conveyed neutral responses, and four (28.6%) conveyed negative responses (e.g., feeling uncomfortable or "a little angry").

Among the 62 therapists who reported having laughed loudly in a therapy session, 13 (21.0%) did not provide information about their client's response or the impact on his/her treatment. Of the remaining 49 therapists, 46 (93.9%) conveyed positive responses to their emotional display (e.g., the client felt validated, appreciative, or connected or the laughter served to build rapport). Three therapists (6.1%) conveyed neutral responses, and no therapists (0.0%) conveyed negative responses. Among the 23 clients who

reported having experienced a therapist laugh loudly in session, six (26.1%) did not provide information about their response or the impact on their treatment. Of the 17 remaining clients, 15 (88.2%) conveyed positive responses to their therapists' emotional display (e.g., feeling comfortable or relaxed or having a bonding or "cathartic" experience). One client (5.9%) conveyed a neutral response, and one (5.9%) conveyed a negative response (i.e., feeling embarrassed).

Among the 64 therapists who reported having raised their voiced or shouted/yelled in a therapy session, 15 (23.4%) did not provide information about their client's response or the impact on his/her treatment. Of the remaining 49 therapists, 23 (46.9%) conveyed positive responses to their emotional display (e.g., the client felt validated or motivated, or the client refocused, calmed down, or complied). Sixteen therapists (32.7%) conveyed neutral responses, and nine therapists (18.4%) conveyed negative responses (e.g., the client felt misunderstood or angry, or the client became "combative" or withdrawn). Among the 30 clients who reported having experienced a therapist raise his/her voice or shout/yell in a session, seven (23.3%) did not provide information about their response or the impact on their treatment. Of the 23 remaining clients, 16 (69.6%) conveyed positive responses to their therapists' emotional display (e.g., feeling heard or being able to refocus). Three clients (13.0%) conveyed neutral responses, and four clients (17.4%) conveyed negative responses (e.g., feeling upset, angry, or "shut-down").

On a final note, among the 43 clients who indicated that their therapist has never shown any signs of crying or tearing up in session, 20 (46.5%) did not provide information about their response or the impact on their treatment. Of the 23 remaining

clients, 13 (56.5%) conveyed positive responses to their therapists' neutrality (e.g., feeling calmed or comfortable). Five clients (23.7%) conveyed neutral responses, but most notably, four clients (17.4%) conveyed very strong negative responses (e.g., feeling disrespected or disconnected or as if their therapist were disinterested), and all four of these clients indicated having discontinued therapy due to their therapists' lack of emotional expressivity.

Discussion

Review of Findings

Prevalence rates. In this study, 106 therapists and 87 clients responded to online survey questions about their opinions of and experiences with therapists crying, laughing, and shouting/yelling in therapy sessions. Among the therapist sample, one in three reported having cried in session, nine in ten having laughed in session, and one in six having shouted/yelled in session. Among the client sample, one in 20 reported having a therapist cry in session, nine in ten having a therapist laugh in session, and one in 17 having a therapist shout/yell in session. It makes sense for these prevalence rates to be higher among therapists because they spend more time in the therapy room than do clients. Clearly, laughing by therapists is a very common occurrence in treatment, with crying and shouting/yelling being less common, but still occurring. The prevalence rate for crying obtained in this study was about half the rate obtained in Nelson's (2009) informal online survey of 19 colleagues. Given the current study's larger sample size, the one in three estimate is likely more accurate than Nelson's two in three estimate. The prevalence rate for having raised one's voice obtained in this study (i.e., seven in ten) was somewhat higher than the rate obtained in Pope and Tabachnick's (1993) large national

survey (i.e., one in two), but those researchers asked only about raising one's voice out of anger.

Female therapists reported crying more in both their personal and professional lives, while male therapists were more likely to raise their voices in sessions, but not in their personal lives. These gender differences in emotional expressivity are consistent with those reviewed by Archer (2004), Bekker and Vingerhoets (2001), and Brody and Hall (2000). Overall, therapists who reported being more emotionally expressive in their personal lives also reported being more expressive in their professional lives, suggesting that many therapists strive to be authentic or true to their emotional inclinations in the therapy room.

Potential effects. When therapists responded to open-ended questions about the potential beneficial and harmful effects of their emotional displays, clear themes emerged. Therapists agreed that any of the emotional displays could benefit clients by normalizing or modeling the emotional experience or expression. In reporting on other benefits, at least one in five therapists commented that crying can convey empathy, provide validation or support, or build or strengthen rapport. However, they also indicated that crying can take the focus off the client and put it on the therapist, cause an inappropriate role reversal in which the client becomes caretaker or comforter, violate therapeutic boundaries, or suggest that the therapist is unstable or weak. At least one in five therapists commented that laughing can also build or strengthen rapport, whereas shouting/yelling can capture a client's attention or help them focus or redirect. However, they also indicated that laughing and shouting/yelling can harm a client if the expression is directed at him/her. At least one in five therapists indicated that laughing can be

harmful if it is inappropriate or incongruent, whereas shouting/yelling can induce negative emotions, be abusive or retraumatizing, or damage rapport.

Opinions. Contrary to expectations, male and female participants endorsed comparable opinions of the different emotional displays. In the only identified attitudinal gender difference, male clients reported expecting to react less negatively to their therapists shouting/yelling in session than did female clients. Considering the ways in which male therapists and male therapy clients differ from the average adult male may help explain the lack of additional gender differences in the attitudes of these samples. For example, in their review of personality studies on counselors, Heikkinen and Wegner (1973) found that male counselors tend to have more feminine and nurturing qualities and to be less prejudiced than the average person, and Schutte and colleagues (1998) found that male therapists are higher in emotional intelligence than the average person.

Therapists and clients also endorsed comparable opinions of the different emotional displays. Overall, respondents held much more favorable opinions of therapists laughing in session as compared to crying and more favorable opinions of therapists crying in session as compared to shouting/yelling. These differences in opinions are consistent with the differences in experiences reviewed below.

In considering predictors of therapists' opinions of the emotional displays, neither age nor years of clinical experience were associated with therapists' opinions. However, therapists' levels of emotional expressivity in session, but not in their personal lives, were positively related to their opinions. This implies that therapists who have reached higher levels of emotional expressions in session have higher opinions of doing so, or that therapists with higher opinions of therapeutic emotional expressivity are more likely to be

expressive in session, or both. Any interpretation is consistent with cognitive-dissonance theory (Festinger, 1957).

In considering predictors of clients' opinions of the emotional displays, more years in therapy, experiences with having therapists be emotionally expressive, and (to a lesser degree) stronger working alliances were all related to clients' more favorable opinions of therapists' emotional displays. The first two associations are consistent with the mere exposure effect (Bornstein, 1989; Zajonc, 1968) and suggest that spending more time in the therapy room increases clients' liking and/or acceptance of their therapists' emotional displays, even shouting/yelling.

Experiences. According to both therapists and clients, when therapists are laughing, clients tend to be equally emotional, but when therapists are crying or shouting/yelling, clients tend to be more emotional. Therapists' responses indicated that they are equally comfortable across different levels of emotional expressivity, whereas clients' responses indicated that they are more comfortable with higher levels of laughing and lower levels of shouting/yelling.

The most commonly reported reasons for therapists to tear up or cry were while discussing trauma or abuse, death, or a client's termination from therapy. These themes are consistent with those discussed by Waldman (1995) and Nelson (2005, 2009). The reasons reported for therapists to laugh quite simply suggested that something amusing had occurred or was being discussed. Contrary to fears, therapists did not admit to and clients did not report having been laughed at when reporting on memorable incidents of therapists' laughter. Finally, the most commonly reported reasons for therapists to raise their voices or shout/yell were described somewhat differently by therapists and by

clients. Therapists tended to admit that they had been provoked by clients and/or felt frustrated, whereas clients tended to report that their therapists' increased volume was intended to help them by confronting or encouraging them.

Consistent with this discrepancy, two in three clients' comments conveyed positive clinical outcomes to memorable incidents of therapists raising their voices or shouting/yelling, whereas only one in two therapists' comments conveyed positive outcomes. The same ratios held true for incidents of therapists tearing up or crying, whereas nine out of ten clients and nine out of ten therapists conveyed positive outcomes from therapists laughing. Nonetheless, only clients associated higher levels of laughing with more positive effects on treatment, whereas both clients and therapists associated higher levels of crying with more positive treatment effects.

Limitations

The samples for the current study were limited to English-literate individuals with internet access, and the client sample was limited to adults being treated in outpatient settings. The therapist sample likely overrepresents therapy trainees, while the client sample certainly overrepresents higher education levels. Minority individuals were underrepresented in both samples, and men were underrepresented in at least the client sample. Precise response rates for the study could not be determined once the study turned to online recruitment due to the inability to reach target sample sizes during the phase of site-specific recruitment. Lower response rates from the online-recruited participants suggest that these individuals may have self-selected for participation, perhaps because they had particularly strong beliefs or atypical experiences with the identified topic of therapists who express emotions in sessions. As a result of all these

factors, results may not generalize to the target populations of all mental health professionals/therapists and all mental health consumers/clients.

As with all self-report data, demand characteristics can affect research findings (e.g., Barber, 1976; Orne, 1962). In particular, participants tend to provide responses that they believe are socially acceptable or desirable (e.g., Crowne & Marlowe, 1964; Tanur, 1991). In the current study, that tendency may have led therapists and clients to report more positive experiences with and more favorable outcomes from therapists' emotional displays. In addition, as with all retrospective data, participants' reports of their experiences in therapy may have been influence by reconstructive memory biases (e.g., Barclay, 1988; Brennan, Stewart, Jamhour, Businelle, & Gouvier, 2007). In the current study, those biases could have led therapists and clients to distort the effects of therapists' emotional displays in either direction.

The methods of analysis in the current study represent one final area of limitations. Violations of the assumption of normality forced the use of nonparametric tests, which are not as powerful as their parametric equivalents. However, use of the power analysis program G*Power Version 3 (Faul, Erdfelder, Lang, & Buchner, 2007) revealed that the study's analyses still had 80% power to detect medium effect sizes (i.e., *r*s from .26 to .32, with two-tailed tests, an alpha level of .05, and the obtained uneven sample sizes when grouping by gender). This level of power is generally considered adequate for exploratory (rather than confirmatory) analyses (Cohen, 1988). The use of nonparametric analyses also necessitates running more, separate tests which would have been run as fewer, combined tests with parametric analyses. This increase in the number of tests increases the likelihood of obtaining a Type I error (i.e., concluding a statistically

significant effect exists when one does not). However, given that the current study was exploratory in nature, researchers opted against lowering the alpha level to decrease the likelihood of Type I errors, thereby maintaining statistical power. Finally, the free-text responses in this study were coded by only the principal investigator, and so the reproducibility of the identified themes and reliability of the response codes could not be determined. A different or an additional coder may have provided somewhat different answers to the study's three qualitative questions of interest.

Practical and Theoretical Implications

Saper (1987) offered a "succinct and relatively neutral and nonpartisan formulation of the essential ingredients of the therapeutic process" (p. 363). Translating his mathematical expression into words, we gather that change, cure, or outcome is a function of therapist variables (demographics, personality traits, and past experiences, including clinical training), client variables (demographics, personality traits, and past experiences), the therapeutic relationship, and environmental factors outside therapy. Given that emotional displays by mental health professionals are regulated by therapist variables, interpreted under the lenses of client variables, and exert influence on the therapeutic relationship, they must also affect change, cure, or outcome. In support of such an effect, Kafka (2008) wrote, "I contend the analyst's non-verbal emotive self-revelations are basic to the transformative power of a therapeutic relationship" (p. 166). Taking this power into consideration, what do the results of the current study imply for expression rules for therapists that will elicit the most positive outcomes for clients?

By large, the current findings support Chapman and Foot's (1976) contention that "to laugh freely and frequently at humorous and pleasurable events is regarded as

thoroughly healthy and desirable" (p. 1). Clients reported high opinions of therapists laughing, predominantly positive experiences with therapists' laughter, and increased comfort levels and more positive treatment effects with higher levels of laughing. One best practice guideline for therapists might thus state, if you feel like laughing, go ahead and laugh (unless your intentions are mean-spirited in which case you are likely violating the ethical tenant of nonmaleficence). Current results also suggest that therapists can feel more confident following this recommendation with younger clients, clients with more experience in therapy, and clients with stronger working alliances.

Current findings do not support best practice guidelines that are quite as clear cut with respect to therapists crying rather than laughing. Although clients reported mixed opinions of therapists crying, they still reported mostly positive experiences with therapists' tears and more positive treatment effects with higher levels of crying. Thus, a general recommendation might still be that if you feel like crying, go ahead and cry (but be prepared to put the focus back on the client if it shifts to you). Current results also suggest that therapists can feel more confident following this recommendation with clients dealing with anger issues, clients with more experience in therapy, and clients with stronger working alliances.

Given some clients' mixed feelings about therapists' tears, this emotional display might warrant additional discussion in the therapy room. Nelson (2005) recommended that, if the following applies, therapists should inform new clients that they are someone who cries easily "to stave off their confusion and misunderstandings" (p. 175). She also recommended that therapists who are experiencing grief or high stress levels in their personal lives warn clients, "I might seem a bit more emotional for a while" (p. 186). In

support of such open dialogs, Frank (1997) wrote: "I have found that an *attitude of willingness to be known by the patient* [emphasis in original] advances [the] relational approach. Such an attitude empowers the work….[and] facilitates an authentic emotional presence and empathic responsiveness" (p. 309).

Current findings support best practice guidelines that are even less clear cut with respect to therapists shouting/yelling rather than crying. Although clients reported mostly negative opinions of therapists shouting/yelling and increased comfort levels with lower levels of shouting/yelling, they still reported mostly positive experiences with therapists' raised voices. In addition, male clients, younger clients, clients with more experience in therapy, and clients dealing with grief/loss issues all reported less negative views of therapists shouting/yelling. Thus, a general recommendation might be that if you feel like shouting/yelling, do not, but considering raising your voice somewhat to help get through to your client.

In an effort to clarify the most direct implications of the current study, surely the guidelines put forth have oversimplified matters. It would be reckless to apply any rule of thumb indiscriminately to every clinical situation without giving thought to relevant contextual factors. Clinical training programs must still impart solid theoretical understandings of concepts such as countertransference, therapeutic boundaries, neutrality, and affective engagement. However, this can be done in a manner that is sensitive to the reality that sometimes therapists have strong feelings which they may be unable to suppress in session. Clinical educators and supervisors should discuss the topic of therapists' emotions to allow trainees to share their fears, process the ethical implications, and learn from the research and experiential literatures. Unfortunately, the

fears are real, but the training discussions are lacking (Curtis et al., 2003; Matise, 2006; Pope & Tabachnick, 1993).

Fortunately, two excellent articles provide guidance to educators and supervisors aiming to help therapy trainees understand and manage their emotional reactions to clients (Bridges, 1999; Grant, 2006). As explained by Bridges (1999):

> Trainee-therapists need trustworthy, professional, mentoring relationships wherein they can safely sort out shamefully held co-created countertransferences, the tug of complex identifications, and knotty relational dilemmas with patients. Whether the experience of intense, often taboo, affects in therapeutic relationships will be held by trainee-therapists as shameful secrets with the inherent risks of technical mishandling or behavioral enactments—or fruitfully discussed in supervision—is central to clinical outcomes. (p. 224)

With this understanding of the risks of providing no guidance (or bad guidance) to new therapists trying to deal with strong emotions, Bridges proposes a model of individual supervision that establishes an interpersonally safe, shame-free learning environment. Her model emphasizes normalizing intense feelings, using supervisory self-disclosure, making the process transparent, inviting discussing and feedback, assuming an educational rather than a therapeutic stance, providing a cognitive framework for understanding affect, and constructing clinically useful and ethically sound therapeutic boundaries. With similar emphases, Grant (2006) presents the model for a graduate course using experiential training methods to teach appropriate emotional responsiveness to therapy trainees. The course utilizes extended role plays with hired actors who attempt to elicit strong reactions from their therapists. These role plays allow trainees to explore

differences in their emotional reactions compared to those of their peers and to test the effects of varying levels of emotional expression or suppression on the therapeutic alliance and on clinical outcomes. Both of these articles are highly recommended readings for individuals interested in teaching both practical and theoretical issues in therapist emotionality.

Future Directions

Given the relative dearth of empirical investigations concerning therapist emotionality to date, the potential avenues for future research are numerous. Most simply, the current study should be replicated with larger, more representative samples of mental health professionals/therapists and mental health consumers/clients. The current survey could also be used or modified for use with child or adolescent clients, inpatient populations, or clients with specific disorders or clinical issues. These would be important tests of whether the current findings on prevalence rates, opinions, and clinical outcomes generalize to other populations.

Future studies might also explore different aspects of therapist emotionality. The current study focused on three specific emotional displays; other displays for future evaluation may include blushing, eye rolling, eye widening, glaring, snarling, winking, or yawning. Future studies could also include verbal expressions of therapists' emotions and compare direct (e.g., "I'm so happy for you"), indirect (e.g., "How wonderful"), and nonverbal expressions (e.g., smiling). The subtle differences in these manners of expression may affect different clients in as yet unrecognized ways. Another direction of focus could be on therapists' emotional experiences, including those emotions suppressed, expressed intentionally, or expressed inadvertently. Differences in

emotional experience may predict individual differences in therapeutic effectiveness or propensity for burnout. For example, a therapist who often inadvertently expresses idiographic reactions may not be very effective, or a therapist who always suppresses emotions may be prone to burning out.

Future studies might also explore different predictors of therapists' and clients' opinions of and experiences with therapists' emotional displays. The current study focused on gender as a potential predictor, but it is possible that specific aspects of gender identity (e.g., levels of masculinity/femininity or sexist attitudes) mediated the obtained relationships or are involved in other, more direct relationships. Aspects of ethnic identity or cultural differences might represent other mediators or predictors. For example, individuals from different background may be more or less comfortable with different levels of emotionality. In addition, the timing of the emotional displays within the course of therapy with an individual client might affect the prevalence rate or clinical outcomes from the displays. In particular, emotional displays may become more prevalent and be better received by clients at later stages of treatment. Other salient individual difference variables which may predict opinions and experiences include therapists' theoretical orientations, clients' attachment styles, or personality traits of either member of the dyad. For example, behavioral therapists or insecurely-attached clients may be particularly averse to high-level emotional displays by therapists. In another example, a usually stoic or composed therapist might surprise and confuse a client by crying, or a very serious client might be offended by a therapists' laughter.

Finally, future studies might utilize other research methodologies to explore different aspects of therapist emotionality. Researchers might create written or video-

recorded vignettes of sessions in which therapists express varying levels of emotionality and participants rate their perceptions of the therapists and predict their reactions if they were the client. Such vignettes would provide a richer context in which to assess clients' opinions and expected reactions (i.e., compared to the current survey questions asking, "If your current therapist [cried, laughed, or shouted/yelled] in a therapy session with you (regardless of the reason), how do you think…?"). Alternatively, researchers might conduct naturalistic observations using video-recordings of actual therapy sessions. Although the coding involved in such studies is labor intensive, the data obtained are of maximum ecological validity, and the potential directions are nearly endless. Such studies could answer important questions about the therapeutic effectiveness of being emotionally expressive or neutral in different contexts.

Conclusion

Evidence-based practice integrates "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Although not "best" in terms of randomized, controlled trials, the current study provided a wealth of rich information and experiential data from behind the closed doors of the therapy room. Therapists expressed their expertise, and clients stated their preferences. Both parties agreed: laughter is almost always welcome in the room, and both crying and even shouting/yelling have their places and can contribute positively to the therapeutic process under the right circumstances. We shall continue to increase our understanding of what makes those circumstances "right" with every passing hour on the proverbial couch and under the proverbial microscope.

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Appendix A

Therapist Invitations to Participate

Fall/Winter 2011

Dear [AMHC/EUPC/EUSCC/UCAC therapist/member of the _____],

You may or may not know me, as I [was a predoctoral psychology intern with Aurora Mental Health in 2009-2010/was a student clinician at the Emory Psych Center from 2006-2009/am a new clinician at the UCAC]. I am writing **to invite you to participate** in my doctoral research project. [Your office staff/team manager/listserv manager/The clinic director] has been kind enough to distribute/forward this invitation at my request. To be eligible to participate, you must be at least 18 years of age, be able to read English, have internet access, and be currently involved in providing mental health services.

If you are interested in participating in my research, you will need **10 to 20 minutes** to complete an online survey. You will be asked questions about yourself, your clinical training, and your beliefs about and experiences with expressing emotion in therapy sessions with clients. All the information that you provide will be completely confidential, and you will not receive any feedback about your responses. If you would like to participate or read more about what participation entails, please go to the following link –
https://www.surveymonkey.com/s/therapist-emotion-survey

After you have completed the survey, you will be **asked to invite your own therapy clients to participate** in this research as well. Doing so is completely optional, and you will only be asked to indicate how many client invitations (see following pages) you intend to distribute. To be eligible to participate, your client must:

- be at least 18 years of age, be able to read English, have internet access,
- not be an inpatient in a psychiatric hospital at present, and
- be scheduled for an appointment with you during the next week.

You will be asked to use your own clinical judgment (or consultation with your supervisor) to determine if inviting any of your eligible clients to participate in this study would negatively affect his or her treatment. You will not receive any feedback about your clients' responses, nor will your clients receive any information about your responses. Your data would not be linked in any way.

If you have any questions, please contact me at 978-758-1144 or mlcaron@emory.edu or my research advisor Marshall Duke, Ph.D. at psymd@emory.edu. This study has been approved by the Institutional Review Board of Emory University, Atlanta, Georgia. Permission to invite you to participate has been granted by the [Institutional Review Board of the Aurora Mental Health Center/University of Colorado at Colorado Springs/clinic director of the Emory University Psychological Center/Emory University Student Counseling Center].

Thank you for your valuable time! My hope is that the results of my study can help improve the quality of therapist training and client outcomes in treatment.

Sincerely,
Marcia L. Caron-Besch, M.A.
Emory University, Department of Psychology

Enclosed/Attached: Invitations to distribute to eligible clients

Appendix B

Client Invitations to Participate

Fall/Winter 2011

Dear therapy client [at Aurora Mental Health/the Emory University Psychological Center/Student Counseling Center/the Aging Center],

Your therapist[/psychiatrist] recently completed an **online survey** about his/her work in general (i.e., not his/her work with you in particular). After s/he finished the survey, I asked him/her to distribute this invitation to his/her clients who qualify to participate. To be eligible to participate, you must be at least 18 years of age, be able to read English, have internet access, and not be an inpatient in a psychiatric hospital at present. Your therapist believes that you are eligible to participate, but if you are not willing or able to complete an online survey, simply discard this letter. Doing so will have no effect on your treatment in therapy.

If you are interested in participating in my research, you will need **10 to 20 minutes** of internet access. My online survey will ask you questions about yourself, your experiences in therapy, and your opinions about how therapists express their emotions. All the information that you provide will be **completely confidential**, and neither you nor your therapist will receive any feedback about your responses. If you would like to participate or read more about what participation entails, please go to the following link – https://www.surveymonkey.com/s/client-emotion-survey

If you have any questions, please contact me at 978-758-1144 or mlcaron@emory.edu or my research advisor Marshall Duke, Ph.D. at psymd@emory.edu. This study has been approved by the Institutional Review Board of Emory University, Atlanta, Georgia. Permission to invite you to participate has been granted by the [Institutional Review Board of the Aurora Mental Health Center/University of Colorado at Colorado Springs/clinic director of the Emory University Psychological Center/Emory University Student Counseling Center].

Thank you for your valuable time! My hope is that the results of my study can help improve the quality of therapist training and client outcomes in treatment.

Sincerely,
Marcia L. Caron-Besch, M.A.
Emory University, Department of Psychology

Appendix C

Consent Form

Emory University
Consent to be a Research Subject

Title: Emotional Displays by Mental Health Professionals:
A Survey Study of Therapists' and Clients' Opinions and Experiences

Principal Investigator: Marcia L. Caron-Besch, M.A., Department of Psychology

Funding Source: Emory University, Department of Psychology

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.**

Before making your decision:

- Please carefully read this form or have it read to you.
- Please ask questions about anything that is not clear.

You may print a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form (electronically) you will not give up any legal rights.

Study Overview

The purpose of this study is to explore specific occurrences in therapy: when a mental health professional/therapist cries, laughs, or shouts/yells in front of a mental health consumer/client. We are interested in the opinions and experiences of both therapists and clients. We hope to determine the following: what do therapists and clients think about therapists expressing emotions in front of clients; how common/uncommon is it for therapists to cry, laugh, or shout/yell in front of clients; and what outcomes have resulted when these have actually occurred.

Procedures

If you agree to be in this study, you will be asked to complete an online survey. Most participants will complete the survey within 10 to 20 minutes, but you are free to stop at any time. You will be asked questions about yourself, your experiences in therapy, and your opinions about things that happen in therapy. Your responses may affect the subsequent questions that you will be asked to complete. You should only take the survey one time.

Risks and Discomforts

This study involves only minimal risk of temporary, emotional discomfort. Responding to survey questions may remind you of uncomfortable experiences in your life or in therapy. These risks are no greater than thinking about such experiences or feelings in your everyday life. Please remember that you have the right to skip questions, including any that you consider potentially upsetting.

It is not foreseeable that this study will involve a loss of confidentiality that would affect your employability, insurability, or social standing.

Benefits

This study is not designed to benefit you directly. This study is designed to learn more about people's reactions when therapists express emotions in front of clients. The study results may be used to help others in the future. For example, therapist training programs may use recommendations from this study to teach trainees about best practices in therapy.

Compensation

You will not be offered payment for being in this study.

Confidentiality

No names or other identifying information will be asked within the survey. Only general demographic data will be requested (e.g., gender, age, etc.). However, it is understood that no computer transmission can be perfectly secure. Thus, reasonable efforts will be made to protect the confidentiality of the survey responses you transmit. Internet numbers that potentially identify your location (i.e., your URL and IP address) will not be stored. All data will be transmitted through a tool developed for transmitting private documents and information via the Internet (i.e., a Secure Sockets Layer or SSL).

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Emory Institutional Review Board, the Emory Office of Research Compliance, and the Aurora Research Institute. Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.

Study records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Voluntary Participation and Withdrawal from the Study

You have the right to leave a study at any time without penalty. You may refuse to do any procedures you do not feel comfortable with, or answer any questions that you do not wish to answer. If you withdraw from the study, you may request that your research information not be used by contacting the Principal Investigator listed above and below.

Contact Information

Contact Marcia L. Caron-Besch, M.A. at 978-758-1144 or mlcaron@emory.edu:

- if you have any questions about this study or your part in it,
- if you have questions, concerns, or complaints about the research, or
- if you would like information about the survey results when they are prepared.

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant, or
- if you have questions, concerns, or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

Consent

Please, check the appropriate box below if you agree to be in this study. By doing so, you will be signing this consent form electronically. The date and time of your consent will be recorded electronically. By signing this consent form electronically, you will not give up any of your legal rights. You may print a copy of this consent form, to keep.

[Electronic check box] Clicking here indicates that I have read the description of the study, and I agree to participate.
[Electronic check box] Clicking here indicates that I have not read the description of the study, and/or I do not agree to participate.

Appendix D

Demographics Questions for Therapists

1. Gender: □ Male □ Female □ Not Applicable/Other: _____
2. Age (in years): _____
3. Racial Background (select all that apply): □ African American/Black
   □ Asian American/Pacific Islander □ European American/White
   □ Hispanic/Latino/Latina □ Native American/Alaska Native
   □ Prefer not to answer □ Other: _____
4. Current Relationship Status: □ Single or dating casually □ Dating seriously or engaged
   □ Married or partnered □ Unable or prefer not to answer
5. Highest Degree (or equivalent): □ Bachelor's □ Master's □ Doctoral □ Other: _____
6. Professional Status: □ Trainee □ Licensed □ Unlicensed
7. Years of Experience Treating Clients/Patients (include training; if unsure, please estimate; it is acceptable to enter decimal values): _____
8. Clinical Experience: □ Mostly with children/adolescents □ Mostly with adults
   □ With all ages
9. Current Treatment Site(s) (select all that apply):
   □ Aurora Mental Health Center (AMHC)
   □ Emory University Psychological Center (EUPC)
   □ Emory University Student Counseling Center (EUSCC)
   □ University of Colorado Aging Center (UCAC)
   □ Private practice □ Other(s): _____

Appendix E

Demographics Questions for Clients

1. Gender: □ Male □ Female □ Not Applicable/Other: _____
2. Age (in years): _____
3. Racial Background (select all that apply): □ African American/Black
   □ Asian American/Pacific Islander □ European American/White
   □ Hispanic/Latino/Latina □ Native American/Alaska Native
   □ Prefer not to answer □ Other: _____
4. Current Relationship Status: □ Single or dating casually
   □ Dating seriously or engaged □ Married or partnered
   □ Unable or prefer not to answer
5. Educational Level: □ Grade 8 or lower □ Some high school
   □ High school diploma or GED □ Some college □ Associate's degree
   □ Bachelor's degree □ Master's degree □ Doctoral degree □ Other: ____
6. Total Years in Therapy (across lifetime; if unsure, please estimate; it is acceptable to enter decimal values, e.g., 0.1 for one month or 0.5 for six months): _____
7. Gender of your current therapist (i.e., the person who gave you the invitation to participate in this research): □ Male □ Female □ Not Applicable/Other: _____
8. Age of your current therapist (in years; if unsure, please estimate): _____
9. Please estimate the number of times you have met with your current therapist: _____
10. Current Issues (select all that apply): □ Alcohol/drugs □ Anger □ Anxiety/panic
    □ Depression □ Educational/Occupational problems
    □ Family/Relationship problems □ Grief/loss □ Mania/bipolar
    □ Psychosis/paranoia □ Stress □ Other: _____
11. Current Treatment Site(s) (select all that apply):
    □ Aurora Mental Health Center (AMHC)
    □ Emory University Psychological Center (EUPC)
    □ Emory University Student Counseling Center (EUSCC)
    □ University of Colorado Aging Center (UCAC)
    □ Private practice □ Other(s): _____

Appendix F

Operational Definitions

Psychiatrists, please note: For all survey questions, the term *therapist* is meant to apply to your role as a psychiatrist, the term *client* is meant to apply to your patients, and the term *session* is meant to apply to any of your appointments with clients/patients. *Crying* is defined as the visible trickling down of tears as the result of an emotional response. *Laughing* is defined as the audible emission of laughter as the result of an emotional response. *Shouting/yelling* is defined as the significant raising of one's voice as the result of an emotional response.

Therapists, please note: For all survey questions, the term *session* is meant to apply to any treatment modality in which you are involved (i.e., individual, group, or family psychotherapy or school-based or home-based meetings). *Crying* is defined as the visible trickling down of tears as the result of an emotional response. *Laughing* is defined as the audible emission of laughter as the result of an emotional response. *Shouting/yelling* is defined as the significant raising of one's voice as the result of an emotional response.

Clients, please note: For all survey questions, *crying* is defined as the visible trickling down of tears as the result of an emotional response. *Laughing* is defined as the audible emission of laughter as the result of an emotional response. *Shouting/yelling* is defined as the significant raising of one's voice as the result of an emotional response.

Appendix G

Opinion Questions for Therapists

Note: These questions will appear three times in the survey, once with reference to crying, once with reference to laughing, and once with reference to shouting/yelling.

1. How often do you [cry, laugh, or shout/yell] in your personal life (i.e., outside of sessions with clients)?
   □ Daily □ Weekly □ Monthly □ Yearly □ Never/Almost never
2. Please estimate the number of times that you [cried, laughed, or shouted/yelled] during the past month: _____
3. When is the last time you [cried, laughed, or shouted/yelled]?
   □ Within the last 24 hours □ Within the last week □ Within the last month
   □ Within the last year □ Longer than one year ago
4. In your opinion, it is _____ acceptable for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
5. In your opinion, it is _____ unprofessional for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
6. In your opinion, it is _____ unethical for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
7. In your opinion, it is _____ desirable for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
8. In your opinion, how might a client benefit from a therapist [crying, laughing, or shouting/yelling] in a session with him/her? _____
9. In your opinion, how might a client be harmed by a therapist [crying, laughing, or shouting/yelling] in a session with him/her? _____

Appendix H

Opinion Questions for Clients

Note: These questions will appear three times in the survey, once with reference to crying, once with reference to laughing, and once with reference to shouting/yelling.

1. In your opinion, it is _____ acceptable for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
2. In your opinion, it is _____ unprofessional for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
3. In your opinion, it is _____ unethical for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
4. In your opinion, it is _____ desirable for a therapist to [cry, laugh, or shout/yell] during a session with a client.
   □ Never □ Rarely □ Sometimes □ Usually □ Always
5. If a therapist [cried, laughed, or shouted/yelled] during your first session together, how likely would you be to return for a second session?
   □ Very unlikely □ Somewhat unlikely □ Neither unlikely or likely/Not sure
   □ Somewhat likely □ Very likely
6. If your current therapist (i.e., the person who gave you the invitation to participate in this research) [cried, laughed, or shouted/yelled] in a therapy session with you (regardless of the reason)…

a) How do you think you would feel?
   □ Very uncomfortable □ Somewhat uncomfortable
   □ Neither comfortable nor uncomfortable/Not sure □ Somewhat comfortable
   □ Very comfortable

b) How do you think your relationship with your therapist would be affected?
   □ Very negatively □ Somewhat negatively □ No effect/Not sure
   □ Somewhat positively □ Very positively

c) How do you think your opinion of your therapist would be affected?
   □ Very negatively □ Somewhat negatively □ No effect/Not sure
   □ Somewhat positively □ Very positively

d) How do you think your work in therapy and/or personal mental health would be affected?
   □ Very negatively □ Somewhat negatively □ No effect/Not sure
   □ Somewhat positively □ Very positively

Appendix I

Experience Questions for Therapists

Note: These questions will appear three times in the survey, once with reference to crying, once with reference to laughing, and once with reference to shouting/yelling.

1. Using the following scale, please rate how often you reach each of the following levels of emotional expression during sessions with clients. If unsure, please guess.
0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Very often

(0) Do not feel like crying
(1) Feel like crying but do not show any signs
(2) Have tears in my eyes
(3) Have tears down my face
(4) Sob/cry heavily

(0) Do not feel like laughing
(1) Feel like laughing but do not show any signs
(2) Smile but do not laugh
(3) Laugh quietly
(4) Laugh loudly/hysterically

(0) Do not feel like raising my voice
(1) Feel like raising my voice but use normal voice
(2) Raise voice but do not shout/yell
(3) Shout/yell
(4) Shout/yell loudly

a) Think of the most memorable time during a session with a client that you reached the highest level of emotional expression that you reported ever reaching in the question above. What gender was that client?

□ Male □ Female □ Not Applicable/Other

b) How old was that client (in years; if unsure, please estimate): _____

c) What were that client's primary issues (check all that apply)?

□ Alcohol/drugs □ Anger □ Anxiety/panic □ Depression
□ Educational/Occupational problems □ Family/Relationship problems
□ Grief/loss □ Mania/bipolar □ Psychosis/paranoia □ Stress □ Other: _____

d) Please describe your understanding of what was occurring in the session/treatment and/or in your personal life that resulted in you reaching that level of emotional expression. _____

e) Please rate your client's level of emotions at the time that you reached this level of emotional expression.

□ Less emotional than I was □ About the same as I was
□ More emotional than I was □ Unsure/I do not remember

f) Please describe your client's response to your level of emotional expression during that session. _____

g) Please describe any impact that reaching that level of emotional expression had on your client and/or your client's treatment. _____

h) Please rate how you felt about reaching that level of emotional expression with your client.

□ Very uncomfortable □ Somewhat uncomfortable
□ Neither comfortable nor uncomfortable/Not sure □ Somewhat comfortable
□ Very comfortable

i) Please rate how much you believe that reaching that level of emotional expression affected your client's overall treatment.

□ Made it much worse □ Made it somewhat worse □ Did not affect it/Not sure
□ Made it somewhat better □ Made it much better

j) Please provide any additional information that you think is important that I know about your emotional expressivity during this or other therapy sessions. _____

Appendix J

Experience Questions for Clients

Note: These questions will appear three times in the survey, once with reference to crying, once with reference to laughing, and once with reference to shouting/yelling.

1. Using the following scale, please rate how often your current therapist (i.e., the person who gave you the invitation to participate in this research) appears to reach each of the following levels of emotional expression during sessions with you. If unsure, please guess.
0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Very often

(0) Does not show signs of crying
(1) Has tears in his/her eyes
(2) Has tears down his/her face
(3) Sobs/cries heavily

(0) Does not smile or laugh
(1) Smiles but does not laugh
(2) Laughs quietly
(3) Laughs loudly/hysterically

(0) Uses normal voice
(1) Raises voice but does not shout/yell
(2) Shouts/yells
(3) Shouts/yells loudly

a) Think of the most memorable time that your therapist reached the highest level of emotional expression that you reported in the question above. Please describe your understanding of what was occurring in the session/treatment and/or qualities of your therapist that resulted in him/her reaching that level of emotional expression. _____
b) Please rate your own level of emotions compared to those of your therapist at that time.

□ Less emotional than him/her □ About the same as him/her
□ More emotional than him/her □ Unsure/I do not remember

c) Please describe your response to your therapist's level of emotional expression during that session. _____
d) Please describe any impact that your therapist reaching that level of emotional expression had on you and/or your treatment. _____
e) Please rate how you felt when your therapist reached that level of emotional expression during that session with you.

□ Very uncomfortable □ Somewhat uncomfortable
□ Neither comfortable nor uncomfortable/Not sure □ Somewhat comfortable
□ Very comfortable

f) Please rate how much you believe that your therapist reaching that level of emotional expression affected your overall treatment.

□ Made it much worse □ Made it somewhat worse □ Did not affect it/Not sure
□ Made it somewhat better □ Made it much better

g) Please provide any additional information that you think is important that I know about your therapists' emotional expressivity during this or other therapy sessions (including those with previous therapists, if applicable). _____

Appendix K

Final Question for Therapists

Now that you have completed your participation in the survey, you have the opportunity to invite up to three of your own therapy clients to participate in this research as well. Doing so is completely optional. To be eligible to participate, your client must:

- be at least 18 years of age,
- be able to read English,
- have internet access,
- not be an inpatient in a psychiatric hospital at present, and
- be scheduled for an appointment with you during the next week.

Please use your own clinical judgment (or consultation with your supervisor) to determine if inviting any of your eligible clients to participate in this study would negatively affect their treatment.

How many client invitations to participate do you intend to give to eligible clients?

□ 0 – I do not wish to complete this optional step OR I have no eligible clients.

□ Estimate number: _____

Appendix L

Working Alliance Inventory, Short Form, Client Version (WAI-S)

INSTRUCTIONS: On this page there are sentences that describe some of the different ways you might think or feel about your therapist. As you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Choose the number that best describes the way you think or feel about your therapist at the present moment.

(1) Never
(2) Rarely
(3) Occasionally
(4) Sometimes
(5) Often
(6) Very Often
(7) Always

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.
2. What I am doing in therapy gives me new ways of looking at my problem.
3. I believe _____ likes me.
4. _____ does not understand what I am trying to accomplish in therapy.
5. I am confident in _____'s ability to help me.
6. _____ and I are working towards mutually agreed upon goals.
7. I feel that _____ appreciates me.
8. We agree on what is important for me to work on.
9. _____ and I trust one another.
10. _____ and I have different ideas on what my problems are.
11. We have established a good understanding of the kind of changes that would be good for me.
12. I believe the way we are working with my problem is correct.

Table 1

Response Rates for Samples Across Recruitment Sites

	Therapist Sample			Client Sample		
Recruitment Site	Invited	Consented	RR	Invited	Consented	RR
AMHC	182	17	9.3%	51	3	5.9%
EUPC	20	13	65.0%	33	4	12.1%
EUSCC	21	4	19.0%	63	4	6.3%
UCAC	27	13	48.1%	21	2	9.5%
Online/Unknown	>1000	72	<7.2%	>800	92	<11.5%
Total	>1250	119	<9.5%	>968	105	<10.8%

Note. AMHC = Aurora Mental Health Center; EUPC = Emory University Psychological Center; EUSCC = Emory University Student Counseling Center; UCAC = University of Colorado Aging Center; RR = response rate.

Table 2

Levels of Survey Completion Across Samples

Level of Completion	Therapists	Clients
Accessed consent form	122	110
Consented to participate	119	105
Partially completed survey	106	87
Fully completed survey	83	57

Table 3

Skewness and Kolmogorov-Smirnov Test Results for Dependent Variables

Variable	*n*	Skew	*Z*	*p*
Therapist age	105	0.93	1.96	.00
Client age	87	0.83	1.88	.00
Therapist years of experience	101	1.34	2.27	.00
Client years in therapy	86	4.00	2.68	.00
Client sessions with current therapist	81	2.04	2.20	.00
Client total WAI-S score	57	-1.17	1.32	.06
Therapist crying propensity	98	-0.08	0.91	.37
Therapist laughing propensity	99	-0.65	1.61	.01
Therapist shouting/yelling propensity	97	0.29	1.04	.23
Therapist opinions of crying	89	-0.76	1.77	.00
Client opinions of crying	70	0.09	0.97	.31
Therapist opinions of laughing	92	0.70	1.64	.01
Client opinions of laughing	69	0.36	1.66	.01
Therapist opinions of shouting/yelling	91	-0.29	1.97	.00
Client opinions of shouting/yelling	68	0.36	1.63	.01
Client expected reactions to crying	65	-0.02	0.86	.46
Client expected reactions to laughing	67	-0.56	1.07	.20
Client expected reactions to shouting/yelling	64	0.92	1.64	.01
Therapist highest level of crying in session	88	-0.40	2.36	.00
Client highest level of crying by therapist	64	1.79	3.23	.00
Therapist highest level of laughing in session	89	-2.43	3.79	.00
Client highest level of laughing by therapist	64	-0.64	2.20	.00
Therapist highest level of s/yelling in session	91	-0.10	2.75	.00
Client highest level of s/yelling by therapist	64	1.24	2.82	.00

Note. WAI-S = Working Alliance Inventory, Short Form, Client Version. s/yelling = shouting/yelling.

Table 4

Descriptive Statistics for Summative Measures Across Emotional Displays and Working Alliance Inventory Scores

Measure	*n*	Min	Max	Mean	*SD*	*α*
			Therapist Sample			
Crying propensity	98	0.00	4.00	2.00	0.99	.84
Laughing propensity	99	2.00	4.00	3.26	0.58	.47
Yelling propensity	97	0.00	4.00	1.66	0.98	.88
Opinions of crying	89	0.00	3.25	1.88	0.61	.80
Opinions of laughing	92	1.75	4.00	2.54	0.51	.84
Opinions of shouting/yelling	91	0.00	2.00	0.96	0.57	.78
			Client Sample			
Opinions of crying	70	0.00	3.80	1.55	0.80	.84
Opinions of laughing	69	1.50	4.00	2.49	0.57	.80
Opinions of shouting/yelling	68	0.00	2.50	0.79	0.69	.75
Expected reactions to crying	65	0.00	3.20	1.57	0.80	.89
Expected reactions to laughing	67	0.40	4.00	2.61	0.79	.91
Expected reactions to s/yelling	64	0.00	3.20	0.71	0.74	.90
Total WAI-S score	57	2.08	6.92	5.31	1.22	.97

Note. WAI-S = Working Alliance Inventory, Short Form, Client Version. s/yelling = shouting/yelling. α = Cronbach's alpha.

Table 5

*Spearman Correlations Among Measures in Therapist Sample (*N = *105)*

Measure	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1. Crying propensity	.18	.30**	.08	.03	-.11	.34**	.03	.11
2. Laughing propensity	—	.21*	-.12	-.01	-.02	-.36**	-.03	-.08
3. Shouting/yelling propensity		—	-.05	-.02	.03	.08	.23*	.35**
4. Opinions of crying			—	.25*	.28**	.54**	.22*	.13
5. Opinions of laughing				—	.06	-.01	.30**	-.08
6. Opinions of shouting/yelling					—	.22*	.09	.17
7. Highest level of crying						—	.12	.14
8. Highest level of laughing							—	.27*
9. Highest level of s/yelling								—

Note. WAI-S = Working Alliance Inventory, Short Form, Client Version. s/yelling = shouting/yelling

*$p < .05$. **$p < .01$.

Table 6

*Spearman Correlations Among Measures in Client Sample (*N = *87)*

Measure	*2*	*3*	*4*	*5*	*6*	*7*
1. Total WAI-S score	.19	.27*	-.23	.33*	.42**	.06
2. Opinions of crying	—	.27*	.25*	.71**	.28*	.13
3. Opinions of laughing		—	.11	.23	.56**	.14
4. Opinions of shouting/yelling			—	.13	.13	.27*
5. Expected reactions to crying				—	.23	.14
6. Expected reactions to laughing					—	.11
7. Expected reactions to shouting/yelling						—

Note. WAI-S = Working Alliance Inventory, Short Form, Client Version.

*$p < .05$. **$p < .01$.

Table 7

Numbers and Percentages of Therapists Reaching Each Level of Emotional Expressivity in Session Across Samples

Emotional Display	*n*	*N*	%	*n*	*N*	%
	Therapist Sample			Client Sample		
Teared up	69	88	78.4	21	64	32.8
Cried	29	88	33.0	3	64	4.7
Cried heavily	4	88	4.5	1	64	1.6
Smiled	87	89	97.8	62	64	96.9
Laughed quietly	81	89	91.0	57	64	89.0
Laughed loudly	62	89	69.7	23	64	35.9
Raised voice	64	91	70.3	30	68	44.1
Shouted/yelled	16	91	17.6	4	68	5.9
Shouted/yelled loudly	5	91	5.5	1	68	1.5

Table 8

Spearman Correlations for Predictors of Therapists' and Clients' Opinions of Emotional Displays by Mental Health Professionals

Predictor	Crying	Laughing	Shouting/Yelling
Therapist age	.15	.19	-.18
Therapist years of experience	.16	.17	-.13
Client age	.09	-.29*	-.29*
Client years in therapy	.27*	.34**	.27*

*$p < .05$. **$p < .01$.

Table 9

Mann-Whitney U *Tests for Presenting Problems as Predictors of Clients' Opinions of Emotional Displays by Mental Health Professionals*

Presenting Problem	*N*	*U*	*Z*	*p*	*r*
		Opinions of Crying			
Anger	70	121.00	-1.96	.05	.23
Anxiety/Panic	70	561.50	-0.60	.55	—
Grief/Loss	70	343.00	-0.42	.68	—
		Opinions of Laughing			
Anger	69	155.50	-0.73	.47	—
Anxiety/Panic	69	475.50	-1.47	.14	—
Grief/Loss	69	344.50	-0.31	.76	—
		Opinions of Shouting/Yelling			
Anger	68	157.50	-0.63	.53	—
Anxiety/Panic	68	502.5	-0.95	.34	—
Grief/Loss	68	211.00	-2.35	.02	.28

Table 10

Spearman Correlations Between Therapists' Levels of Emotional Expressivity and Respondents' Comfort Levels and Reported Effects on Treatment

Emotion/Respondent	Comfort	Effect
Crying		
Therapist	.13	.30**
Client	-.07	.32*
Laughing		
Therapist	.14	.20
Client	.32*	.33**
Shouting/Yelling		
Therapist	.02	.03
Client	-.27*	.04

*$p < .05$. **$p < .01$.

Table 11

Percentages of Therapists Reporting Specific Effects of Therapists' Emotional Displays in Their Free-Text Responses

Effect	Crying	Laughing	Shouting/Yelling
		Beneficial	
Conveys empathy	37.7	1.3	10.5
Provides validation	37.7	18.8	11.8
Normalizes emotion	27.3	33.8	23.7
Builds rapport	24.7	50.0	2.6
Conveys authenticity	10.4	8.8	2.6
Comforts/relaxes client	1.3	18.8	0.0
Provides insight	0.0	15.0	9.2
Never has any benefit	2.6	0.0	21.1
		Harmful	
Shifts focus inappropriately	34.7	21.8	0.0
Causes role reversal	26.7	0.0	5.4
Violates boundaries	24.0	0.0	18.9
Causes negative emotions	16.0	17.9	32.4
Is directed at client	0.0	56.4	17.6
Invalidates/shames client	0.0	19.2	18.9
Reinforces maladaptive behavior	0.0	16.7	8.1
Is abusive/retraumatizing	0.0	0.0	31.1

Note. Numbers of respondents per item are provided in text.

Table 12

Percentages of Therapists' and Clients' Free-Text Responses as Coded by Valence of Clinical Outcomes Across Emotional Displays

Emotion/Valence	Therapists	Clients
Crying		
Positive	53.4	64.3
Neutral	44.8	14.3
Negative	1.7	28.6
Laughing		
Positive	93.9	88.2
Neutral	6.1	5.9
Negative	0.0	5.9
Shouting/Yelling		
Positive	46.9	69.6
Neutral	32.7	13.0
Negative	18.4	17.4

Note. Numbers of respondents per item are provided in text.

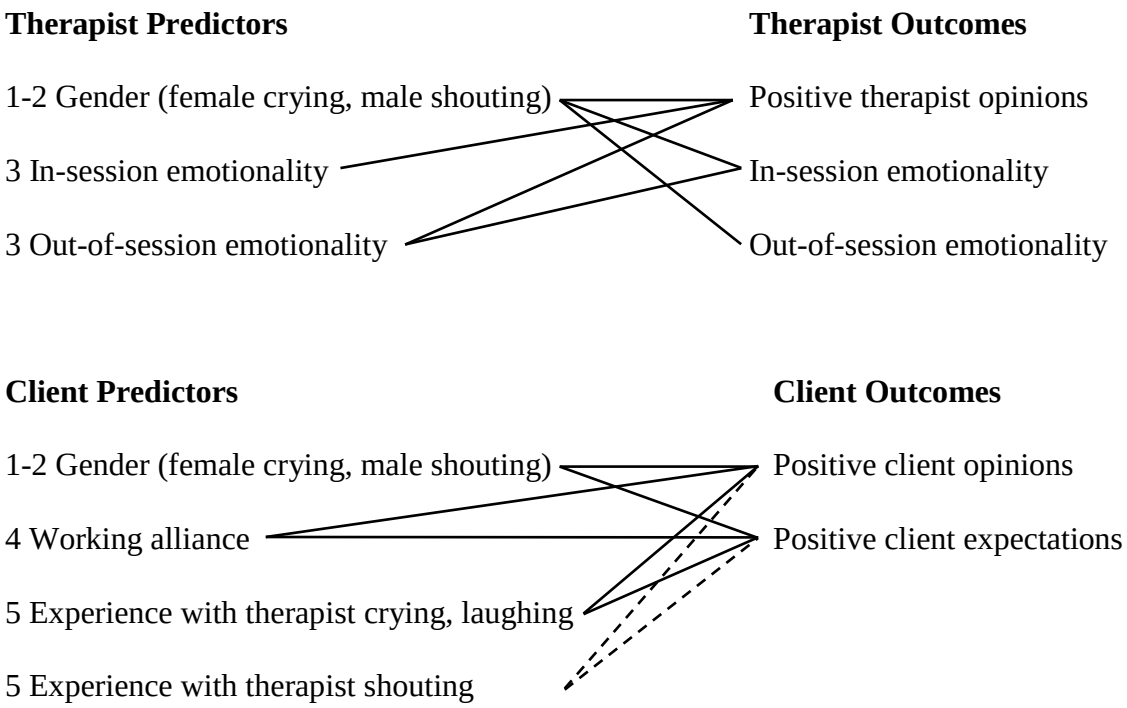
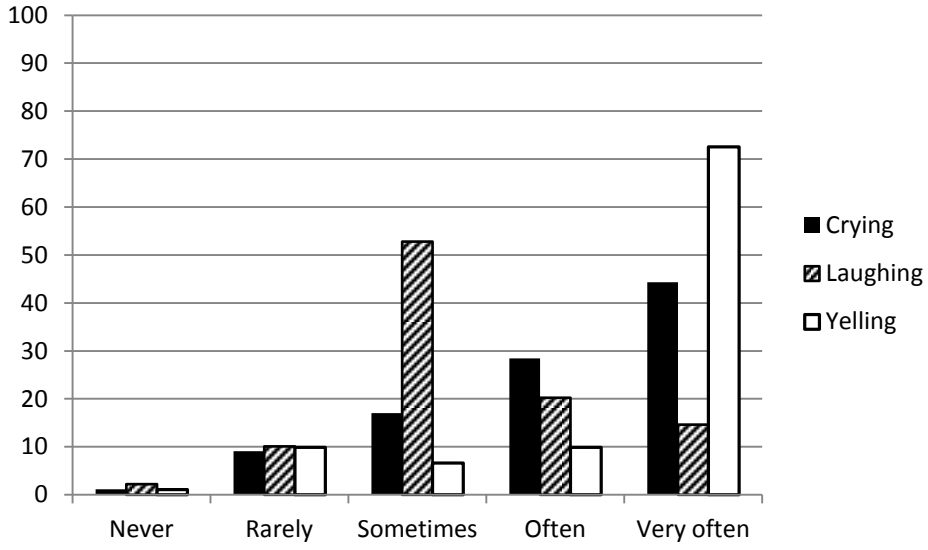
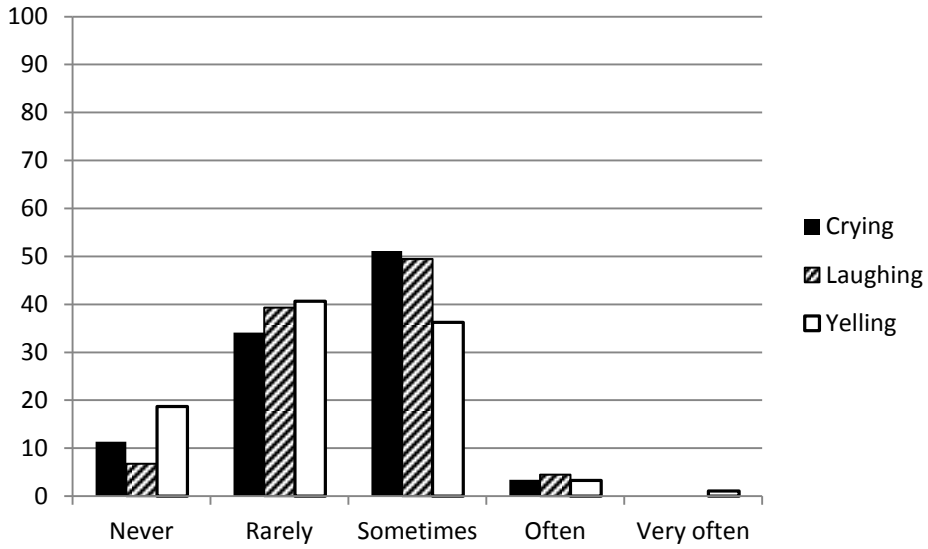


Figure 1. Diagrammed representation of study hypotheses. Numbers refer to hypotheses as enumerated in the text. Solid lines indicate a predicted positive relationship; dashed lines indicate a predicted negative relationship.

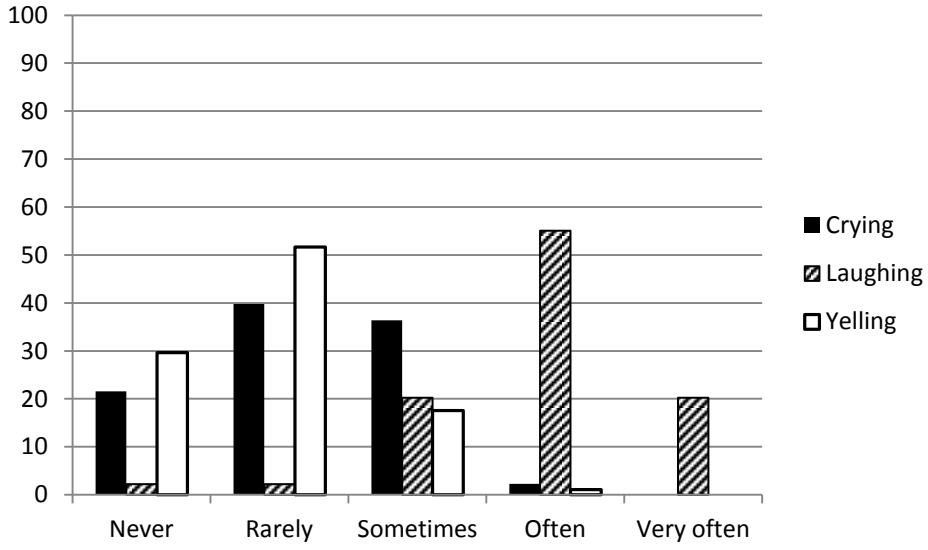
Do not feel like expressing



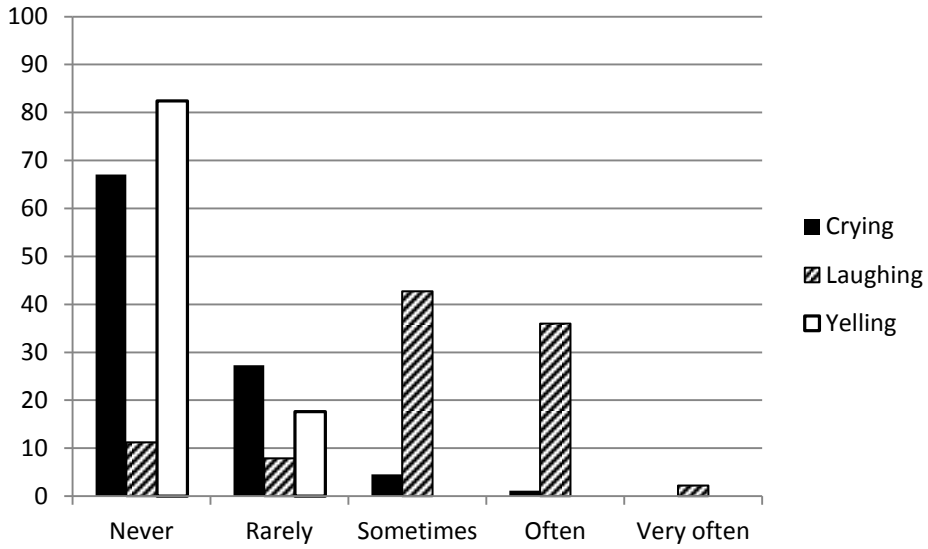
Feel like expressing but do not



Express at low level



Express at moderate level



Express at high level

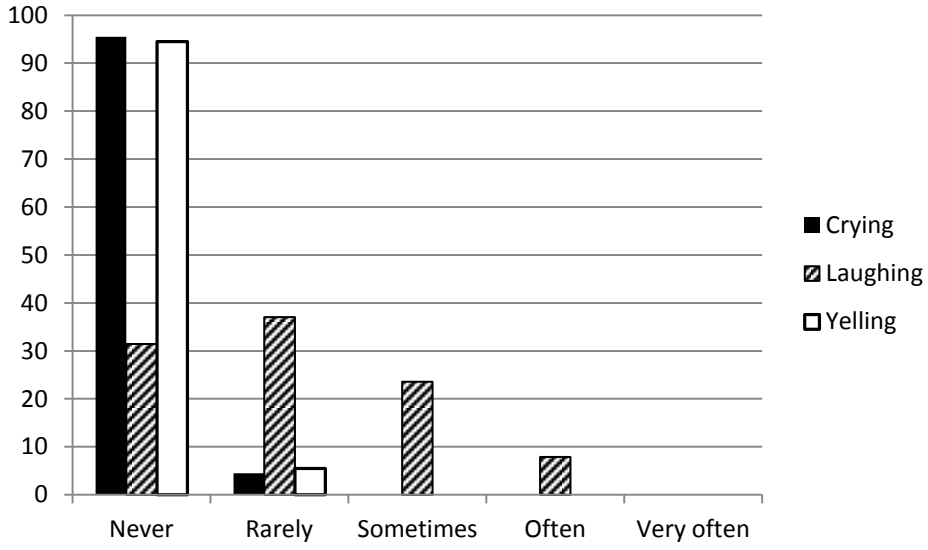
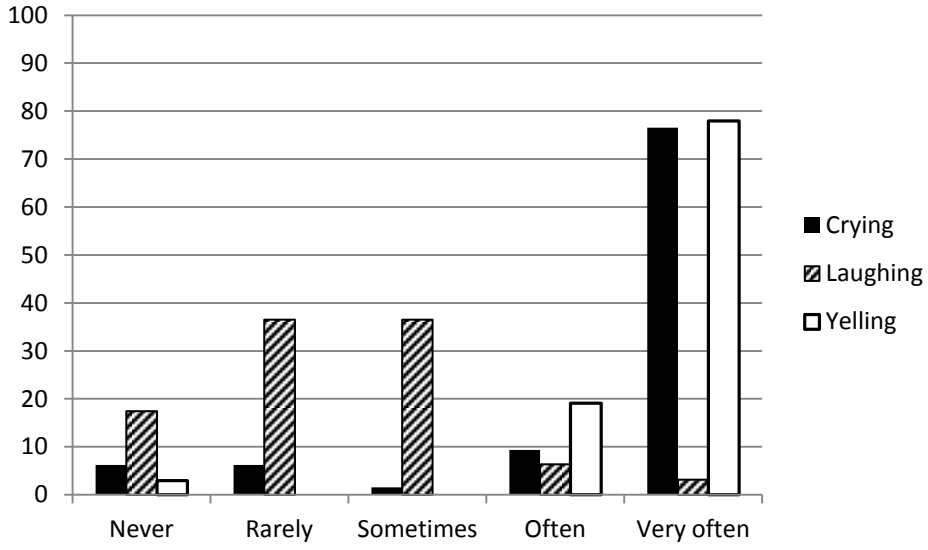
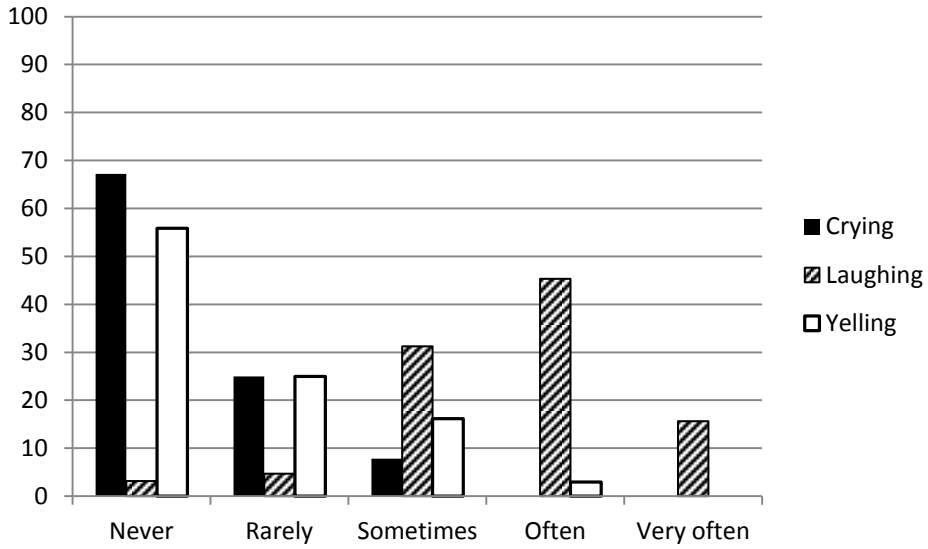


Figure 2. Bar graphs of percentages of therapists who endorsed each frequency of each level of emotional expression in their therapy sessions. Crying sample $n = 88$, laughing sample $n = 89$, and shouting/yelling sample $n = 91$.

Does not express



Expresses at low level



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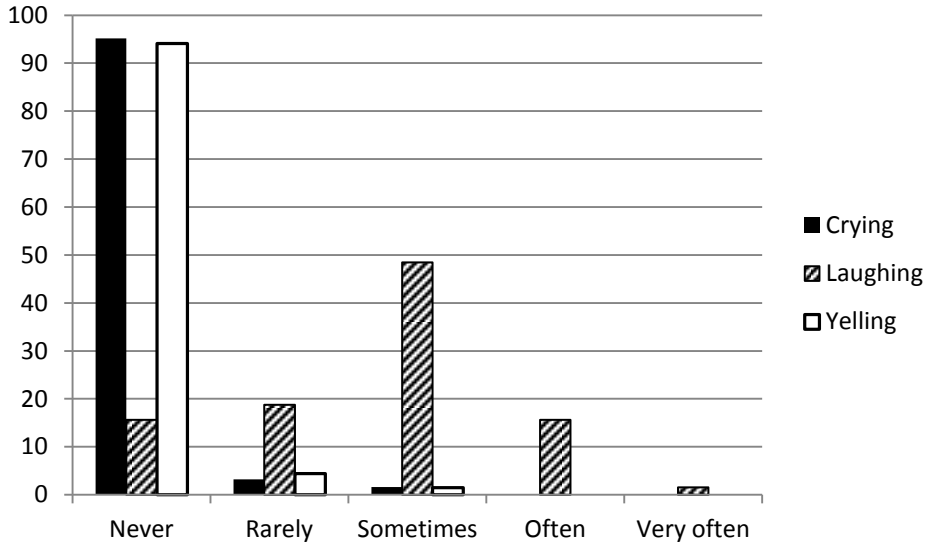

Expresses at high level

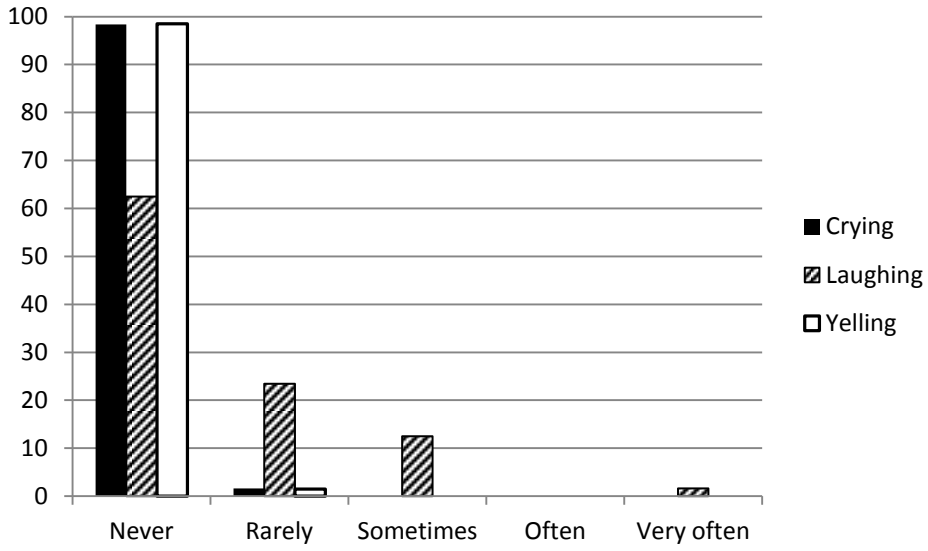

Figure 3. Bar graphs of percentages of clients who endorsed each frequency of each level of emotional expression that their therapist displays in sessions. Crying sample $n = 62$, laughing sample $n = 64$, and shouting/yelling sample $n = 68$.

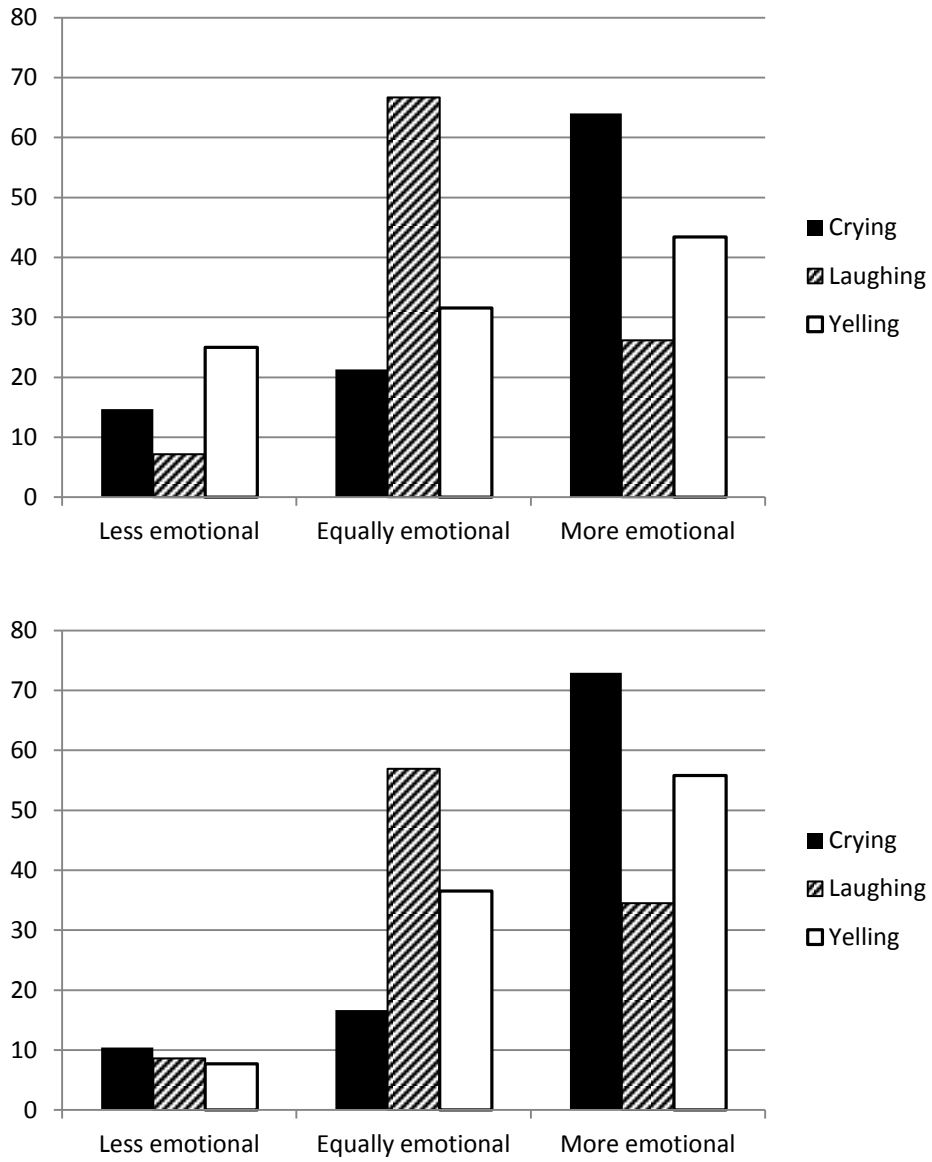

Figure 4. Bar graphs of percentages of therapists (top panel) and clients (bottom panel) who endorsed each relative level of emotionality (i.e., comparing clients to therapists) for memorable incidents of each emotional display. These percentages collapse across different levels of therapist emotionality and thus convey general differences in emotional expressivity between therapists and clients in sessions. Crying n = 75 therapists, 48 clients; laughing n = 84 therapists, 58 clients; and shouting/yelling n = 76 therapists, 52 clients.