Crying is a Two-Person Behaviour:
A Relational Perspective Based on Attachment Theory

Judith Kay Nelson

Introduction

To understand crying, clinicians have generally relied upon the earliest layer of a one-person psychoanalytic theory of emotion where affects are quantitative, building up and therefore needing to be discharged. Breuer and Freud in Studies on Hysteria written in the final decade of the nineteenth century, refer to tears as ‘involuntary reflexes’ that discharge affect so that a ‘large part of the affect disappears’ (Breuer & Freud, 1895d, p. 8). They used the German term sich austoben, meaning ‘to cry oneself out’, to express the view that feelings build up and are released by shedding tears – a view that persists in popular psychology as well as in psychoanalytic literature and practice.

Current psychoanalytic views regarding the intersubjectivity of human behaviour are built upon the central tenet of mutuality of experience, including affect. As Stolorow (1997) writes, ‘Affective experience is something that, from birth onward, is regulated or misregulated, within an intersubjective system of reciprocal mutual influence’ (p. 865). Crying, while recognized as belonging to the affective sphere, is often treated as incidental to affective experience rather than consciously examined as an intersubjective phenomena with a particular meaning in the context of the therapeutic relationship. Individual clinicians develop theories about individual patients and the meaning of their crying or its absence, but often without a theoretical context for deepening their understanding of crying intersubjectively.

The ‘proper domain of psychoanalytic inquiry’, Stolorow and Atwood (1992) write, ‘is not the isolated individual mind, but the larger system created by the mutual interplay between the subjective worlds of patient and analyst, or of child and caregiver . . .’ (p. 1). The intersubjective paradigm was launched in part by research that showed infants and parents to be dynamic and evocative partners in a mutually regulating attachment and care-giving relationship.
Looking at crying as attachment behaviour that triggers care-giving behaviour sheds light on the mutual interplay between both child and care-giver and patient and therapist and helps to provide a bridge between these two related pair bonds.

Thinking consciously about the attachment and care-giving aspects of crying – or not crying at times when it would be expected or appropriate – adds important information about the intricacies of the intersubjective process. It sheds light on some of the mysterious, unexplained choices we make in our work, including some of what seem to be ‘intuitive’ interventions and some of the enactments that occur in the course of long-term psychotherapy. A deeply integrated understanding of crying and attachment and care-giving behaviours can also help the relational analyst or psychotherapist to more consciously monitor affect attunements and misattunements and the dynamics of affect regulation.

Crying, separation and grief

Crying, along with smiling and the arms-up signal, is among the attachment behaviours that function to beckon the parental care-giver to the infant. Based on evidence from comparative animal studies and tribal cultures living closer to our environment of evolutionary adaptiveness, Bowlby theorized that crying is an inborn behaviour whose purpose is to bring and keep the parent or care-giver close to the dependent infant for purposes of protection. He also postulated that infant crying triggers care-giving behaviours in parents, thus completing the circle of connection: separation, attachment behaviour, care-giving behaviour, and bonding. Although he never pursued the idea or the implications, Bowlby also stated that crying is attachment behaviour throughout life.

The default reason for crying throughout life is separation: in infancy it is separation from the care-giver and in adulthood it is the death of, or permanent separation from, a loved one (Nelson, 1998, 2005). In infancy, according to attachment theory, the pain of separation is the point from which all other pains radiate. Hunger, physical pain, startle noises, all trigger the same behaviour based on the same principle: come here; I need you. In adulthood, the separations and losses may be literal object losses, but they may also be multi-layered, implied, threatened, averted, symbolic, fantasized, and even unconscious ones. The ‘Come here; I need you’ of adulthood is equally complex. The beckoning for care and consolation may also be internal, symbolic, implicit or unconscious, while only in extreme or particular circumstances is it literal.

Separations and losses of all kinds and levels may also result in grief reactions with varying levels of intensity. If crying is prototypically an activation of attachment behaviour in reaction to separation or loss, then it might also be seen as representing some facet of a grief reaction, as it does when the separations or losses become permanent. The little deaths of everyday life may trigger
miniature grief reactions that mirror those that occur following the death of a close loved one, when they are far more intense, pronounced, and easy to identify.

Using Bowlby’s stages of grief – protest, despair, and detachment (Bowlby, 1960, 1961) – as the basis for a classification of types of crying, or inhibited crying at a time when tears would be expected or appropriate, created a framework for a classification of crying. It is based on his description of different types of crying that accompanied each stage in infants, and his observation that adults’ responses to death of a close loved one paralleled those of infants separated from their care-givers, with the exception of the adult’s ability to move through grief to reorganization rather than necessarily ending up in life-threatening detachment.

Although even tears of joy may reflect an aspect of grief (Weiss, 1952), some adult crying does appear to go beyond personal loss to symbolize universal or transcendent attachment, love, or bonding. This type of weeping is triggered by aesthetic, mystical, or as Freud (Freud, 1930a) would have it, ‘oceanic’ feelings, or by moments of exceptional human connectedness. Crying due to neurological, biochemical, or other physiological causes may also occur independent of any separation or loss. For a thorough discussion of the clinical assessment of crying, as well as its relationship to different styles of adult attachment, see Nelson (2000, 2005).

The care-giving system of behaviour

Looking at crying and care-giving as reciprocal systems of behaviour, as they are described in attachment theory, is a way to understand the mutual interplay of forces relative to crying. Parents of infants do not just ‘decide’ to respond to infant cries. They are compelled by powerful reactions, including physiological changes, that alert and disturb them when they are exposed to crying infants (Sullivan, 1940; Frodi, Lamb, Leavitt, & Donovan, 1978; Boukydis & Burgess, 1982; Boukydis, 1985; Donovan & Leavitt, 1985; Weinfield, Sroufe, Egeland, & Carlson, 1999). Crying helps to establish and maintain the attachment bond in parent–child partners by signalling the infant’s need for physical proximity to the care-giver and initiating a care-giving response (Bowlby, 1969; Kobak, 1999).

Care-giving may have a biological substrate but it is, of course, far more subject to conscious control than is infant crying. All parents – and others within earshot of crying infants – are alerted and/or disturbed by the sound of infant crying, but how quickly and effectively they respond varies widely based on early experience, child-rearing philosophies, and the fit between the temperament of the infant and care-giver. Responses vary from prompt nurturing to ignoring or isolating the crying infant, or, in less optimal circumstances, impatient, irritated, or even angry, enraged, or abusive care-giving.
When adult crying takes place in the presence of others – as it does in psychotherapy – it may also be seen as activating the companion’s care-giving behavioural system, with varying results depending on the type of cry, the nature of the relationship, learned behaviour, socio-cultural values and the attachment experiences and attachment style of the potential care-giver (Nelson, 2000, 2005). Adult crying, even though it often lacks the characteristic cry-sounds of infancy, still alerts and ‘disturbs’ those in the crier’s presence. Some crying evokes empathy and a desire to comfort, while other crying annoys, distances, or frustrates potential care-givers. Being able to distinguish different types of crying and the types of care-giving responses each evokes is the first step necessary for tracking the reciprocal attachment–care-giving cycles of interaction that take place with crying in psychotherapy.

Types of crying and crying inhibition and the care-giving responses they evoke

As Bowlby (1961) noted, infants respond to separations first with protest, then with despair, and finally with detachment. In passing, he mentioned the quality of crying that accompanies each stage. ‘In the early hours and days, the child’, he wrote, ‘will often cry loudly, shake his cot, throw himself about, and look eagerly towards any sight or sound which might prove to be his missing mother’ (p. 15). This stage he called ‘protest’. If the care-giver does not return within a matter of hours or days, the protest crying ceases and is replaced by a low intermittent wail, which accompanied the stage Bowlby labelled ‘despair’. If the missing care-giver still does not return and no stable, consistent care-giver is found as a replacement, the infant goes into a final, life-threatening stage of detachment marked by a non-crying silence.

While the prototype of loss in infancy is separation from the care-giver, the prototype of loss in adulthood is the death of a close loved one. When Bowlby studied the reactions of adults to such a loss, he found parallels to the protest, despair, and detachment evidenced by infants in response to the loss of the care-giver. ‘[W]hen he weeps,’ Bowlby (1961) wrote, ‘the bereaved adult is responding to loss as a child does to the temporary absence of his mother’ (p. 333). The difference, of course, is that bereaved adults may proceed from despair to reorganization rather than necessarily ending in the silent, withdrawn detachment of infancy. Adults who are unable to cry over severe losses and who withdraw from emotional connections with others may be exhibiting a form of detached depression parallel to that of infants in the final stage of separation from their care-giver.

If adults pass through similar stages of grief to those of infants separated from their parents, it occurred to me that perhaps the quality of adult crying might also change in relationship to each stage. Adult crying might then be classified as either protest crying, the sad crying of despair, or, in the case of
some inhibited crying, detached tearlessness (Nelson, 1998, 2000, 2005). Such a schema for classifying crying according to the stage of grief to which it corresponds gives the therapist a baseline from which to understand the always complex intersubjective moments that involve crying. Such a classification is, of course, a reference point rather than an absolute category. It positions the feelings and experience of the non-crying partner dyadically, as well as those of the crier.

Consciously integrating the principle of crying as attachment behaviour aimed at signalling a care-giver to respond provides a point of departure for the many subtle variations on a theme, as well as the deviations from it. Understanding that we as analysts and psychotherapists are always part of the equation when a patient cries, and looking to the system of attachment and care-giving behaviour activated between us as a point of orientation, helps to make sense of the intersubjective dialogue and of the many highly nuanced affect attunements that take place in the therapeutic relationship as well as the dynamics of mutual affect regulation.

Attachment and care-giving are always intersubjective and, in fact, may co-exist in adulthood, with each behaviour tinged by some of the other: attachment and care-giving. This idea fits with the view that has emerged from research that ‘the developing organization of the child’s experience must be seen as a property of the child-caregiver system of mutual regulation’ (Stolorow & Atwood, 1992, p. 23). When someone is crying in our presence, our own attachment behaviours and/or experiences may also be activated, even as we are care-giving. In a moment of mutual attachment, tears may represent a connective bond between the two criers. Or, we may show attachment by crying over a loss we feel empathically with someone to whom we are attached. Care-giving, too, can be mutually evoked and mutually experienced (Bader, 1996).

Both partners, then, are inextricably involved in both sides of the crying–care-giving equation. From a theoretical standpoint, it is necessary to enter the circle at some point, to highlight and clarify the mutually influenced dynamics of the crying–care-giving pair. However, it is important to realize, as we do so, that the strands are always interwoven in complex and highly particular ways for each pair in each situation.

**Protest cries**

In infancy, protest crying is aimed at avoiding or undoing a loss and bringing about a reunion. Bowlby noted that most losses are indeed temporary, which makes protest crying, from an evolutionary standpoint, highly functional. It is a signal by the infant for action from care-givers to avoid what could become a permanent, life-threatening separation for the child.

Young children continue to use protest crying; i.e., they ‘cry loudly, shake
[their] cot[s], throw [themselves] about’ to avert threatening separations from their parents. However, they also use protest crying to avert less profound threats and losses such as giving up a toy or turning off the cartoons, relying on their earlier successes with crying to beckon care-givers as a way to get the care-giver to come forward with a desired toy or treat. At this point the attuned care-giver responds by helping the child to regulate the affect rather than simply soothing the child or complying with the child’s wish. One mother said she told a son crying loudly over a missing Snoopy sock, ‘Crying is for broken legs and lost friends.’ A father, whose son said he didn’t know why he was still crying five minutes after being denied an ice cream, suggested that he stop. His son replied, ‘Okay’, and dried his tears.

In the case of adult bereavement, as with traumatic separations in infancy, protest crying is often very intense. It may also be accompanied by verbal protest such as ‘No, it can’t be’, or ‘I won’t let this happen.’ Protest crying represents the phase of grief when the loss and its impact cannot be taken in or accepted. In the early stages of a traumatic loss of a loved one, protest crying touches the deepest layers of sympathy and empathy in potential care-givers who readily identify with the anguish of the bereaved and can therefore understand their resistance to the loss.

When protest crying occurs in response to everyday losses, however, it often has a harsh, almost angry-sounding force behind it. The quality it conveys to potential care-givers may be accusatory, demanding, or hostile, especially when the crier is seeking action: ‘Fix this! Stop that! Help me! Make this go away!’ He or she wants something done and may even reject offers of consolation or empathy. Protest crying is especially problematic for potential care-givers when they are being accused of causing the loss or not doing enough to rectify the situation causing the pain. Protest crying may then distance potential care-givers rather than bringing them close. It can leave care-givers, including therapists, feeling defensive, despairing, devalued, frustrated, and hopeless.

There are times, however, when protest crying represents an important phase in the therapeutic relationship and process. In an earlier article I describe treating a woman who had developed a strong aversion to crying as a result of being attacked by a sadistic father whenever she shed tears. I welcomed her initial protest crying, realizing that it represented diminished anxiety about her attachment to me and the beginning of her ability to grieve for her traumatic early experiences. I was easily able to respond to this crying empathically and to encourage her new-found voice of protest grief.

Not until much later, when the protest was aimed at me – as when she accused me of being abusive to her by going on vacation even though I knew perfectly well how traumatized she was by these separations – did I feel frustration and annoyance. At that point I had to rely on a developmental view of care-giving, using my professional–parental affect regulating skills to control
my irritation. I patiently explained, as one might to a child still learning about affect regulation, my understanding of her feelings and their origins, my need for a vacation, and my plans for her care in my absence. In effect, my words intersubjectively soothed both of us: her overburdened attachment system and my overburdened care-giving one. The next time I left on a trip, she prepared a package of notes full of all her hostile, accusatory thoughts that I was to take with me to read on the plane. She used words to protest without the accusatory tears. I did take the packet with me, knowing that it was important that I did not completely leave her behind, but the notes were so murderous that I was only able to glance at them until just before her first post-vacation hour. In that way, I was able to contain both my affect and hers.

Eventually, she learned to handle my travels based on our attachment rather than its rupture. We were both deeply moved when she said at one of our post-trip reunions, ‘I finally understand what “missing someone” means. I never had even an inkling before what people meant when they said that.’ She finally had enough sense of security in her attachment to me that she was able to sustain it in my absence with a manageable amount of pain instead of being overwhelmed by complete abandonment.

Sad cries of despair

Sad cries of despair in infancy correspond to giving up hope of reunion with the primary care-giver. These tears represent a deeper, quieter, more profound stage of grief—silent weeping rather than the highly vocalized screams of protest. Sad cries of despair are also seen in young children who are learning to handle the grief and loss of everyday life. A child’s cries of despair over losing a pet or not being invited to a friend’s birthday party evoke in attuned care-givers the deepest kind of empathy and wish to give care and consolation.

In adult bereavement, despair is the stage of grief when the reality of the loss is recognized and faced. The quality of the crying is about surrender and giving in to despair rather than resistance and demands for change. Crying in despair may also occur in response to less extreme losses, such as receiving a lay-off notice at work, a hurtful telephone message from an old friend or a loss in an important sports competition.

Being in the presence of this kind of grief typically stirs up great empathy and sympathy in others and evokes a powerful urge to offer solace and comfort. It is this feature of crying in despair that provides the healing component in working through grief. It does what attachment behaviour is designed to do: establish and maintain a close bond with others. Even in solitary adult crying in those with ‘good enough’ attachments, the appeal to symbolic, internalized, or even fantasized care-givers can bring comfort and consolation (Kobak, 1999). In the face of loss, tears bring us back to love. In connection, in attachment, there
is hope for a resolution of grief as well as for maintaining a connection to whatever or whomever has been lost.

**Detached tearlessness or inhibited crying**

The final stage of reaction to the loss of a primary care-giver in infancy is a life-threatening, silent detachment. The parallel for bereaved adults is silent, tearless depression that isolates the sufferer and frustrates and distances potential care-givers. In its own way, this detached adult state can also be life-threatening: literally, in terms of suicide, and symbolically in that the sufferer withdraws from daily life and the caring, comforting presence of friends or loved ones.

Not all inhibited crying in response to loss is detached, however. Some non-criers find other connected ways to seek the care and closeness of others when they are bereaved. They might do it verbally by expressing their despair in words or physically by touch or hugging (sexual closeness may also stand in for attachment needs when other kinds of closeness are not available or cannot be tolerated). Symbolic acts, such as planting a tree or writing a letter, or creative expressions of grief through music, painting, or poetry may also provide connected, rather than detached, ways to grieve without tears.

**The intersubjective aspects of crying in the psychotherapeutic relationship**

By using the insights gained from attachment theory, crying becomes a gateway for bringing the nuances of attachment and care-giving to consciousness in the intersubjective process. Crying marks a place where the therapist may function as both a new object or attachment figure and a repetition of past objects or attachments. As Winnicott said, there is a link between the ‘here and now’ and the ‘then and there’. At the same time crying and care-giving responses necessarily involve the therapist’s ‘here and now’ and ‘then and there’ as well. Susie Orbach (1999) writes:

> If attachment is the paradigm, and the problematic is attachment, then the nature of attachment, the fears and the defenses around attachment, all the nuances of relationship need to be something with which both the analysand and the analyst are grappling. [p. 80]

Crying is our first behaviour and part of our first intersubjective experience, since our care-givers respond to our cries beginning at the moment of birth. Over time, the successes and failures at beckoning care-givers by crying and the appropriateness, effectiveness, and promptness of their responses contribute to the establishment and maintenance of the attachment bond and its quality, whether secure, ambivalent, avoidant, or disorganized/disorientated.
By adulthood, experiences with attachment behaviour and care-giving are embedded in our very beings.

One place for to begin looking at what is happening in the therapeutic dialogue when the patient cries – or when the therapist cries or feels like it but does not – is to examine the type of internal response a particular crying episode evokes. To use internal reactions as our guide assumes that we have examined our own attachment styles and are conscious of any idiosyncratic responses to the tears of others based on our own experiences of attachment and care-giving. For example, personal experiences with tearful, needy parents, unattuned or punitive care-givers, or controlling, guilt-inducing protest tears in parental or partner relationships may have rendered adult therapists resistant to certain kinds of crying, perhaps depending on the gender of the crier. On the other hand, the more usual therapist profile may include early attachment experiences that lead to the development of overly ready care-giving to others (Bader, 1996).

Assuming that we bring a developed level of awareness about our own attachment and care-giving responses to crying in general, the internal reaction that a particular crying, or inhibited crying, episode evokes is an important key to understanding what is happening intersubjectively. Do the patient’s tears or words about loss make us feel pushed away with little or no room to feel empathy and offer solace or understanding? If so, we may be in the presence of protest crying or a tearless phase of protest grief. This type of grief can feel whiney, manipulative, or demanding, and leave therapists wondering about their own lack of empathy in response. Alternatively, if understood as a phase in the grieving process, it can be appreciated – even cheered on – as a patient finds his or her way into protesting a loss, as with the patient I mention above.

In the presence of sad cries of despair we may feel deeply saddened, at times empathically tearful ourselves, and drawn to offer understanding and care with our words, sounds and/or facial expressions. We may feel exceptionally connected and effective as therapists. We may sense that we are ‘getting somewhere’ in terms of working through loss and grief, as the tears of despair indicate the patient is in a state of sadness and surrender to the experience of loss rather than resisting or trying to undo it. There is often a sense of connection between us and our patients and a feeling that they are truly allowing us to ‘be there’ for them and with them in their grief.

With inhibited crying, when shedding tears would be expected or appropriate, we may feel frustration at having our care-giving behaviours devalued or rejected. We may feel pushed away when depressed patients complain that it does no good to talk about painful losses, never mind cry, or that the therapy is not helping. At other times inhibited crying may trigger empathy for a closed-off or isolated sufferer and even lead us to feel like crying ourselves, evoked by our connection with the bereaved patient who is unable to do so.
Case examples

I have selected two cases from Julie Gerhardt and Annie Sweetnam’s 2001 article on Christopher Bollas. One is his case and the other is theirs, and they have each graciously agreed to my using their cases for this purpose. These vignettes provide examples of patients struggling with protest grief over an extended period of time, to their own consternation and sometimes to that of their analysts. Then, following an intervention by the analyst, the patients begin to cry in despair, a sign of increasingly secure attachment in the therapeutic relationship.

I am in no way suggesting that adding an attachment perspective would or should have changed what the analysts did or said. Clearly, these are master clinicians describing a highly developed sense of their work and themselves. Rather, I am impressed by how what they did do is enhanced by an understanding of crying based on attachment theory.

Case One

Christopher Bollas, whose case first appeared in his book Being A Character (Bollas, 1992), helped a patient of his who was experiencing a prolonged period of protest – verbal, not tearful – by sharing an empathic image of her as a child. His image moved the woman to tears for the first time in her analysis, sad crying of despair, not protest crying, and to a deepening attachment to her analyst. Bollas’s descriptions of the period leading up to his intervention are tinged with the frustration and helplessness often felt by analysts or therapists dealing with a prolonged bout of protest. For example, he notes that his patient was ‘listlessly moaning about the many disappointments in her life’ (ibid., p. 120). At the same time, she rejected his interpretations even though he identified the ‘despair’ underlying the protest grief and suggested that it derived from ‘unconscious envy of her father’.

In language that resonates with thwarted care-giving, Bollas writes that his interpretations ‘were unable to reach her’. She would not let him in or allow him to soothe and comfort her in her despair. Instead she protested mightily—wanting something reparative that she was not taking in or getting from him.

At this point Bollas chose to share the following image with his patient:

‘You know, as you are speaking I have a picture of you, a little girl of three in tutu and ballet shoes, asked by Mummy and Daddy to perform for guests, and who, warmed by the applause, believes the world will always be like this.’ [Bollas, 1992, p. 121]

At that moment the patient responded by bursting into tears for the first time in her analysis. Bollas attributed his intervention to a kind of ‘unconscious rapport’ between the patient and himself. He was intuitively connected to her
attachment wounds, in the here and now as well as in her past, and made his exquisitely crafted and timed intervention based on the nuances of the intersubjective processes going on between them.

Bollas knew that despair was beneath her protest and he was able to forge a connection with that despair by using the fantasized image of her childhood. From that new position, Bollas could feel, and perhaps show, a compassionate care-giving response (Frank, 1997, p. 295) that his patient could hear and accept. By using this evocative image he was able to help dislodge their mutual frustration. He connects with her from the standpoint of the vulnerable child, not the insecurely attached adult. As Bollas put it, the image ‘captured something about my patient that I had previously put in the abstract’ (1992, p. 121).

With that, the woman’s tone changed and softened. Tears came for the first time ever in the therapy. She was able to let in the reality of the sadness and despair over her loss, and to let her analyst be there for her as well. Crying provided both the means for establishing the attachment and the evidence of its existence. Now there was hope that she could move forward in grieving for the disappointments and losses she had experienced throughout her life and hope of a positive, healing connection with her analyst. A year later she had a dream incorporating Bollas’s fictional image of her as a ballet dancer, confirmation of her growing internal attachment to him.

Case two

Gerhardt and Sweetnam (2001) also describe a case where one of the authors interposed her fantasy image into the patient’s material and, again the patient cried, not protest crying as had previously been the case, but sad crying of despair. The therapist writes, in language that clearly represents her feelings about the protest grief, that she (the therapist) was being driven to ‘despair’ by ‘the harsh piercing intonation’ of the complaints, ‘as if they bore the ragged edge of accusation: i.e., “Do something for me! You haven’t done enough to help me!”’ (p. 84). Yet, when the therapist tried to be empathic or when she attempted to interpret the distancing, self-protective manoeuvres, the patient felt reproached and protested even more.

This therapist, too, shared a ‘spontaneous’ image of her patient as a child, and the response was immediate and tearful, triggering a change which the therapist described in her process notes thus:

For the first time in almost five years, the patient’s cry had a distinctly more plaintive, hurt quality to it—the cry of a disappointed/rejected/rejecting little girl—rather than the accusatory shaft of despondency and hate she had so often expressed. [ibid., p. 87]

Another way of saying this is that the crying changed from protest crying to sad crying of despair and the type of care-giving the patient was able to receive in
that moment changed also. The therapist, by being attuned to the patient’s insecure resistant attachment (her attachment behaviour was easily activated but could not be soothed by care-giving) and adjusting her care-giving to the remove of history and fantasy, enabled the patient to tolerate the grief and to ‘let the therapist in’.

After briefly working with the image from the past, the focus of the discussion shifted to the therapeutic relationship. The therapist said, ‘Sounds like you’ve thought about this a lot – how to feel close when we seem so different.’ The patient responded, ‘I think about it all the time – that’s what you don’t realize – all the time.’ At this point, Gerhardt and Sweetnam questioned having pulled the patient ‘back into the contemporary transference, away from her beginning slide into the co-constructed regressed space’. Based on the attachment behaviour displayed and the subsequent discussion, however, I believe that the therapist sensed that her patient could not handle too much raw grief and too much raw attachment and care-giving at this stage. Instead, drawing on the fragile strand of care-giving that had so recently been accepted, the therapist moved to an intuitively sensed need for affect regulation and helped the patient shift the focus to the present. Her move was especially fitting because it acknowledged the ongoing interplay between the original care-giving deficits and the current symbolic and real relationship with the therapist.

Conclusion

As the above cases illustrate, analytically informed psychotherapists and analysts have been using attachment and care-giving data in their work with patients. I am suggesting that a differentiated understanding of those data in relationship to crying offers a way to refine clinical understanding, particularly in the realm of affect attunements and misattunements and mutual affect regulation.

Crying is part of the therapeutic dialogue, an interweaving of two subjectivities, mutually generated and mutually regulated. However, it is seldom approached with conscious insight or analysis. Identifying the attachment appeals, the type of crying, and the care-giving responses of each partner in the therapeutic relationship offers new understanding of the source of our interventions, interpretations, and comments; both where they come from and a way to evaluate how and why they have been effective or missed the mark. In addition, understanding the intricacies of crying and attachment can help to make sense of some of the therapist’s often puzzling and unexpressed internal reactions and a way to help sort out some of the enactments that inevitably occur in long-term psychotherapy and analysis.
References


