17 The effects of emotional disclosure during bereavement

Emmanuelle Zech and Bernard Rimé
University of Louvain, Louvain-la-Neuve, Belgium

James W. Pennebaker
The University of Texas at Austin, USA

Any emotionally upsetting experience has the potential to aggravate mental and physical health problems. This is clearly the case after the death of a close friend or family member. Bereavement is associated with extended periods of anguish and pain, increased risk of depression, physical illness, and mortality (W. Stroebe, Schut, & Stroebe, 2005a). It is widely assumed in Western societies that people have to confront their feelings and reactions to the death of a loved one in order to adjust to the loss. Despite some dissenting voices (e.g., M. Stroebe & Stroebe, 1991; Wortman & Silver, 1989, 2001), it is widely accepted, not only by lay persons but also bereavement professionals, that the bereaved must do their "grief work".

The concept of grief work implies a process of confronting the reality of loss, of going over events that occurred before and at the time of the death, and of focusing on memories and working towards detachment from the deceased (M. Stroebe, 1992). The concept has been central in the major theoretical formulations on grief and bereavement since Freud's (1917) classic monograph. Freud's view that grief work was necessary for the resolution of grief was shared by other major theoreticians who dominated bereavement research, such as Lindemann (1944), Bowlby (1980) and Parkes (1996). Principles of counselling and therapy also assign a central role to grief work in adjustment to loss. Failure to confront and experience the intense emotions that accompany the loss is considered maladaptive.

Pathological grief is generally regarded as the failure to undergo or complete grief work. For example, many researchers and clinicians in the field of loss agree that the absence of grief following bereavement ("absent grief") indicates that the grieving process may be abnormal or "pathological" (e.g., Middleton, Raphael, Martinek, & Misso, 1993). It is assumed that if grief is not expressed due to an intrapsychic cause (such as denial or inhibition), it will surface at some later point or health problems will subsequently emerge (Worden, 2001). Thus, counselling and therapy programmes for the bereaved share the common goal of helping the bereaved to adapt to life without the loved one, by facilitating grief work (e.g., Worden, 2001).

Research conducted on the one hand by Pennebaker and colleagues on the effects of written self-disclosure on health and on the other hand by Rimé and colleagues on the effects of oral social sharing of emotion (i.e., talking to others about the emotions one experienced) on recovery, is highly relevant to this principle. Written disclosure and social sharing of emotions are not necessary conditions of grief work, because individuals can also confront their grief and work through it in isolation, nonverbally, or in thoughts. Nevertheless, verbal emotional expression and grief work are closely linked, because people will probably confront their loss when they write or talk about it. Confronting one's emotions in the course of a written or verbal disclosure task should thus be particularly helpful for the bereaved. Moreover, similarly to the grief work hypothesis, much of the early research conducted by Pennebaker and colleagues was based on an inhibitory model, which suggested that the act of inhibiting or holding back one's thoughts, feelings, or behaviours involved biological work that, in and of itself, was stressful. If individuals were forced to actively inhibit over long periods of time, it was argued, the greater the probability that they would suffer from a variety of psychosomatic diseases (for a discussion of this model, see Pennebaker, 1989). Not talking about a significant emotional experience or trauma with others could certainly invoke inhibitory processes: the active restraining of the urge to share one's story.

Writing about or sharing one's story may also produce a number of interesting cognitive side-effects. Talking with others about an important event may help the person to organise the experience, find meaning, and come to terms with it. This is why, in the "writing paradigm", respondents are typically asked to write for 15 to 30 minutes on several consecutive days, either about their deepest thoughts and feelings related to past traumatic experiences or about trivial control topics (e.g., Pennebaker & Beall, 1986).

By the same token, talking with others may also clarify one's psychological state for others. The person's social network, then, can make accommodations based on what the person is feeling and saying. For example, if a bereaved person expressed utter loneliness, friends or family members could phone, visit, or invite the bereaved person more regularly. Without talking, the traumatised individual would be less likely to come to terms with the event and would be more socially isolated. The work conducted by Rimé and colleagues on the effects of social sharing of emotion is thus also relevant for the grief work hypothesis. Rimé and colleagues mainly focused on the oral verbalisation of *emotional events* in the context of a social interaction (i.e., to someone listening—and in most cases responding—empathetically) and the effects it may have on the *emotional recovery from such events* (for reviews, see Rimé, Finkenauer, Luminet, Zech, & Philippot, 1998; Rimé, Philippot, Boca, & Mesquita, 1992). Emotional recovery was defined as the evolution over time of the arousal still elicited when a given emotional memory is reaccessed. It is now known that people who experience an emotion usually feel compelled to talk about it and to share it, preferably with

their intimates. They do so quite willingly, despite the fact that the sharing process will reactivate the negative aspects of the emotional experience. There is widespread belief that sharing an emotion should bring emotional relief (Zech & Rimé, 2005). Yet both correlative and experimental studies which were conducted to test the validity of this belief consistently failed to support it. It does not seem that talking about an emotional memory has a significant impact on the emotional load associated with this memory. Nevertheless, people who share their emotions generally express the feeling that the process is beneficial (Zech & Rimé, 2005). Thus, while it is debatable whether sharing bereavement-related feelings would bring emotional relief, bereaved individuals may well feel that sharing their emotions with intimates is meaningful and beneficial for various reasons. In particular, the development and maintenance of close relationships that may be involved when one shares one's emotions, may be a fundamental function of social sharing of emotion.

The question still remains as to whether specifically writing or talking about the loss of a loved one would be associated with improved physical and mental health, including recovery from the loss. Literature reviews of the data on disclosure and coping among bereaved individuals are clearly mixed, if not negative (Pennebaker, Zech, & Rimé, 2001; M. Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002; W. Stroebe et al., 2005a). There was no evidence from the three published experimental studies on non-suicide deaths that emotional disclosure facilitates adjustment (Range, Kovac, & Marion, 2000; Segal, Bogaards, Becker, & Chatman, 1999; M. Stroebe et al., 2002). It is noteworthy, however, that significant improvements of symptoms of distress, avoidance, intrusion, and doctor visits were found over time, suggesting that, in case of non-suicide deaths, time was a great healer. Only one study on bereavement after suicide deaths found evidence of a beneficial effect, but this effect was limited to one of several health measures included in that study (Kovac & Range, 2000).

These findings are in line with the pattern that emerged in a recent review of the efficacy of different types of general preventive interventions for bereaved individuals (Schut, Stroebe, van den Bout, & Terheggen, 2001). There is no evidence that counselling or therapy helps the normally bereaved (i.e., those who did not themselves seek professional help) to adjust to their loss. Preventive interventions seem to be only effective for bereaved people at high risk of complications in their grieving process.

These findings are also consistent with the pattern that emerged in several studies of the impact of social support in bereavement (e.g., W. Stroebe, Stroebe, Abakoumkin, & Schut, 1996; W. Stroebe, Zech, Stroebe, & Abakoumkin, 2005b). In these longitudinal studies of the influence of social support on psychological well-being of bereaved and non-bereaved men and women, no evidence of a *differential* effect of social support for the bereaved was found. Although individuals who perceived their level of social support as high were less likely to show depressive symptomatology than

individuals who thought they had little support, this beneficial effect was of the same magnitude for bereaved and non-bereaved alike. Taken together, these findings suggest that in cases of uncomplicated bereavement, the help from others is a moderator rather than a mediator of the grieving process: there is a main effect, suggesting that support helps, but not more when the person is suffering from bereavement.

How can we reconcile the widely held assumption that in order to cope with loss, bereaved individuals have to confront and express their emotions, with the mainly negative findings that have been reviewed so far? Elsewhere, we have argued that the disclosure paradigm was usually—but not always—powerful enough to swamp individual differences between respondents (Pennebaker & Keough, 1999). We also acknowledged that the manipulation could not be viewed as helping everyone. Thus, it is important to identify individuals for whom disclosure would be more versus less likely to be associated with health and well-being. This suggests that not everyone will benefit, but that specific individuals might. The questions then arise: "who benefits?" and "under what conditions?". Next, we turn to the specific conditions that may enhance the likelihood of finding beneficial disclosure effects on health, well-being, and emotional recovery for bereaved individuals.

Moderators of the effects of emotional disclosure

Highly distressed bereaved individuals?

Previously, we suggested that the beneficial effects of writing-induced emotional disclosure might only emerge for bereavements that are relatively traumatic, such as sudden and unexpected losses (Pennebaker et al., 2001). This hypothesis was partially tested by M. Stroebe and colleagues (2002, Study 2). They divided the widowed participants into those whose loss was expected and those whose loss was not. They then examined the moderating effect of expectedness on the health benefits of the writing instructions. Results failed to indicate that writing-induced disclosure had more beneficial effects for bereaved people who suffered an unexpected loss than for those whose partner died expectedly after a long illness. Nevertheless, the bereaved individuals in the Kovac and Range (2000) study had lost a person to whom they had been close; in this case to suicide. It is possible that suicide deaths, as voluntary deaths, are characterised by a feature that sets them apart from normal losses. It is noteworthy that writing about their deepest feelings about this loss rather than a trivial topic decreased only suicide-specific grief symptoms but did not reduce general grief, intrusion or avoidance of the event, or health centre visits.

The question concerning who signs up to participate in an intervention study is also relevant. One of the most difficult aspects of studying bereavement is in collecting truly random samples. The Stroebe group has been doing this by directly contacting individuals 4 to 8 months after the death of

their spouse. Other researchers, such as Segal et al. (1999), advertised for participants in the local newspaper. We suspect that those who seek out researchers (as in the Segal et al. project) could represent very different groups from those who are directly contacted. Because most people cope quite well with the death of a spouse—especially if it is not a traumatic death (cf., Wortman & Silver, 1989)—disclosure interventions may only be effective with those coping poorly. A randomly selected sample, then, will be less likely to show the benefits of disclosure, since most of the participants will be in relatively good shape. A sample that self-selects to participate in a study on spousal bereavement may, in fact, comprise the very people who have not had the opportunity to work through their emotions. In line with the research on the efficacy of bereavement counselling, those who might benefit the most are actually those who suffer the most.

Gender

Gender may also be a significant moderating factor in the effects. Indeed, in his review of the literature, Smyth (1998) reported that males are more likely to demonstrate health improvements after writing than females. Similarly, Schut, Stroebe, van den Bout, and de Keijser (1997) reported that the ways in which men versus women are *counselled* differentially predicts positive bereavement responses. Specifically, in this study, highly distressed bereaved persons entered a counselling programme. The interventions were done by trained and experienced social workers (seven times over a period of 10 weeks). When men were asked to focus on the acceptance of emotions and emotional discharge (client-centred type of counselling), they became less distressed than when asked to focus on problems (behaviour therapy type). Women showed the opposite pattern. It is thus possible that writing instructions focusing on specific aspects of the grieving process would be more beneficial to men than women (and vice versa). In other words, specific writing or talking instructions could benefit men more, while other instructions could benefit women more. Evidence that gender might be a good candidate for moderating the impact of emotional disclosure on health is also provided by the Stroebes, who demonstrated 15 years ago that widowers who participate in research were less depressed than those who refused, while the reverse was true for widows (M. Stroebe & Stroebe, 1989). It is thus possible that men who agree to participate are actually better off and may not need help in the form of expressive writing or disclosure. On the contrary, women who participate in bereavement research tend to be more depressed than those who refuse and are thus likely to use more ruminative coping strategies. They might therefore need specific instructions that help them to reframe or reappraise, or see the loss and its consequences in a more positive light.

Insecurely attached individuals?

The attachment style of the bereaved person to the deceased may also be a major individual difference factor accounting for the effects of emotional disclosure on well-being and health. Indeed, attachment researchers have demonstrated that attachment styles were associated with patterns of both emotional disclosure and well-being (e.g., Mikulincer & Nachshon, 1991). Attachment theory claims that people's attachment styles evolve as a result of experiences related to communication and the expression of emotions within interpersonal relationship exchanges, especially with caregivers (Feeney, Noller, & Roberts, 1998; Kennedy-Moore & Watson, 1999). According to attachment theory, learning experiences involving emotional expression between caregiver and infant lead to the development of mental models (representations) of the self and of relationships (Bartholomew & Horowitz, 1991). These emerge as attachment styles and are, in turn, linked to patterns of (non)expressive emotional behaviour (Mikulincer & Shaver, 2003).

Persons with a *secure* style, which is characterised by relative ease in closeness to others and feeling comfortable both depending on and having others depend on oneself (Cassidy & Shaver, 1999), will be more likely to experience and express emotions to a moderate degree (M. Stroebe, Schut, & Stroebe, 2005b). There are three insecure attachment styles: avoidant or dismissive, ambivalent or preoccupied, and disorganised or fearful. People with a *dismissive-avoidant* attachment style are uncomfortable with closeness to others, find it difficult to trust others completely, or to allow themselves to depend on others, and present an apparent lack of anxiety about abandonment. They restrict expressions of distress and avoid seeking support from others. As a result they are found to report less emotional disclosure than other persons (e.g., Mikulincer & Nachshon, 1991). Adults with a *preoccupied* attachment style see others as reluctant to get as close to them as they would like. They worry about their attachment to others, about their own desire to stay very close to them, and about the fact that this sometimes scares others away. They tend to disclose highly and indiscriminately to persons. Finally, individuals classified as having a *disorganised* attachment style are uncomfortable with closeness to others, find it difficult to trust others or to depend on them, and tend to avoid seeking support from others. They would be likely to have difficulties talking coherently about their emotions and their loss (M. Stroebe et al., 2005b).

These attachment patterns and their disclosure correlates may be relevant for predicting well-being in general, but they are even more likely to be important in the case of bereavement, where the main problem is the loss of an attachment bond. According to Shaver and Tancredy (2001), people with different attachment styles cope with grief differently. M. Stroebe, Schut, and Stroebe (2005a) proposed that secure persons who are more at ease in disclosing emotional information, and who have less difficulty interacting with others, would be less distressed in such a situation. They should not benefit

more from a written or oral disclosure session, since they already cope well with their loss and disclose coherently to others. On the contrary, the insecure attachment styles would require specific disclosure instructions. In line with Pennebaker's inhibition theory, dismissive individuals, who are the most reluctant to disclose personal information, were predicted to benefit from any disclosure induction. Preoccupied individuals were predicted not to benefit from an emotional disclosure intervention since they might just ruminate about their intense grief. They could benefit from instructions that would force reappraisal of the meaning of loss. Finally, disorganised individuals were also predicted to benefit from an emotional disclosure, but provided that this could help the "development of a coherent account in terms of logic, fluency, and understanding" (M. Stroebe et al., 2005a, p. 25).

In a recent survey we investigated depressive affect among persons visiting their general practitioner (GP)—both patients and their accompanying persons—and a number of factors likely to be associated with depressive affect, including emotional disclosure and attachment style (Zech, de Ree, Berenschot, & Stroebe, 2006). Contrary to popular culture and clinical lore, but consistent with some previous research and our own predictions, we did not find evidence that disclosure was associated with well-being in general. However, when attachment dimensions were taken into account, this was indeed the case. This suggested that one needs to take people's attachment tendencies into account when examining the efficacy of emotional disclosure on affective states. As expected, avoidant attachment was associated with less depressive affect and less emotional disclosure. This could be indicative of the fact that patients who felt more discomfort depending on others—that is, who were more independent of others—were less depressed, or at least less willing to admit to negative feelings. The avoidant attachment style has indeed been related to the use of defensive strategies to suppress affective reactions (Mikulincer & Orbach, 1995). That avoidant attachment was associated with higher levels of self-perceived well-being was consistent with the image of this group as strong, silent types who can—or try to—get by without revealing their emotions.

These findings are particularly interesting when considering the relationship between avoidant attachment and the reason patients had for consulting their GP. Participants who visited their GP for severe *physical* reasons were those who were more avoidantly attached (suggesting that they may have delayed seeking help until problems became intense). Consistent with these findings, the attachment literature indicates that persons with an avoidant attachment style are less inclined to trust others, share their problems with others, or seek support from others (Bartholomew & Horowitz, 1991; Mikulincer & Nachshon, 1991). Thus, these findings were consistent with inhibition theory (Pennebaker, 1989) and with M. Stroebe et al.'s predictions.

Avoidantly attached people, who were also found to report discomfort with emotional disclosure of distressing information and to perceive that such disclosure is actually not useful, tend to seek less help from counsellors and

have more negative attitudes towards help seeking (Vogel & Wester, 2003). Since they have a more negative view of others, a first step towards helping such persons could be to instruct them to write down their emotions. As a second step, early discussions could be useful in identifying and addressing likely problematic expectancies regarding their potential sharing partners' trustworthiness and dependability. A change in attitudes and sharing behaviours among this group would probably require repetitive as well as positive sharing interactions.

With respect to the other attachment dimension, the Zech et al. study (2006) found that those having high anxious attachment reported more depressed affect. Results also indicated that the anxiously attached individuals were more inclined to visit their GP for severe *psychological* problems. They were also found to disclose their emotions more frequently. This would suggest that, although anxiously attached persons disclose their emotions and problems to a great extent, this strategy was not efficient in reducing their depressive affect or severe psychological problems. On the other hand, patients high on anxiety may be more prone to seek help for their problems and report more psychological problems. Since they have a more negative view of themselves, we speculated that such individuals could be helped by reinforcing their own, independent treatment capacities (e.g., trying to involve them more in their treatment to improve their self-efficacy, giving them a more positive view of themselves). Using similar reasoning, anxiously attached persons could be helped by guidance to reinforce their self-efficacy and positive viewpoint.

Socially constrained individuals?

Another plausible moderator of the impact of disclosure could be the frequency with which the bereaved individuals have already engaged in social sharing before and have already disclosed their deepest emotions about the loss to others. It would seem plausible that the beneficial effects of induced disclosure are weakened to the extent that individuals have already engaged in disclosure outside the laboratory. This hypothesis was tested by M. Stroebe and colleagues (2002, Study 2). Results showed that there was no indication that the frequency with which the bereaved participants had previously talked about their loss to others and, in social sharing, had disclosed their emotions, moderated the impact of writing-induced disclosure. In fact, *low* disclosers were found to suffer less from intrusive thoughts and also had fewer visits to the doctor than high disclosers. This suggested that, rather than facilitating adjustment, the extent to which bereaved people disclose their emotions at a given point in time may be a symptom of poor recovery.

During bereavement, people usually work through grief naturally and do not need intervention strategies to help them to cope with their grief. There may be several reasons why some bereaved individuals continue to show extreme grief reactions several months or years after the death, including a

hostile or non-existent social network that does not allow for the open discussion of the death. In this case, intervention may be needed and a written disclosure task might help to provide a situation for expressing emotions, without the direct evaluation of another person. Because the writing intervention does not need a real recipient to be present, such a tool may be particularly useful in cases where persons feel social constraints. This could then be further used in therapeutic sessions, if necessary (e.g., in the form of a diary or letters that would be discussed with a therapist).

Unsupported bereaved individuals

The assumption that support from family and friends is one of the most important moderators of bereavement outcome is still widely accepted among bereavement researchers and practitioners (e.g., W. Stroebe & Stroebe, 1987; Stylianos & Vachon, 1993). Indeed, the loss of a partner leads to deficits in areas that can be broadly characterised as loss of instrumental support, loss of validational support, loss of emotional support, and loss of social contact support (W. Stroebe & Stroebe, 1987). In the case of widowhood, the loss of a spouse also represents the loss of one's main sharing target (Rimé et al., 1998). These deficits could be partially compensated through social support from family and friends. This compensation assumption provides the theoretical basis for the buffering hypothesis (Cohen & Wills, 1985). Supportive reactions from a listener could thus be important in explaining beneficial effects of disclosure. Yet, as indicated above, there is little research supporting this view (W. Stroebe et al., 2005b).

In fact, attachment theory rejects the assumption that supportive friends can compensate for the loss of an attachment figure (Bowlby, 1969; Weiss, 1975). Bowlby (1969) proposed that the attachment figure was uniquely able to foster general feelings of security and that other people could not simply take over this function. Attachment theory also predicts that social support and partner loss affect health and well-being by separate pathways (Weiss, 1975). The loss of a partner, and thus of an important attachment figure, results in emotional loneliness—the feeling of utter aloneness, even when one is with others. Emotional loneliness can only be remedied by the integration of another emotional attachment or the reintegration (after separation) of the one who has been lost. However, social support should reduce social loneliness, which results from the absence of an engaging social network. Thus, even though attachment theory denies the possibility of buffering processes in bereavement, it would predict that social support has a general beneficial effect on health and well-being, which is independent of the stress situation (i.e., a main effect). These predictions were confirmed in several studies (e.g., W. Stroebe et al., 2005b).

Even if supportive family and friends do not *accelerate* the grieving process, it is possible that unsupportive family and friends are actually detrimental for one's adjustment to bereavement. In addition, it remains possible

that specific types of supportive reactions may be beneficial for a particular index of health and well-being, while this would not be the case for a different dependent variable. Indeed, research conducted by Nils (2003) suggests that, although providing empathy and understanding when listening to someone who has just been exposed to an emotion-inducing film is perceived by the sharer as beneficial and helpful (especially for the quality of one's affiliation with the listener), this type of supportive response did not help the sharer to recover more quickly. However, when a listener answered to the disclosure with reappraising comments this was perceived as less beneficial for one's relationship, but actually helped the participant to gain cognitively and emotionally (for a review of types of supportive partners, their reactions and their effects, see Zech, Rimé, & Nils, 2004).

This research suggests that natural social sharing may not always address cognitive demands implied in recovering from an emotion (e.g., reappraisal). However, natural social sharing may actually fulfill socio-affective needs such as attention, interest, empathy, support, nonverbal comforting, and help (Rimé, 2005). Indeed, when shared emotions are intense, listeners' use of verbal mediators were found to be reduced, and listeners switched to the nonverbal mode (Christophe & Rimé, 1997). This leaves less opportunity for cognitive work and more place for manifestations of the socio-affective kind. Nils's research also suggests that there is a need to specify the dependent variable for which the beneficial effect would be most likely to occur (i.e., one could expect a beneficial effect on one dimension of well-being, but the reverse effect on another).

In fact, it is also possible that timing is very important during the grieving process. Bereaved individuals could be perceiving other persons' supportive attempts at one time as beneficial and at the next moment as detrimental. In other words, we suggest that one may need to see helpful or unhelpful disclosures as on-going processes rather than as a present-or-absent phenomenon. Next, we will delineate such a viewpoint in more detail.

Mediators of the effects of emotional disclosure

In this section, we will propose not only that certain individuals might benefit more from disclosure than others, but that specific processes should be at hand when disclosing about the loss of a dear person. We will also propose that one specific individual may actually benefit more at certain moments from specific types of disclosure than at other times.

Coping with bereavement implies "working through grief"

As indicated above, grief work implies a process of confronting a loss, an active, ongoing, effortful attempt to come to terms with the loss (M. Stroebe, 1992). In contrast, ruminations reflect a passive repetition of events without any active attempts at reaching a detachment from the lost person. It is a

truism that the best predictor of future depression is a prior episode of depression. Similarly, if we have a group of bereaved spouses 6 months post-loss, the best predictor of their grief responses 2 years later will be their current grief responses. It is thus important to distinguish between disclosure as an intervention versus a reflection of grief. Asking participants about their thoughts and feelings during a brief interview may be a reflection of their grief rather than an intervention. We found such effects with gay men who are dealing with the death of their lovers due to AIDS (Pennebaker, Mayne, & Francis, 1997). For a disclosure session to be an intervention, the person should be actively working through an upsetting experience.

In the writing paradigm, people write about emotional topics multiple times over several days. When the language of their writing samples is analysed, the people who benefit most are the ones who show clear cognitive change from the first writing session to the last. Those who are highly emotional across all four days of writing but who do not show cognitive change do not experience any health benefits (cf., Pennebaker, 1997). Similarly, those who are able to change their perspectives in writing from one session to another are the ones who evidence greatest improvements (Campbell & Pennebaker, 2003). These perspective shifts are apparent in people's use of pronouns. That is, they switch from using first person singular pronouns (e.g., I, me, my) to other more social pronouns (he, they, we). Taken together, the language results indicate that the more that people change or "grow" in their writing, the more their health and adjustment improve.

Coping with bereavement implies more than "working through grief": Loss- and restoration-oriented coping strategies

In the last decade, some theoreticians and researchers have not supported the view that expressing the negative emotions associated with grief is essential for its successful resolution (e.g., Bonanno & Keltner, 1997; M. Stroebe & Stroebe, 1991). Depending on the theoretical view of bereavement, other tasks may be regarded as equally essential for the resolution of grief. The dual-process model of bereavement (DPM) developed by M. Stroebe and H. Schut (1999, 2001) postulates that adaptive coping with bereavement requires a fluctuation or oscillation between strategies aimed at addressing the loss of the deceased person (referred to as loss-oriented strategies) and strategies aimed at addressing the secondary stressors that come about as an indirect consequence of the bereavement, such as changing identity and role or mastering new skills (referred to as restoration-oriented strategies). Grief work corresponds essentially to loss-oriented strategies, such as expressing emotions related to the loss of one's loved one. The DPM also postulates that the bereaved person will have to deal with the situational changes and will have to rebuIld "assumptions about the world and one's own place in it" (M. Stroebe et al., 2005b, p. 9). It thus proposes that both confrontation and distraction/avoidance strategies will be used to deal effectively

with both loss- and restoration-stressors and tasks. Focusing on only one orientation would not be adaptive: exclusively focusing on loss would lead to chronic grief, while exclusively focusing on restoration would lead to absent or inhibited grief. A disturbance of the oscillation process, with extreme involuntary confrontation and avoidance of the stressors, would be indicative of traumatic grief.

The extension of this model (M. Stroebe et al., 2005a, 2005b) postulates that the disclosure paradigm will work for those who are unable, alone or in their daily interactions with others, to create a coherent discourse about their thoughts and feelings. Thus, flexible and smooth oscillation will be characteristic of securely attached individuals who should not benefit very much from a disclosure intervention. Again, the disclosure intervention should benefit according to one's attachment style, which should be related to loss-oriented (preoccupied), restoration-oriented (dismissive) coping strategies, or saccadic oscillation (disorganised). Thus, one of the important features of the DPM is the oscillation process. This could explain why a specific disclosure intervention would not work. There is a need to investigate the process as it develops over time and people need to (learn to) oscillate in a coherent manner. Instructions that would address these different coping strategies and restore a smooth oscillation when needed would most likely be beneficial.

Conclusions

The work of Wolfgang Stroebe and his colleagues (most notably Margaret Stroebe and Henk Schut) has been instrumental in debunking any simple models that have been put forward to explain grief reactions. More importantly, their research has clearly demonstrated that no interventions seem to work for most people in reducing the pain of bereavement. These conclusions are disturbing, but they also raise new challenges for the next generation of bereavement researchers.

Given the spectacular failings of grief counselling, written disclosure (except in cases of traumatic experiences), or other known interventions, should psychologists pack their bags and move on to other lines of research? Before closing, two questions must be addressed. Do people naturally seek out a grieving style that works best for them? If this is the case, we would expect that no intervention would ever work, since it would deviate from people's natural styles. Ironically, of course, it would mean that certain grieving styles *are* working effectively—we just cannot see them because life is not a function of random assignment. Let us consider a rather outrageous suggestion: Perhaps the best strategy to test this idea would be to actively block people from grieving in a natural way. Perhaps banning them from the funerals of loved ones, forcing them to be happy and not to think of their dead relatives could help to disentangle (un)helpful coping strategies. If the "people choose what's best for themselves" hypothesis is true, these

dire interventions would prove to prolong long-term grief (of course, such a proposal for intervention would raise ethical concerns).

An equally provocative hypothesis hinted at by the Stroebe work is that the entire process of grief is a social construction that people actually would not need. If working through is not a viable hypothesis, perhaps we should assume that cultural working through is actually maladaptive. A logical intervention, then, would be some form of "snap-out-of-it" therapy: no funeral, get back to work, and no talking about the deceased.

The strength of the Stroebes' research has been in pointing to the shortcomings of many of the basic assumptions most of us hold about death and loss. Through carefully controlled real-world studies, they have repeatedly demonstrated the difficulty of modifying grief reactions. Before throwing out the baby with the bath water as just proposed, one should remember that the potential moderators and mediators of the effects of emotional disclosure in coping with bereavement that were outlined in this chapter need further investigation. In short, in line with Stroebe's group, we have highlighted that understanding human reactions to bereavement is more complex than previously proposed: specific sharing interactions should work for specific individuals at a precise point in time of their grieving process.

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References

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, *61*, 226–244.

Bonanno, G. A., & Keltner, D. (1997). Facial expressions of emotion and the course of conjugal bereavement. *Journal of Abnormal Psychology*, *106*, 126–137.

Bowlby, J. (1969). *Attachment and loss. Vol. 1. Attachment*. London: Hogarth Press.

Bowlby, J. (1980). *Attachment and loss. Vol. 3. Loss: Sadness and depression*. London: Hogarth.

Campbell, R. S., & Pennebaker, J. W. (2003). The secret life of pronouns: Flexibility in writing style and physical health. *Psychological Science*, *14*, 60–65.

Cassidy, J., & Shaver, P. (1999). *Handbook of attachment: Theory, research and clinical applications*. New York: Guilford Press.

Christophe, V., & Rimé, B. (1997). Exposure to the social sharing of emotion: Emotional impact, listener responses and the secondary social sharing. *European Journal of Social Psychology*, *27*, 37–54.

Cohen, S., & Wills, T. A. (1985). Stress, social support and buffering. *Psychological Bulletin*, *98*, 310–357.

Feeney, J. A., Noller, P., & Roberts, N. (1998). Emotion, attachment, and satisfaction

in close relationships. In P. A. Andersen & L. K. Guerrero (Eds.), *Handbook of communication and emotion: Research, theory, applications, and contexts* (pp. 473–505). San Diego, CA: Academic Press.

Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed. & Trans.) *Standard edition of the complete psychological works of Sigmund Freud*. London: Hogarth Press, 1957.

Kennedy-Moore, E., & Watson, J. C. (1999). *Expressing emotion*. New York: Guilford Press.

Kovac, S. H., & Range, L. M. (2000). Writing projects: Lessening undergraduates' unique suicidal bereavement. *Suicide and Life-Threatening Behavior*, *30*, 50–60.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, *101*, 141–148.

Middleton, W., Raphael, B., Martinek, N., & Misso, V. (1993). Pathological grief reactions. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and interventions* (pp. 44–61). Cambridge, UK: Cambridge University Press.

Mikulincer, M., & Nachshon, O. (1991). Attachment styles and patterns of self-disclosure. *Journal of Personality and Social Psychology*, *61*, 321–331.

Mikulincer, M., & Orbach, I. (1995). Attachment styles and repressive defensiveness: The accessibility and architecture of affective memories. *Journal of Personality and Social Psychology*, *68*, 917–925.

Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 35, pp. 56–152). San Diego, CA: Academic Press.

Nils, F. (2003). *Le partage social des émotions: déterminants interpersonnels de l'efficacité de la communication des épisodes émotionnels* [Social sharing of emotion: interpersonal determinants of the efficay of the communication of emotional episodes]. Unpublished doctoral dissertation, University of Louvain, Louvain-la-Neuve, Belgium.

Parkes, C. M. (1996). *Bereavement: Studies of grief in adult life*. London: Routledge.

Pennebaker, J. W. (1989). Confession, inhibition, and disease. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 22, pp. 211–244). New York: Academic Press.

Pennebaker, J. W. (1997). *Opening up: The healing power of expressing emotions* (Revised edition). New York: Guilford Press.

Pennebaker, J. W., & Beall, S. K. (1986). Confronting a traumatic event: Towards an understanding of inhibition and disease. *Journal of Abnormal Psychology*, *95*, 274–281.

Pennebaker, J. W., & Keough, K. (1999). Revealing, organizing, and reorganizing the self in response to stress and emotion. In R. Contrada & R. Ashmore (Eds.), *Self, social identity, and physical health: Interdisciplinary explanations* (pp. 101–121). Oxford, UK: Oxford University Press.

Pennebaker, J. W., Mayne, T. J., & Francis, M. E. (1997). Linguistic predictors of adaptive bereavement. *Journal of Personality and Social Psychology*, *72*, 863–871.

Pennebaker, J. W., Zech, E., & Rimé, B. (2001). Disclosing and sharing emotion: Psychological, social, and health consequences. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 517–543). Washington, DC: American Psychological Association.

Range, L. M., Kovac, S. H., & Marion, M. S. (2000). Does writing about bereavement lessen grief following sudden, unintentional death? *Death Studies*, *24*, 115–134.

Rimé, B. (2005). *Le partage social des émotions* [The social sharing of emotions]. Paris: Presses Universitaires de France.

Rimé, B., Finkenauer, C., Luminet, O., Zech, E., & Philippot, P. (1998). Social sharing of emotions: New evidence and new questions. In W. Stroebe & M. Hewstone (Eds.), *European review of social psychology* (Vol. 8, pp. 145–190). Chichester, UK: Wiley.

Rimé, B., Philippot, P., Boca, S., & Mesquita, B. (1992). Long-lasting cognitive and social consequences of emotion: Social sharing and rumination. In W. Stroebe & M. Hewstone (Eds.), *European review of social psychology* (Vol. 3, pp. 225–258). Chichester, UK: Wiley.

Schut, H., Stroebe, M. S., van den Bout, J., & de Keijser, J. (1997). Gender differences in the efficacy of grief counselling. *British Journal of Clinical Psychology*, *36*, 63–72.

Schut, H., Stroebe, M. S., van den Bout, J., & Terheggen, M. (2001). The efficacy of bereavement intervention: Who benefits? In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care*. Washington, DC: American Psychological Association Press.

Segal, D. L., Bogaards, J. A., Becker, L. A., & Chatman, C. (1999). Effects of emotional expression on adjustment to spousal loss among older adults. *Journal of Mental Health and Aging*, *5*, 297–310.

Shaver, P. R., & Tancredy, C. M. (2001). Emotion, attachment and bereavement: A conceptual commentary. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research—Consequences, coping, and care* (pp. 63–88). Washington, DC: American Psychological Association Press.

Smyth, J. M. (1998). Written emotional expression: Effect sizes, outcome types, and moderating variables. *Journal of Consulting and Clinical Psychology*, *66*, 174–184.

Stroebe, M. S. (1992). Coping with bereavement: A review of the grief work hypothesis. *Omega*, *26*, 19–42.

Stroebe, M. S., & Schut, H. W. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, *23*, 197–224.

Stroebe, M. S., & Schut, H. (2001). Meaning making in the dual process model of coping with bereavement. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 55–73). Washington, DC: American Psychological association Press.

Stroebe, M. S., Schut, H., & Stroebe, W. (2005a). Attachment in coping with bereavement: A theoretical integration. *Review of General Psychology*, *9*, 48–60.

Stroebe, M. S., Schut, H., & Stroebe, W. (2005b). Who benefits from disclosure? Exploration of attachment style differences in the effects of expressing emotions. *Clinical Psychology Review*, *26*, 66–85.

Stroebe, M. S., & Stroebe, W. (1991). Does grief work, work? *Journal of Consulting and Clinical Psychology*, *59*, 479–482.

Stroebe, M. S., & Stroebe, W. (1989). Who participates in bereavement research? An empirical study of the impact of health on attrition. *Omega*, *20*, 1–29.

Stroebe, M. S., Stroebe, W., Schut, H., Zech, E., & van den Bout, J. (2002). Does disclosure of emotions facilitate recovery from bereavement? Evidence from two prospective studies. *Journal of Consulting and Clinical Psychology*, *70*, 169–178.

Stroebe, W., Schut, H., & Stroebe, M. S. (2005a). Grief work, disclosure and counseling: Do they help the bereaved? *Clinical Psychology Review*, *25*, 395–414.

Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss*. New York: Cambridge University Press.

Stroebe, W., Stroebe, M., Abakoumkin, G., & Schut, H. (1996). The role of loneliness and social support in adjustment to loss: A test of attachment versus stress theory. *Journal of Personality and Social Psychology*, *70*, 1241–1249.

Stroebe, W., Zech, E., Stroebe, M. S., Abakoumkin, G. (2005b). Does social support help in bereavement? The impact on vulnerability and recovery. *Journal of Social and Clinical Psychology*, *24*, 1030–1050.

Stylianos, S. K., & Vachon, M. L. S. (1993). The role of social support in bereavement. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 397–410). New York: Cambridge University Press.

Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology*, *50*, 351–361.

Weiss, R. S. (1975). *Loneliness: The experience of emotional and social isolation*. Cambridge, MA: MIT press.

Worden, J. W. (2001). *Grief counseling and grief therapy. A handbook for the mental health practitioner* (3rd ed.). New York: Springer Publishing Company.

Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology*, *57*, 349–357.

Wortman, C. B., & Silver, R. C. (2001). The myths of coping with loss revised. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 405–429). Washington, DC: American Psychological Association.

Zech, E., de Ree, F. F., Berenschot, A. F., & Stroebe, M. S. (2006). Depressive affect among health care seekers: How it is related to attachment style, emotional disclosure, and health complaints. *Psychology, Health & Medicine*, *11*, 7–19.

Zech, E., & Rimé, B. (2005). Is talking about an upsetting experience helpful? Effects on emotional recovery and perceived benefits. *Clinical Psychology & Psychotherapy*, *12*, 270–287.

Zech, E., Rimé, B., & Nils, F. (2004). Social sharing of emotion, emotional recovery, and interpersonal aspects. In P. Philippot & R. Feldman (Eds.), *The regulation of emotion* (pp. 157–185). New York: Lawrence Erlbaum Associates Inc.