Review of General Psychology
2007, Vol. 11, No. 3, 235–257

Copyright 2007 by the American Psychological Association
1089-2680/07/$12.00 DOI: 10.1037/1089-2680.11.3.235

Being the Best Bearer of Bad Tidings

Kate Sweeny and James A. Shepperd
University of Florida

Giving bad news is an unpleasant task, and the medical literature provides numerous guidelines for giving bad news well. However, what people mean by "giving bad news well" is less clear. What should be the goal when communicating bad news? The authors suggest that the goal of news-givers should be to guide recipients toward a desired response and the authors propose a theoretical framework, the Bad News Response Model, for delivering bad news that draws from research in health and social psychology. The model is applicable to all forms of bad news and specifies that three characteristics of the news (controllability, likelihood, and severity) influence which response (Watchful Waiting, Active Change, or Acceptance) will most often lead to the best quality of life for the recipient.

Keywords: bad news, communication, coping, situational factors

> God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.
>
> *Serenity Prayer, source uncertain*

In the book *The Anatomy of Hope* (Groopman, 2004), an oncologist recounts the stories of two patients whose prognoses permitted little hope. The first patient's physician repeatedly misled her into thinking that a cure was likely rather than providing more accurate information about her inevitable fate. When the cancer was about to take her life, the patient expressed dismay at the false hope promoted by her trusted physician. In contrast, the second patient's physician conveyed the gravity of her situation at each step of the cancer's progression. This patient lived her last moments to the fullest and died with little regret or dismay. Although the two diagnoses were equally dire, the patients' experiences were decidedly different. Such stories emphasize the role of those charged with giving bad news in providing the recipients with wisdom to know when their situation can be changed and when the situation simply calls for serene acceptance. These anecdotes suggest the need for a systematic model of giving and responding to bad news.

Giving bad news is an unpleasant task (Rosen & Tesser, 1970). Unfortunately, most people must transmit bad news at some point in their lives. They may have to break up with a lover or tell a student about a failing grade. Moreover, many professions entail bad news transmission as part of the job description. Health care employees must convey diagnoses, military personnel must deliver news of wartime casualties, and managers must occasionally hand out pink slips. Although giving bad news is uncomfortable for the giver, the opening medical examples point to the importance of giving bad news "well". A number of researchers in the medical field have provided guidelines to help those who must give bad news, but what people mean by "giving bad news well" is less clear. Evaluating the success of a bad news transmission requires that news-givers have a goal in mind when giving bad news and compare the outcomes of their transmission to that goal. Some researchers focus on the goal of providing hope to the recipient of the news, others focus on making the transmission easier and less painful for the news-giver, and others focus on increasing recipients' satisfaction with the bad news transmission. What should be the primary goal when communicating bad news?

Kate Sweeny and James A. Shepperd, Department of Psychology, University of Florida.

We thank J. T. Ptacek, Kevin McCaul, Marie Helweg-Larsen, Michael Weigold, Barry Schlenker, and Greg Neimeyer for their helpful comments on earlier versions of this article.

Correspondence concerning this article should be addressed to Kate Sweeny or James Shepperd at the Department of Psychology, P.O. Box 112250, University of Florida, Gainesville, FL 32611-2250. E-mail: kdockery@ufl.edu or shepperd@ufl.edu

The purpose of this review is to investigate how to give bad news well. Central to the notion of "giving bad news well" is having a clear understanding of the goal of bad news transmission. We critically evaluate six goals suggested by prior research and propose a broader, more comprehensive goal for giving bad news. We then offer a theoretical framework, the Bad News Response Model, which draws from research in health and social psychology and is designed to maximize positive long-term outcomes for news-recipients. The model specifies four possible responses to bad news and three situational factors that influence the response choice. Finally, we discuss future directions for research.

The goals of this review are, by necessity, limited in scope. We do not address specific aspects of bad news transmission, such as tone of voice, setting, eye contact, and amount of information. Although many studies have addressed these issues (e.g., Holland, 1989; Loge, Kaasa, & Hytten, 1997; Ptacek & Eberhardt, 1996; Ptacek & Ptacek, 2001), and these aspects of the communication can affect how people respond to bad news, they fall outside of the scope of this article. Furthermore, we do not address the process by which people respond to bad news. The literature on coping focuses on how people appraise and respond to bad news (see Snyder, 1999 for a review). We focus on the goals people have when giving bad news. Finally, we do not attempt to predict with certainty the best responses to bad news. The Bad News Response Model predicts how situational factors might affect responding, but the model does not stipulate how people "should" respond.

Giving Bad News Well

A review of the medical literature reveals a rich yet disorganized picture of how to give bad news well. Some consensus exists as to the stages of the bad news transmission process and the important aspects of the situation and the message itself (see Fallowfield & Jenkins, 2004; Faulkner, 1998; Ptacek & Eberhardt, 1996), but little consensus exists about the goals these suggestions are designed to achieve, and often no goal is mentioned at all. The medical literature suggests six possible goals of a bad news communication: (a) decreasing news-givers' discomfort, (b) providing sufficient information to recipients, (c) promoting recipients' satisfaction with the transmission, (d) improving news-recipients' memory for and understanding of the news, (e) reducing recipients' distress in response to the news, and (f) promoting hope. We briefly review the evidence supporting each of these goals and then offer a new, alternative goal that incorporates the positive aspects of the other six goals. Although we treat these goals as distinct for the purpose of this review, it is noteworthy that a news-giver may simultaneously pursue multiple goals during a bad news communication.

Decreasing the News-Giver's Discomfort

One goal of bad news-givers is to decrease the discomfort they feel about giving bad news. Giving bad news is often extremely unpleasant for the news-giver. Physicians and nurses report discomfort with giving bad news because of lack of training, fear of patients' emotional reactions, fear of their own emotional reactions, fear of being blamed for the bad news, fear of the patients' suffering and dying, personal fear of illness and death, and uncertainty associated with not knowing all the answers (Ambuel & Mazzone, 2001; Buckman, 1984). Reducing news-givers' discomfort is an important goal because discomfort with giving bad news can produce negative consequences for both news-givers and recipients. One study found that burnout and poor mental health are common among physicians who must frequently give bad news, and that physicians who felt insufficiently trained in giving bad news experienced the greatest distress (Ramirez et al., 1995). Furthermore, research shows that physicians who are more comfortable and confident with giving bad news are perceived as more trustworthy by patients, and patients who trust their physicians are more likely to comply with treatment recommendations (Holland, 1989).

With the importance of this goal in mind, several training programs for health care professionals aim to decrease discomfort and increase confidence and skills with giving bad news (Baile et al., 1999; Parathian & Taylor, 1993; Unger, Alperin, Amiel, Beharier, & Reis, 2001). In addition to formal training programs, a number of professionals suggest strategies to make the job of giving bad news easier (e.g., Clark & LaBeff, 1982; Eggly et al., 1997; McClenahen

& Lofland, 1976; Radziewicz & Baile, 2001). For example, one paper describes five strategies to smooth the process of giving news of death and suggests that the best method of communication depends on several situational factors (the type of death, the age at death, the place of death, and the occupation and experience of the news-giver) (Clark & LaBeff, 1982).

Helping people to feel comfortable giving bad news is clearly important. However, the goal of decreasing news-givers' discomfort is problematic for several reasons. First, making news-givers as comfortable as possible may mean that they portray the news in a more positive light than is warranted, omitting negative information in an attempt to avoid eliciting negative responses from the receiver. Second, this goal relegates to secondary importance the needs of the news-recipient. An appropriate goal for bad news transmission should account for the needs of both the news-giver and news recipient.

Providing Sufficient Information

A second goal for giving bad news described in the medical literature is to provide news-recipients with sufficient information about the news. Researchers who address the ethics of giving medical bad news primarily focus on how much information people should receive about diagnoses and prognoses. In medical settings, ethical treatment requires that patients receive clear, honest information because it allows the patients to accept the situation and make plans for the future (Fallowfield, Jenkins, & Beveridge, 2002; Girgis, Sanson-Fisher, & Schofield, 1999; Goldie, 1982; Ward, 1992). The information provided should also be consistent among patients and their family members to avoid distrust and suspicion (Doyle & O'Connell, 1996). Furthermore, cultural, family, and personal preferences affect the amount of information patients wish to receive, and it is the physician's responsibility to consider these preferences (Sabbioni, 1997).

However, personal comfort with disclosing bad news often determines what and how much information many physicians disclose. Giving and receiving bad news are both unpleasant experiences, and physicians and patients may be eager to avoid the experience at all costs. In one study, 40% of physicians admitted to giving patients inaccurate life expectancy estimates, mostly in an optimistic direction (Lamont & Chisakis, 2001). Although some people may not be prepared to hear the full truth about an undesirable diagnosis (Bor et al., 1993; Goldie, 1982; Greer, Morris, & Perringale, 1979; Lubinsky, 1994; Michaels, 1983; Radziewicz & Baile, 2001), evidence suggests that patients with serious conditions often suspect that they will hear bad news (Fallowfield, Jenkins, & Beveridge, 2002). Knowing how much information to disclose is difficult, leading some to recommend that physicians repeatedly ask patients how much they want to know, thus allowing the patients to determine the level of information conveyed (Freedman, 1993).

Providing sufficient information is clearly a necessary goal in medical interactions, including bad news communication. Patients who do not receive sufficient or accurate information are unable to make informed decisions as to how they want to respond to their diagnosis. However, this goal is insufficient for guiding bad news-givers. The ethical guideline of providing clear, complete information to patients is a means to an end, not an end in itself; it is only a starting point for guiding bad news transmission.

Promoting Recipient Satisfaction

A third goal for bad news-givers is to give the news in a way that satisfies recipients. A predominant belief in the medical literature is that patients should be satisfied with the way they receive bad news and that they should have their needs met in the communication experience. One review of the literature concluded that, when giving bad news, the patients' desires and needs are far more important than the physicians' (Ptacek & Eberhardt, 1996). Many studies reinforce this idea by asking patients how they want to hear bad news and then using their responses to design bad news communication strategies (e.g., Ambuel & Mazzone, 2001; Back & Curtis, 2002; Butow et al., 1996; Girgis et al., 1999; Hagerty et al., 2005; Randall & Wearn, 2005; Salander, 2002). Other studies measure patients' satisfaction with their experience receiving bad news to assess the competence of bad news-givers (e.g., Damian & Tattersall, 1991; Derdiarian, 1989; Dunn et al., 1993; Ellis & Tattersall, 1999; Gillotti, Thompson, & McNeilis,

2002; Hurwitz, Duncan, & Wolfe, 2004; Mast, Kindlimann, & Langewitz, 2005; Ptacek & Ptacek, 2001; Reynolds, Sanson-Fisher, Poole, Harker, & Byrne, 1981). Such studies typically find that the needs patients express are in line with established guidelines for giving bad news (Girgis et al., 1999; Ptacek & Ptacek, 2001; Randall & Wearn, 2005).

However, some differences arise when comparing patients' needs and the ways physicians typically give bad news. For example, patients rate information about treatment and future outcomes as more important to them than diagnostic information (Back & Curtis, 2002; Butow et al., 1996; Salander, 2002). Patients also view the experience of receiving bad news as an ongoing process throughout their treatment, not as a one-time conversation with their physician (Randall & Wearn, 2005). Finally, a number of studies find that small talk and general expressions of support, not in-depth conversation about diagnoses or prognoses, are most helpful to patients receiving bad news (Dean, 2002; Gillotti et al., 2002).

Increasing patient satisfaction with bad news communication is a worthy goal for bad news-givers. However, asking patients how they want to hear bad news assumes that patients can objectively and accurately evaluate their own emotions and the reasons for them. People are generally poor at accurate introspection and thus poor at understanding the reasons behind their emotional and cognitive responses (Nisbett & Wilson, 1977). For example, patients reporting that their physicians are unskilled at presenting bad news may be unaware of the effects that their location, mood, and relationship with the physician have on their feelings about the news transmission. In this light, it seems that patients' opinions, although important and valid, may be a somewhat inaccurate source of suggestions for how to give bad news. Finally, satisfaction with a bad news communication is undoubtedly influenced to some extent by the content of the communication. Other things being equal, the worse the news, the less satisfied people will be with the communication. Although the medical literature does not speak to this point, it seems likely that a focus on promoting recipient satisfaction with the communication creates the possibility that news-givers will alter or water down the bad news.

Improving Memory and Understanding

A fourth goal for giving bad news is to ensure that recipients understand and remember information about the bad news and its implications. People receiving bad news often find it difficult to understand and remember the information they receive. For example, a patient may hear the word "cancer" during a diagnostic conversation and fail to process any information thereafter. Presenting information in a way that patients can understand is crucial in bad news communication because it can improve patients' outcomes, avoid confusion and distress, and increase patients' satisfaction with the communication (Baile et al., 2000; Ellis & Tattersall, 1999; Fallowfield & Jenkins, 2004; Loge et al., 1997; Quill, 1991).

A number of researchers suggest that when bad news is complicated or difficult to understand, bad news-givers should be careful to clarify, check for understanding, and summarize the information presented (Dias, Chabner, Lynch, & Penson, 2003). Furthermore, a number of communication skills of the news-giver, such as self-confidence, warmth, and honesty, can help the patient to process bad news (Myers, 1983). Finally, providing recall aids (e.g., informational handouts, audiotapes of the bad news communication) often improves patients' memory and understanding, and may reduce patient anxiety (Back & Curtis, 2002; Hogbin, Jenkins, & Parkin, 1992; McHugh et al., 1995; Reynolds et al., 1981).

Improving news-recipients' memory and understanding of the information they receive is clearly an important goal for bad news-givers. People who fail to comprehend the bad news they receive may be unable to cope with the news and may make unwise decisions in response. On the other hand, news-recipients need more than memory and understanding of the facts to cope and respond effectively. For example, even if a breast cancer patient hears, understands, and remembers the details of her diagnosis, she is unlikely to know much about the implications of the diagnosis or what course of action she should take. As such, improving memory and understanding represents an important intermediate goal for bad news communication, but is insufficient as an overarching principle for guiding news-givers.

Reducing Recipients' Distress

A fifth goal for bad news-givers is to minimize recipients' distress in response to the news. People receiving unexpected or traumatic news may be emotionally paralyzed by the experience, and poor communication by news-givers can exacerbate recipients' distress (Lerman et al., 1993). Many physicians and researchers recognize the importance of reducing emotional trauma after a bad news communication (Baile & Aaron, 2005; Boyd, 2001; Brewin, 1991; Fallowfield & Jenkins, 2004; Ptacek & Eberhardt, 1996; Quill, 1991; Rabow & McPhee, 1999; Shields, 1998). Emotional distress may particularly involve fear of death when bad news is health related (Penson et al., 2005), but all types of bad news are capable of producing distress.

Researchers have noted that news-recipients' distress is most severe during and just after a bad news communication, whereas the news-giver's distress is most severe just before and during (Ptacek & Eberhardt, 1996). A consequence of this incongruity is that news-givers may be insensitive to recipients' distress following the communication of bad news. In response to this problem, the medical literature provides a number of suggestions for increasing sensitivity to patients' distress. For example, physicians should prepare in advance for the communication (Holland, 1989; Michaels, 1983; Shields, 1998), demonstrate empathy, sensitivity, and compassion (Boyd, 2001; Brewin, 1991; Fogarty et al., 1999; Mast et al., 2005; Penson et al., 2005; Rabow & McPhee, 1999), allow patients to express their emotions (Boyd, 2001; Penson et al., 2005; Rabow & McPhee, 1999), take sufficient time in the bad news communication (Boyd, 2001; Penson et al., 2005), and help patients put the situation in perspective (Lalos, 1999). In addition, physicians shouldn't simply reassure the patient and move on; instead, they should acknowledge patients' distress, determine the sources of distress, and check the patients' needs before moving on to reassurance (Maguire, 1998).

Although news-givers are in part responsible for managing recipients' distress, this goal is not an end in itself and thus is an insufficient goal for bad news communication. Much like the goal of improving memory and understanding, the goal of reducing recipients' distress is an intermediate goal that makes it possible for recipients to move on to the greater goal of coping and responding to the bad news. Even if the breast cancer patient described earlier understands and remembers her diagnosis and also maintains a manageable level of distress after hearing the news, she may nevertheless lack the resources to move forward and respond. Finally, as with promoting recipient satisfaction, focusing on reducing distress may inadvertently influence the content of the communication. The worse the news, the more likely the recipients will be distressed by the communication. Thus, similar to the goal of promoting recipient satisfaction, attending to recipient distress may lead news-givers to alter or water down the bad news.

Promoting Hope

A sixth goal for giving bad news is to promote hope or optimism in recipients, an idea that has received considerable attention in the medical literature (Bor et al., 1993; Bruhn, 1984; Charlton, 1992; Clayton, Butow, Arnold, & Tattersall, 2005; Groopman, 2004; Yates, 1993). Hope can be defined as a combination of desires for the future, values and goals about future outcomes, and action to bring about hoped for outcomes (Simpson, 2004). The goal of promoting hope is supported by the finding that hope may be a powerful force in predicting positive health outcomes, such as better adjustment to breast cancer (Taylor, Lichtman, & Wood, 1984), lower incidence of hypertension (Richman et al., 2005), better immune functioning (Segerstrom, Taylor, Kemeny, & Fahey, 1998), and faster recovery from a number of illnesses (Groopman, 2004).

A number of factors increase the likelihood of promoting hope in a bad news communication. For example, fostering a good relationship between patient and physician (Bruhn, 1984; Salander, 2002), focusing on the potential for successful treatment (Bruhn, 1984; Clayton et al., 2005; Peteet, Abrams, Ross, & Stearns, 1991; Sardell & Trierweiller, 1993), and discussing the effects of the news on day-to-day living (Clayton et al., 2005) promote hope in patients receiving bad news.

Promoting hope as a goal for news-givers is somewhat problematic. Although hope may lead to positive outcomes in many cases, it must be balanced with honesty and realistic goals

(Clayton et al., 2005; Groopman, 2004; Links & Kramer, 1994). This balance is particularly important when there is a possibility that hope may be shattered at some point down the road, as is often the case during the course of an illness. Shattered hopes can lead to disappointment and distrust of those who initially communicated hopefulness (Peteet et al., 1991; van Dijk, Zeelenberg, & van der Pligt, 1999). On the other hand, hope can always be directed toward the possibility of improving outcomes down the road or having a productive life despite the bad news (Links & Kramer, 1994; Peteet et al., 1991; Yates, 1993), making hope a worthwhile goal for bad news-givers.

However, providing hope is not the same as providing news-recipients with the information they need to cope and respond to negative life events. The breast cancer patient gains strength and other positive outcomes as a result of her physician promoting hopefulness, but she needs more than hope to know which course of treatment to undergo. Hope may be a necessary component of coping with bad news, but news-givers must also help recipients engage in responses that will lead to the best long-term outcomes. Thus, promoting hope, along with improving memory and understanding and reducing distress, is an intermediate step in the greater goal of promoting effective responses to bad news.

Guiding Recipients Toward Desired Responses

The six goals for bad news-givers just described (reducing news-givers discomfort, providing sufficient information, promoting recipients' satisfaction, improving memory and understanding, reducing distress, and promoting hope) suggest different interpretations of what it means to give bad news well. However, these goals are means to an end, not ends in themselves. The six goals described are intermediate goals that may ultimately lead to positive outcomes for the recipient of the news but do not specify how these positive outcomes can be achieved. Furthermore, these goals were developed for use in medical settings and may be difficult to apply to other types of bad news.

We suggest an alternative, broader goal for news-givers that incorporates aspects of each of the other goals. We propose that giving bad news well is defined as guiding news-recipients toward desired responses—responses that news-givers believe will result in the best long-term outcomes for recipients. Although we later provide suggestions as to which responses may be most effective, a desired response refers to the response deemed best by the news-giver.

To illustrate, imagine a physician giving news of cancer. The physician must convey the diagnosis honestly and clearly, but ultimately the physician must encourage the patient to seek the most effective course of treatment or perhaps choose no treatment, depending on the situation. With this goal in mind, news-givers can provide sufficient information and feel confident in their ability to give bad news well. Furthermore, numerous studies suggest that a focus on options for the future increases satisfaction with the communication, reduces distress, and promotes hope (Back & Curtis, 2002; Clayton et al., 2005; Peteet et al., 1991; Salander, 2002; Schofield et al., 2003). Finally, guiding news-recipients toward the most effective course of action (or inaction) maximizes their chances of experiencing positive long-term outcomes and quality of life, although the definition of the best outcomes varies greatly across situations. In general, successful bad news transmission should prompt the recipient to respond in a way that maximizes quality of life and minimizes negative life outcomes. These outcomes include financial stability, physical, mental, and emotional health, and general well-being.

A handful of studies have examined positive long-term outcomes associated with communicating bad news and reveal that a variety of factors can directly influence outcomes such as psychological adjustment to an illness and psychological and emotional health. Findings suggest that strategies such as expressing empathy, allowing sufficient time for the bad news communication, and engaging the patient in treatment decisions, among others, predict better adjustment to breast cancer (Butow et al., 1996; Roberts, Cox, Reintgen, Baile, & Gibertini, 1994). Another study of breast cancer patients found that perceptions of caring and emotional supportiveness during the bad news communication predicted fewer cancer-related PTSD symptoms, less depression, and less general distress (Mager & Andrykowski, 2002). In addition, physicians' personal manner, communication skills, technical skills, and overall care pre-

dicted emotional health in breast cancer patients (Silliman et al., 1998).

Yet the studies just described do not indicate how various aspects of the bad news communication lead to positive or negative health outcomes. For example, how does emotional supportiveness by physicians lead to better emotional outcomes in patients? It may be the case that supportiveness leads to better treatment decisions, or any number of positive behaviors, which then lead to better long-term outcomes. The researchers typically offer no explanation of how factors such as perceptions of caring, emotional supportiveness, the physician's personal manner, communication skills or technical skills produce beneficial outcomes. Moreover, because these studies are largely correlational and rely almost entirely on patients' retrospective reports about how they received their diagnoses, the specific mechanisms are difficult to pin down. Thus, we propose that guiding recipients toward desired responses represents the mechanism by which news-givers can promote positive long-term outcomes.

The medical literature supports the goal of guiding patients toward the best course of action during bad news communications. A number of physicians note that patients want to focus on the future, toward treatment and long-term outcomes, rather than just on the diagnosis (Back & Curtis, 2002; Baile & Aaron, 2005; Baile et al., 2000; Bor et al., 1993). Other physicians describe methods for giving bad news with the stated purpose of improving coping and decision-making (Boyd, 2001; Clayton et al., 2005; Epstein, Alper, & Quill, 2004; Fogarty et al., 1999; Lalos, 1999). Finally, several physicians discuss various possible responses to bad news and the outcomes of engaging in different responses (De Haes & Koedoot, 2003; Greer et al., 1979).

The goal of guiding recipients toward the most effective responses prompts two questions. First, what are the different ways people can respond to bad news? Second, which responses should bad news-givers suggest? We developed the Bad News Response Model to answer these two questions. We propose that all responses to bad news fall into one of four categories: Watchful Waiting, Active Change, Acceptance, and Non-Responding. We further suggest that three factors of the outcomes of bad news (controllability, likelihood, and severity) indicate which response is likely to be effective (see Figure 1).

The Bad News Response Model

The Bad News Response Model suggests that giving bad news well involves guiding news-recipients toward a desired response. Thus, the model is aimed both at the person who must give bad news and at the recipient of the news. Ultimately, the goal of the Bad News Response Model is to elicit a desired response from the recipient of bad news, but bad news-givers must evaluate the characteristics of the possible bad outcome that determine what the desired response should be. Bad news-givers can then tailor their communication of bad news to encourage the desired response from the recipient. In addition, recipients of bad news can individually evaluate their situation and determine the most effective response to the news. It is important to note that the Bad News Response Model does not attempt to precisely predict the response that will lead to the best quality of life. The model provides guidance for bad news-givers as to which responses may be best under different circumstances, but the model addresses a wide spectrum of bad news and must make generalizations based on situational factors. Bad news-givers and recipients should choose the response that is most likely to result in the best outcomes, given their assessment of the situational factors.

In addition, the Bad News Response Model focuses on what lies in the future as a result of the bad news and not on the event that has passed. The model addresses responses to bad news and the outcomes of those responses on the future. Thus, the situational factors in the model do not pertain to the event that is being disclosed, but rather to the possible results of that event. These results include both direct outcomes of the bad news and indirect effects of the news on other parts of life. For example, a professor who must tell a student about a failing exam grade (the past event) should consider the impact of that exam on the student's final grade in the course (a direct future outcome) and on the student's overall academic status (an indirect future outcome) when determining the best strategy for bad news transmission.

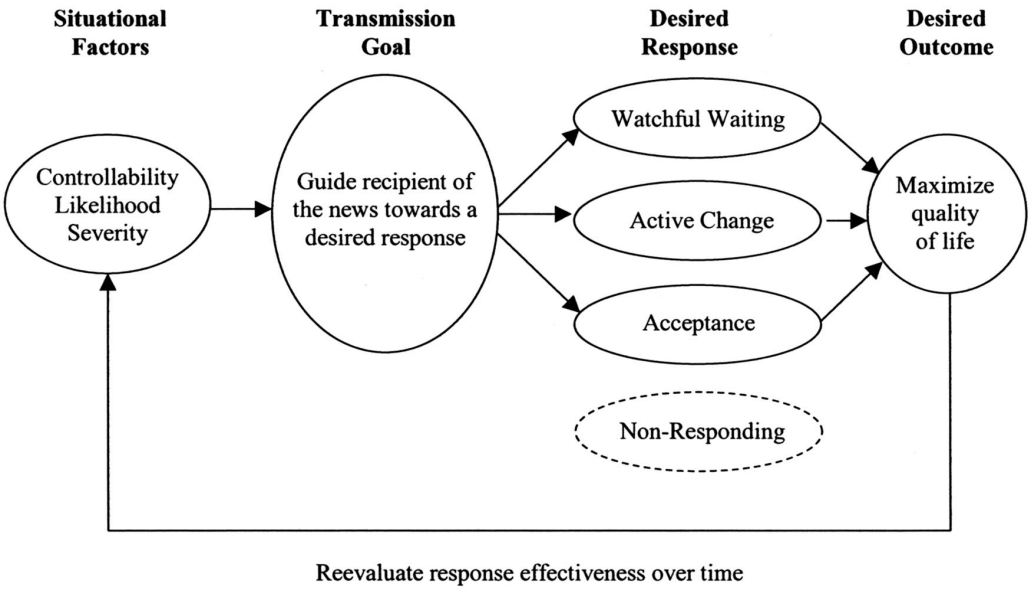

Figure 1. The Bad News Response Model.

How Can People Respond to Bad News?

The Bad News Response Model suggests that people can respond to bad news in one of four ways: (a) Watchful Waiting, (b) Active Change, (c) Acceptance, and (d) Nonresponding. These response categories broadly apply to many kinds of bad news, although the specific nature of each response may differ across domains. For example, a patient who responds to a diagnosis of cancer with Active Change will engage in different specific behaviors than will a student who responds to a failed exam with Active Change. However, we suggest that these two responses will be similar in fundamental ways.

As evident in Table 1, we anticipate that the four response categories will each elicit a unique pattern of characteristics in terms of anxiety, affect and activity level. Anxiety level refers to feelings of worry, concern, or fear. Affect refers to general positive or negative moods and emotions, such as happiness or sadness. Activity level refers to the extent to which energy is directed toward changing the outcomes of the bad news. Of note, the characteristics described may be present with all four responses to varying degrees, but we suggest that they are more likely to occur with their respective response.

The characteristics in Table 1 may be causes, consequences, or concomitants of each response choice. For example, people who experience high levels of anxiety in response to bad news may be more likely to see the need to take action, in which case anxiety serves as a cause. However, people may also deliberately choose to respond to bad news in a certain way, which can then lead to a variety of consequential thoughts and feelings. Finally, certain kinds of bad news may prompt both a particular response and particular thoughts and feelings independently. Within the present model, we simply discuss the dimensions in Table 1 as characterizing a given response category.

Table 1
Characteristics of the Three Response Categories

	Watchful Waiting	Active Change	Acceptance	Nonresponding
Anxiety	Low	High	Moderate	Low
Positive affect	Moderate	Low	Low	High
Negative affect	Low	High	High	Low
Activity level	Low	High	Moderate	Low

Watchful Waiting. The first category represents a relatively passive form of responding. The medical literature has employed the term "watchful waiting" as a specific contrast to aggressive treatment options (e.g., De Haes & Koedoot, 2003). Here, Watchful Waiting indicates a more general "wait and see" mentality regarding the bad news. The term "watchful" emphasizes that people engaged in this response are aware that they are facing a possible threat and are vigilant to changes in their situation. However, they maintain the status quo rather than take action. To illustrate, consider a man diagnosed with prostate cancer. The man is in his late 80s, a widower, and has few financial responsibilities. Although this man registers and accepts his diagnosis of cancer, he may choose not to get a second opinion or undergo treatment but instead go on with his life largely as if nothing had changed. He may make annual appointments to reassess his response, but otherwise his life remains as it was before his diagnosis.

Watchful Waiting bears similarity to the general conceptualization of emotion-focused coping (Folkman & Lazarus, 1980), although the specific characterization of emotion-focused coping differs widely between studies (Carver, Scheier, & Weintraub, 1989). The similarity resides in the fact that both Watchful Waiting and emotion-focused coping focus on distraction and emotional regulation. Emotion-focused coping entails to directing energy toward managing anxiety and other negative emotions arising from a stressful situation rather than engaging in active intervention. People in the Watchful Waiting category may engage in activities that distract them from the bad news. Behaviors that are designed to take one's mind off of a threat may be beneficial if no actions will make a difference, or if action would be too costly or if dwelling on the threat is counterproductive (Lazarus, 1985).

However, Watchful Waiting differs from emotion-focused coping in a fundamental way. Emotion-focused coping is not mutually exclusive with other more active forms of responding, and in fact, people may engage in emotion-focused coping in all four-response categories of the Bad News Response Model. Emotion-focused coping complements all forms of responding by reducing the intensity of stressful emotions and allowing people to gain perspective on their situation (Folkman & Lazarus, 1980). In contrast, Watchful Waiting involves a specific set of behaviors and emotions that represent one way of responding to bad news.

It seems likely that Watchful Waiting involves low anxiety, high general positive affect, and low activity level. Each of these characteristics results from distraction from the bad news and attention toward other, presumably positive aspects of life. Excessive focus on the bad news would increase anxious thoughts and feelings, induce sadness and distress, and lead to high activity levels in an effort to mobilize action toward change. People engaged in Watchful Waiting avoid this process by distracting themselves from the bad news.

Active Change. Active Change represents the most vigorous, engaged form of responding. Unlike the distraction or irrelevant activity characterizing Watchful Waiting, Active Change involves specific responses directed toward addressing the bad news. Active Change aligns most clearly with traditional views of productive coping strategies, such as problem-focused coping, that directly address the negative situation. Problem-focused coping in part involves taking action to solve a problem or change a negative situation (Carver et al., 1989; Folkman & Lazarus, 1980, 1985).

Active Change includes three types of behavior: information seeking, prevention, and treatment. Information seeking serves two purposes. First, information seeking provides recipients of bad news with the information they need to make decisions about how to respond. Second, information seeking serves to connect recipients with others who have dealt with similar experiences and provides a network of support. Of note, other researchers have discussed these roles of information seeking as part of problem-focused or active coping (Aldwin & Revenson, 1987; Lazarus, 1981; Lazarus & Launier, 1978).

The terms "prevention" and "treatment" have medical connotations, but in this context they broadly refer to behaviors directed toward preventing the situation from deteriorating (maintenance) and treating an undesirable situation that has emerged (improvement). To illustrate, consider a different man diagnosed with prostate cancer. This man is in his late 40s, has a wife and several children, and is the primary breadwinner for the family. Unlike the man in his 80s who chooses Watchful Waiting, the

second man may be very willing to undergo chemotherapy and radiation in hopes that it will eradicate the cancer and allow him to live a full and long life with his family. He should actively investigate his condition, perhaps seeking a second opinion or researching prostate cancer online or at the library, and undergo preventative and/or aggressive measures to prolong his life. Active Change also involves high anxiety and high activity levels. The high levels of anxiety result from acknowledgment that a negative event is likely to occur and/or that the consequences are severe. The high activity levels results from mobilization of energy toward active responses.

Acceptance. Acceptance is the third and most complex form of responding. This response is similar to previous conceptualizations of acceptance in the literatures on aging, disability, and death. Previous theories discuss acceptance as a last stage in coping with loss or impending death that comes after a process of denial (Gamliel, 2000; Kübler-Ross, 1969). Many theorists assert that acceptance is a positive coping strategy in uncontrollable circumstances. People who come to accept their circumstances are able to seek meaning in their loss, reduce their dread over what lies ahead, and seek social support to cope (Gamliel, 2000). On the other hand, other researchers have found little support for the assertion that acceptance is an adaptive coping strategy, and some studies even suggest that realistic acceptance might be predictive of negative outcomes (Greer et al., 1979; Reed, Kemeny, Taylor, Wang, & Visscher, 1994; Wortman & Silver, 1989).

We view Acceptance as action toward acceptance rather than passive resignation. People who respond to bad news with Acceptance do not necessarily collapse in a heap, although this response may be unavoidable at first. Instead, they eventually direct their energy toward moving forward and addressing any consequences of the bad news. Acceptance involves looking beyond the negative outcomes to the possibility for hope that lies in the future. Even in the case of imminent death, people can find hope in living life to the fullest during their remaining time and dying with dignity (Dean, 2002). Although this response is similar in many ways to previous conceptualizations of acceptance, it avoids the sense of passivity and hopelessness that may lead to negative outcomes. In addition, Acceptance is not a final, static state of resignation; instead, it involves an ongoing positive process of making the best of a bad situation.

Acceptance combines aspects of Watchful Waiting and Active Change to most effectively address situations in which a lack of engagement is inappropriate yet the person cannot change the outcome. People can direct their energy toward changing their lives rather than changing the negative event. This response bears similarity to the concept of secondary control, in which people change themselves to fit a situation rather than changing the situation to fit the self (i.e., primary control) (Rothbaum, Weisz, & Snyder, 1982). Secondary control represents an important form of control over one's emotional responses, but it does not involve engaging effort toward changing the situation.

Acceptance involves two types of behavior: information sharing and accommodation. Information sharing involves telling others about the negative event, although the extent of sharing with others may vary depending on the news. For example, certain types of bad news, such as testing HIV-positive, may stigmatize the individual, and people may want to limit their information sharing to close friends and family. Furthermore, the effectiveness of information sharing depends in part on the receptiveness of the listener (Harber & Pennebaker, 1992; Kelly & McKillop, 1996).

Information-sharing serves three purposes. First, information sharing helps people accept the negative event by making the event part of their social reality. People who keep negative events, such as a disease or a job loss, a secret from friends and family may be in denial that the event has occurred. Information sharing is both a step toward acceptance and a sign that such acceptance has begun. Second, information sharing elicits social support from friends and family. Researchers have distinguished between seeking social support for emotional reasons versus seeking social support for practical reasons (advice, assistance, etc.) (Carver et al., 1989). Acceptance focuses more on the emotional side of social support, rather than the more active, change-focused practical side. Third, information sharing seems to serve an important function in an end unto itself (Pennebaker, 1988; Pennebaker, Zech, & Rimé, 2001). Research finds that people who talk (or write) more about a traumatic event ruminate less (Pennebaker &

O'Heeron, 1984), experience less anxiety (Pennebaker, Colder, & Sharp, 1990), have fewer negative health outcomes (Pennebaker & O'Heeron, 1984), and have better quality of life (Spera, Buhrfeind, & Pennebaker, 1994), even when the expressions are private.

Accommodation involves making changes, not to affect the news-specific outcome, but rather to incorporate the negative event into one's life. When a negative outcome is uncontrollable, accommodation focuses people's energy on productive activity rather than futile efforts to change the outcome. For example, in most cases a woman who receives a rejection letter from her first choice graduate school should consider alternative schools or career plans rather than continuing to pursue admission at the school that rejected her. Accommodation often involves behavioral changes such as cutting back on strenuous activities in the case of a debilitating disease or putting away a lost loved one's personal items in the case of a death in the family. It often also involves cognitive changes that entail looking for reasons why the tragedy occurred (sense making) and focusing on positive changes resulting from the tragedy (benefit finding) (Davis, Nolen-Hoeksema, & Larson, 1998; Rabow & McPhee, 1999). Of note, other researchers have used the term accommodation differently, referring to a passive means of coping with old age that involves weakened aspirations and lowered standards of living (Brandtstadter, Dirk, & Werner, 1993). Here, we use accommodation to refer to an active process of reordering priorities and adjusting to the new situation.

In addition, the response of Acceptance involves general negative affect (including sadness, regret, guilt, etc.) and moderate activity level. People are likely to experience particularly negative feelings when a severe negative event occurs and they are helpless to change the outcomes. The specific types of negative affect people experience depend on the details of the bad news. For example, people may feel guilt and regret when they feel that they could have changed the outcome, as in the case of failing a class, but people are more likely to experience sadness and grief when they believe they could not have changed the outcome, as in the case of an unavoidable death. Regarding activity level, Acceptance does not involve the same level of energy mobilization as Active Change, but some effort is required to adapt to the negative event. People must direct their energy toward understanding and accepting the situation created by the bad news and dealing with the consequences, rather than taking active steps toward making significant life changes in an effort to change the outcomes of the bad news.

Nonresponding. The fourth category of responding captures a number of responses. Lubinsky (1994) distinguishes between four forms of nonresponding: denial, disbelief, deferral, and dismissal. Although the four may appear similar, their sources differ. Denial is form of repression brought on as a defense mechanism. It involves vehement disagreement with any disliked information, even when evidence makes it clear that the information is correct, and is a relatively rare response to bad news. Disbelief is marked by confusion rather than rejection of bad news and may result from a desire to maintain hope for longer than is warranted. Deferral is marked by avoidance of information about bad news as a result of inadequate resources to cope with the situation. People responding with deferral may accept the basis for bad news (e.g., results of a medical test) but reject or ignore the implications of those findings (i.e., the necessity of lifestyle changes or treatment). Finally, dismissal is marked by anger at the bad news-giver and denial of the news-giver's competence or legitimacy. These four reactions, though different in significant ways, all fall into the response category of Nonresponding.

Nonresponding is distinct from Watchful Waiting. Nonresponding is not an attempt to reduce anxiety about bad news while acknowledging it, but rather an attempt to pretend nothing has happened or "wish away" the bad news. Furthermore, Nonresponding may be most likely to occur in situations when Acceptance is called for. Both Watchful Waiting and Active Change are somewhat attractive responses: one allows people to monitor the news and defer action until it is appropriate, and the other involves taking action to change things for the better (De Haes & Koedoot, 2003). Acceptance, in contrast, requires people to face the news head-on and does not offer the hope that things will turn out well. Although Acceptance is necessary when a very bad outcome is unavoidable,

people may prefer to embrace Nonresponding instead. Nonresponding can feel good for a short time because it allows people to pretend that nothing has changed for the worse, but people eventually must face negative outcomes, such as the death of a loved one or a terminal illness, and cope with the consequences.

On the other hand, nonresponding may be an acceptable response in the short-term. A number of researchers and physicians note that denial is a necessary response for some people under certain circumstances, and a number of theorists have argued that news-givers should not force recipients to face bad news before they are ready (Bor et al., 1993; Faulkner, 1998; Greer et al., 1979; Radziewicz & Baile, 2001). As indicated in Figure 1, the Bad News Response Model indicates that Nonresponding is a legitimate but generally undesired response. News-givers may recognize that recipients are likely to engage in nonresponding at first, but the Bad News Response Model suggests that the goal of the news-giver is to guide people toward the response that will lead to the best long-term outcomes. Although Nonresponding may be functional at first, people must eventually face bad news and choose a different response.

How can people respond? Summary and conclusions. The Bad News Response Model suggests that people can respond to bad news in one of four ways: (a) Watchful Waiting, (b) Active Change, (c) Acceptance, and (d) Nonresponding. Watchful Waiting represents a relatively inactive response characterized by distraction activities and managing anxiety. Active Change is a highly active response primarily characterized by direct attempts to change the situation. Acceptance involves activity directed toward changing one's life to incorporate bad news rather than attempting to change the outcomes of the news. Nonresponding involves unproductive (at least in the long-term) avoidance or denial of bad news.

Although, thus far, we have discussed the four response categories as though they were mutually exclusive and as though selecting one response means rejecting other responses, people may display (or appear to display) multiple responses. Multiple responding can manifest in several ways. First, people may engage in multiple responses simultaneously. By so doing, people hedge their bets by putting some effort toward one response (e.g., trusting that things will go well, as in Watchful Waiting) while also recognizing and preparing for alternative possibilities (e.g., by taking measures to encourage a positive outcome, as in Active Change). For example, someone who learns of upcoming layoffs can engage in Watchful Waiting by delaying the search for a new job while also engaging in Active Change by delaying large purchases. This form of multiple responding recognizes that the future is uncertain and that what a person expects to occur may not occur. As Mohammed, the Muslim spiritual leader said, "trust in God, but tie your camel first" (Cleary, 2001).

People who seem to be engaging in multiple, simultaneous responses may also be responding to multiple levels of abstraction of the bad news. A single news event may include more than one form of bad news. A young man who learns that he failed a major project in a class relevant to a desired career has essentially received two pieces of news. First, he must deal with the possibility that he will fail the course. Second, he must deal with the implications of his failure on his qualifications to enter his desired career. He may respond with Active Change in regards to his course grade while simultaneously responding with Acceptance in regards to his career path. Alternatively, he may respond with Acceptance in regards to his course grade but take active measures to ensure that he performs well on other career-relevant criteria.

Finally, people may respond in different ways to one situation across time. For example, imagine that a physician finds a lump in a patient's breast. The physician may initially encourage Watchful Waiting, suggesting that the patient proceed with life as usual until the biopsy results come in. If the biopsy reveals malignancy, the physician might then recommend Active Change. Finally, if subsequent tests reveal that the cancer is resistant to treatment, the physician may suggest Acceptance. Thus, one broad situation may involve multiple news events, therefore allowing for the possibility of multiple responses. The Bad News Response Model can account for longitudinal events if news-givers and recipients reevaluate the situation at each point when new information is available (see Figure 1).

Which Responses Should News-Givers Suggest?

The Bad News Model suggests that bad news-givers should guide recipients toward desired responses; the model does not attempt to predict with certainty the best responses to bad news. The model ultimately relies on news-givers to determine the response that will lead to the best outcomes for recipients and then guide the recipients toward that response. However, bad news varies on a number of predictable dimensions, and research suggests that certain dimensions may lead one response to be more effective than others, depending on the situation. Specifically, examination of the vast literature on risk perception, health behavior, and coping reveals three factors that repeatedly emerge as playing a particularly important role in people's responses to the possibility of bad news and other stressful situations: the controllability of negative outcomes, the likelihood of negative outcomes, and the severity of negative outcomes.

Table 2 presents a summary of the responses that may be most effective for each combination of high and low controllability, likelihood, and severity. These suggestions represent the responses that seem most likely to be effective under different circumstances, in light of existing research on both responses to bad news and situational factors of the news. In general, we suggest that people should engage in Active Change when two or three of the situational factors are high (high control, high likelihood, and/or high severity) and Watchful Waiting when two or three of the situational factors are low (low control, low likelihood, and/or low severity). The only exception occurs when likelihood and severity are high but control is low. Under these circumstances, when severe negative outcomes are highly likely and little or nothing can be done to change the outcomes, we suggest that Acceptance is the best response.

Table 2
Impact of Situational Factors on Responding

	Low likelihood	High likelihood
Low severity		
Low control	Watchful Waiting	Watchful Waiting
High control	Watchful Waiting	Active Change
High severity		
Low control	Watchful Waiting	Acceptance
High control	Active Change	Active Change

It is noteworthy that perceptions of controllability, likelihood, and severity are somewhat subjective. Numerous studies demonstrate that people often function under an illusion of control when, in fact, chance determines their fate (Crocker, 1982; Langer, 1975; Langer & Roth, 1975). In addition, people misperceive the likelihood of events because of 64 misunderstandings of objective probabilities (Kahneman & Tversky, 1982; Tversky & Kahneman, 1974), undue focus on salient examples (MacLeod & Campbell, 1992; Slovic, Fischoff, & Lichtenstein, 1982), and a desire to avoid disappointment or regret (Carroll, Sweeny, & Shepperd, 2006; Sweeny & Shepperd, 2007). Finally, people often base their perceptions of severity on misleading information, such as prevalence, personal relevance, or illness stereotypes (Croyle & Williams, 1991; Jemmott, Ditto, & Croyle, 1986). One prominent model of coping suggests that people engage in an appraisal process to determine whether a stressful situation demands coping resources (Folkman & Lazarus, 1980; Lazarus, 1966; Lazarus & Folkman, 1984), and this appraisal process is subject to the many biases that color judgments. Thus, news-recipients undoubtedly choose responses that reflect misperceptions of bad news.

Although people's natural responses may be biased, the most effective response to bad news depends more on the actual controllability, likelihood, and severity of potential negative outcomes than on subjective perceptions of these factors. For example, a patient who misperceives the severity of his or her condition because of lack of knowledge or inaccurate understanding will not benefit from, and may even be hurt by, pursuing treatment based on this misperception. The purpose of this section is to discuss situational factors that may predict the effectiveness of responses to bad news. As such, objective levels of controllability, likelihood, and severity are more important for our purposes than subjective appraisals of these factors by news-recipients.

Controllability. The first factor that may influence effective responding to bad news is the controllability of the negative outcomes that may result from bad news. The ability to control the outcomes of bad news varies greatly across

different situations. For example, a student who discovers he or she is failing a course several weeks before the semester's end may be able to improve his or her grade by completing extra credit assignments, getting help from the professor, or studying long and hard for the final exam. However, as the semester draws to a close, control over the course grade diminishes, and once final course grades are turned in, there may be no remaining avenues to affect the outcome of the course.

Controllability plays a significant role in predicting people's responses to threat. The Health Belief Model (Becker, 1974; Janz & Becker, 1984; Kirscht, 1988) and Protection Motivation Theory (Floyd, Prentice-Dunn, & Rogers, 2000; Maddux & Rogers, 1983; Rogers, 1983) include measures of controllability (response efficacy and/or self-efficacy) as factors that predict whether people engage in preventative health behaviors, and the proactive coping model (Aspinwall & Taylor, 1997) indicates that perceived control plays a role in people's attempts to prevent negative events. Research on coping shows that the controllability of a stressful situation affects the strategies people choose to adopt when coping with stressful situations (Folkman & Lazarus, 1980). When people perceive event controllability to be high, they tend to adopt active coping strategies; when people perceive event controllability to be low, they tend to adopt strategies directed toward managing their emotions (Aldwin, 1991; Carver, Scheier, & Weintraub, 1989). Other studies find that the effectiveness of various coping strategies depends in large part on the controllability of the stressful situation, with active strategies proving most beneficial when the situation is controllable (Aldwin & Park, 2004; Park, 2001; Park, Armeli, & Tennen, 2004).

Likelihood. The second factor in determining the appropriate response to bad news is the likelihood of possible negative outcomes. Bad news does not always indicate a guaranteed negative outcome. For example, a boss may have to inform employees that the company must downsize without knowing who will lose their jobs. Physicians frequently give bad news that indicates the possibility of illness or injury based on initial evidence without the ability to diagnose a problem with complete certainty.

For the purposes of the model, "likelihood" refers to how likely negative outcomes are to occur *if* the news recipient does not act to prevent them. For example, the likelihood that a suspicious lump indicates cancer should be evaluated irrespective of treatment options or the patient's intentions to seek treatment. As such, likelihood is distinct from controllability. People may reduce the likelihood of negative outcomes by their response to bad news, but the initial evaluation of likelihood is separate from controllability.

Likelihood influences responding in two ways. First, and most intuitive, people consider the likelihood of a negative outcome in weighing the costs and benefits of an effortful and costly response. Several models include likelihood (or perceived vulnerability) as a predictor of health behavior (Becker, 1974; Rogers, 1983) and preventative behavior in general (see Theory of Reasoned Action, Ajzen & Fishbein, 1980; and Subjective Expected Utility Theory, Edwards, 1954).

Second, and less intuitive, the initial perception of likelihood of a negative outcome influences later affective reactions should the worst actually occur. Expectations about future outcomes play a role in how bad a bad outcome feels. Negative outcomes are unpleasant in their own right, but they are particularly unpleasant when they are unexpected (Shepperd & McNulty, 2002; van Dijk & van der Pligt, 1997). People who respond as if a negative outcome is unlikely to occur may have a particularly unpleasant experience if the outcome does occur, more so than if they had expected the worst. This finding suggests that people may benefit not only in terms of literal preparation, but also in terms of affective preparation by engaging in responses that are more active if the negative outcome is likely to occur.

Severity. The third factor in determining the appropriate response to bad news is the severity of the possible negative event. Bad news varies in terms of how important or consequential the possible negative outcome is. Clearly, a woman who learns that she is at risk for heartburn is hearing very different news than a woman who learns that she is at risk for a heart attack, and both the news-giver and the recipient of the news should proceed differently in these two situations. Of course, even news that has relatively nonsevere consequences can be bad. The woman who learns she has a high risk for heartburn may have to make significant dietary and other lifestyle changes. However, her response

will differ in many ways from the woman learning of her risk for heart attack, and the people giving the news to these women should also proceed differently.

The consequences or severity of bad news may differ based on a characteristic of the outcome (e.g., financial impact, life expectancy, effect on emotional well-being) or characteristics of the individual. The earlier examples of the two men diagnosed with prostate cancer illustrate how characteristics of the individual such as age, family circumstances, financial stability, and responsibilities can influence the consequences of bad news.

People naturally account for the severity of potential negative outcomes when they anticipate and respond to bad news. The severity of potential health outcomes predict whether people will engage in preventative health behavior (Becker, 1974; Rogers, 1983), and research on coping finds that people choose active coping strategies when they judge the event to be highly stressful or important (Anderson, 1977; Parkes, 1986; Terry, 1991). In addition, research on bracing for bad news finds that people only embrace a negative outlook for outcomes or consequences that are important (Shepperd, Findley-Klein, Kwavnick, Walker, & Perez, 2000). People brace less for outcomes that are unimportant because such outcomes are less consequential for them. For example, participants in one study who anticipated soon learning their test results for a medical condition shifted from optimism in their risk estimates only when the consequences of testing positive were severe. If the consequences were not severe, their predictions remained unchanged (Taylor & Shepperd, 1998). If possible negative outcomes are inconsequential or nonsevere, news-recipients gain more from choosing relatively passive responses (Watchful Waiting) than from engaging in physically or emotionally active responses (Active Change or Acceptance).

Communicating Desired Responses

Although the goal of the Bad News Response Model is not to elucidate specific details of the communication of bad news, the model suggests that the bad news-giver direct the recipient toward desired responses and offers insights into which responses may be most effective in different situations. The direction on behalf of the bad news-giver can encourage people to respond in the most effective way even in the face of problems with comprehension, arousal, education, and so forth

When preparing to give bad news, the communicator can evaluate the news situation in terms of the likelihood, severity, and controllability of negative outcomes and direct the communication toward encouraging the recipient to engage in the response that is most likely to be effective. The details of such direction will differ greatly depending on the specific topic and nature of the bad news, but these broad generalizations should be effective across a variety of domains and situations. It is important to note that the Bad News Response Model does not recommend that bad news-givers manipulate the recipient into responding in a particular way using whatever means necessary. Rather, news-givers should present all possible responses and the costs and benefits of each, and then give their opinion regarding the best possible response (Epstein, Alper, & Quill, 2006).

At first glance, the suggestion that news-givers should evaluate multiple aspects of the recipient's situation to give the bad news in the best way may seem impractical. In many cases, news-givers may know little about the recipient or the circumstances surrounding the bad news they must disclose. However, the model's suggestions represent an improvement over leaving bad news-givers to their own devices. News-givers who attempt to evaluate the bad news and guide recipients toward responses that are most likely to be effective, as suggested by the Bad News Response Model, will likely do a greater service for the recipients than would a news-giver with little or no guidance. Without guidance, news-givers often fall victim to personal concerns, such as not wanting to upset the recipient or be blamed for the news, that often trump concern for the best interest of the recipient (Buckman, 1984). Furthermore, recipients of bad news can use the model to evaluate their news and choose the best response when the news-giver is unable to guide them appropriately.

Summary, Critique, and Future Directions

The medical literature suggests a number of goals to help people give bad news well: new-

givers should reduce their own discomfort, provide sufficient information, promote recipient satisfaction, improve memory and understanding, reduce recipients' distress, and promote hope. However, none of these goals provides sufficient information or a broad enough objective to adequately guide people in giving bad news. We propose that giving bad news well should instead be defined as guiding news-recipients toward desired responses—responses that news-givers believe will result in the best long-term outcomes for recipients. The Bad News Response Model suggests that news-givers can look to situational factors (controllability, likelihood, and severity) to determine which of three responses (Watchful Waiting, Active Change, and Acceptance) is most likely to be effective.

Strengths of the Model

The Bad News Response Model has a number of strengths that improve previous attempts in the medical literature to study the processes of giving bad news. First, the model is applicable to a broad set of situations and domains, including academic performance, professional news, interpersonal news, medical diagnoses, and news of death, among others. Second, the model addresses the roles of both the bad news-giver and the recipient of the news by making suggestions for transmission based on the desired response. Third, the model systematically addresses different types of bad news in terms of the likelihood, severity, and controllability of possible negative outcomes of the news. Although the model draws on the strengths of previous research, it represents the first comprehensive model of giving and responding to bad news.

The Bad News Response Model can serve several important purposes. First, the model can assist bad news-givers who otherwise must rely on their own limited experience or personal motivations when giving bad news. The Bad News Response Model provides a goal for bad news transmission that can reduce the impact of the news-giver's concerns on their news-giving strategies by guiding them toward recipient-focused strategies.

Second, bad news-givers can use the model to evaluate their transmission of news after the fact. If news-givers observe recipients making an undesired response, they can examine their transmission strategy in light of the model. The news-giver may have incorrectly assessed one or more of the situational factors, or the suggestion of the best response may have been ineffective. For example, physicians may be unaware of their patients' financial circumstances, and this lack of information could result in misjudgment of the severity and/or controllability of patients' medical conditions. Physicians might assume that expensive treatments are feasible when in fact the patient does not have insurance or the means to pay for the treatments, making the prognosis relatively uncontrollable. Even when physicians perfectly assess the situational factors, patients often mishear or forget information conveyed in a diagnostic communication (Croyle, Loftus, Klinger, & Smith, 1993). The best efforts of news-givers to prompt desired responding can be lost if the recipient tunes out the transmission. Bad news-givers who notice seemingly ineffective responding by recipients can seek additional information to better judge the situational factors or reevaluate the bad news transmission for signs of lack of attention or misunderstanding on the part of the recipient.

Third, bad news recipients can use the model to evaluate their responses to bad news, apart from the giver. After receiving bad news, recipients can use the model to determine the most appropriate response by evaluating the likelihood, severity, and controllability of the possible outcomes. For example, a woman who learns of upcoming layoffs at work can consider the likelihood that she will lose her job, how bad the consequences of a job loss would be, and if she has control over whether she is laid off. Having evaluated the situation, she may have a better sense of the most effective response. This process may help people to override responses based solely on anxiety or fear. In addition, recipients who find that their response to some news is ineffective can reexamine the situational factors involved and possibly adjust their responses accordingly. If the woman facing a possible job loss responds with Active Change and then finds that she is making no progress toward keeping her job, she may decide to shift toward Acceptance by checking the want ads and telling her family about the layoffs.

Limitations of the Model

Although the Bad News Response Model is based on research from psychology, medicine and health, the model is largely speculative and remains untested. In addition, the model makes broad suggestions to allow the greatest breadth of application. This focus on the functionality of the model leads to an emphasis on generality over detail. As a result, the Bad News Response model may be imperfect in certain specific situations, while making suggestions that lead to the best outcomes overall. People often make miracle recoveries from medical conditions that were, by all accounts, beyond hope. Although the model would recommend Acceptance in these cases, people can choose to take risks and pursue unlikely cures in hopes of such a miracle. However, the model plays the odds by suggesting the response that will *most often* result in the best outcomes.

The model does not provide specific suggestions regarding how news-givers should communicate their suggestion of the best response in a way that insures recipients will respond as desired. Other researchers have addressed techniques of news transmission in both the medical literature and in the literatures on persuasion and communication, but future research may be required to determine the specific application of that research to the goal of guiding news-recipients toward desired responses. One strategy that may prove successful is for news-givers to help recipients reach accurate conclusions about the controllability, likelihood, and severity of potential negative outcomes of bad news. The research reviewed earlier suggests that people naturally respond to bad news in light of these situational factors, but their assessment of these factors may be inaccurate or biased. News-givers can provide recipients with more objective information about the bad news, thus making desired responding more likely.

Finally, the model does not specify precisely how people should evaluate the three situational factors, or how to determine whether the factors are "high" or "low". The situational factors fall on a continuum, and the distinction between high versus low is relative. For example, bad news that is low in severity may be significantly more severe than neutral news, but it is low in severity compared to other types of bad news. Research examining people's perceptions of various events, as well as the most effective responses to these events, will address the question of how to evaluate the situational factors of bad news.

Future Directions

The first step for future research is to test the effectiveness of the Bad News Response Model as a model for giving bad news well. Four questions deserve attention. First, are the four responses in the model exhaustive, or are there other possible responses? Second, do the responses suggested in the model, which derive from the three situational factors, produce the best quality of life? Third, how do people naturally respond to bad news under various circumstances, and can bad news-givers improve the likelihood that people will make the desired responses? Fourth, how can news-givers best guide recipients toward a desired response once the desired response is determined? The model makes predictions for each of these questions, and studies are currently underway to test these predictions.

A second direction for future research is to examine the specific characteristics of the four responses to bad news. Table 1 makes predictions regarding the cognitive, emotional, and behavioral characteristics of each response. For example, we suggest that Watchful Waiting is characterized by low anxiety, high general positive affect, and low arousal. Studies examining people's emotional states and activity level while engaging in Watchful Waiting, and likewise Active Change and Acceptance, can examine these characteristics.

A third area for future research is the influence of individual differences on people's responses to bad news. The model attempts to make predictions that generalize across people and circumstances. However, individual differences may affect responding in two ways. First, individual differences likely affect people's natural responses to bad news. For example, self-efficacy could increase the likelihood of choosing Active Change over the other response categories. Second, individual differences likely influence both the actual and perceived experiences of the likelihood, severity, and controllability of negative outcomes. The 80- and 40-year-old men with prostate cancer described earlier provide one example of how differences

such as age, priorities, and resources affect the best response to bad news. For example, the same disease with the same prognosis has more severe consequences for the man with responsibilities to his family than for the man with few responsibilities. Although the disease may be equally severe for the two men, the consequences of the disease on other areas of their lives are likely to differ in severity.

Finally, future studies can examine the application of the Bad News Response Model to different cultures and developmental stages. Several studies find that people give medical bad news differently in different cultures (Searight & Gafford, 2005). For example, patients in China often receive less information about their diagnoses than patients in the United States (Tse, Chong, & Fok, 2003), and cancer patients in England report that their doctors used the word "cancer" much less frequently than patients in the United States (Newall et al., 1987). These findings suggest that the Bad News Response Model may apply across cultures, but it is possible that cultural values and traditions may affect the way in which some aspects of the model are applied. As such, culture may act as an individual difference variable that affects natural responses to bad news. For example, differences in personal agency between Eastern and Western cultures may lead people to respond with Active Change more in the West than in the East, and this difference would affect the ease with which news-givers are able to guide people toward the three responses in different cultures.

Furthermore, although people of all ages receive bad news, the cognitive and emotional responses of children are likely not comparable to those of late-adolescents or adults. Young children and adolescents may have a difficult time expressing complex emotional reactions and making complex decisions (Inhelder & Piaget, 1958). The Bad News Response Model may be applicable to all ages, but the nature of its applicability likely differs across developmental stages. For example, the model may apply better to the primary caregiver than to the child diagnosed with a severe illness, or better to the adult child than to the senile parent given news of failing health. The Bad News Response Model assumes that recipients of bad news are in a position to choose between different possible responses. In the cases just described, the family member, not the primary recipient of the news, will make decisions about treatment options.

Coda

The medical literature provides many useful suggestions for giving bad news but falls short of providing an overarching goal for bad news-givers. The Bad News Response Model represents an improvement over the existing work on giving bad news by providing a framework that includes all types of bad news, incorporates a number of valuable goals for bad news transmission, and addresses the role of both the news-giver and the recipient. A comprehensive and systematic model of bad news transmission benefits not only people who must give bad news, but also those receiving the news. People receiving bad news must not only address the subject of the news itself, but also their emotional reactions to the news. Poor coping can lead to depression, anxiety, and other mental health concerns. The Bad News Response Model strives to provide bad news-givers the tools they need to improve the recipient's ability to respond effectively to the situation at hand.

References

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting behavior.* Englewood Cliffs, NJ: Prentice Hall.

Aldwin, C. M. (1991). Does age affect the stress and coping process? Implication of age differences in perceived control. *Journal of Gerontology, 46,* 174–180.

Aldwin, C. M., & Park, C. L. (2004). Coping and physical health outcomes: An overview. *Psychology and Health, 19,* 277–281.

Aldwin, C. M., & Revenson, T. A. (1997). Does coping help? A reexamination of the relation between coping and mental health. *Journal of Personality and Social Psychology, 53,* 337–348.

Ambuel, B., & Mazzone, M. F. (2001). Breaking bad news and discussing death. *Primary Care, 28,* 249–267.

Anderson, C. R. (1977). Locus of control, coping behaviors, and performance in a stress setting: A longitudinal study. *Journal of Applied Psychology, 62,* 446–451.

Aspinwall, L., & Taylor, S. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin, 121,* 417–436.

Back, A. L., & Curtis, A. R. (2002). Communicating bad news. *Western Journal of Medicine, 176,* 177–180.

Baile, W. F., & Aaron, J. (2005). Patient-physician communication in oncology: Past, present, and future. *Current Opinion in Oncology, 17,* 331–335.

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Baile, E. A., & Kudelka, A. P. (2000). SPIKES: A six-step protocol for delivering bad news. *Oncologist, 5,* 302–311.

Baile, W. F., Kudelka, A. P., Beale, E. A., Glober, G. A., Myers, E. G., Greisinger, A. J., et al. (1999). Communication skills training in oncology. *Cancer, 86,* 887–897.

Becker, M. H. (Ed.) (1974). The health belief model and personal health behavior. *Health Education Monographs, 2.*

Bor, R., Miller, R., Goldman, E., & Scher, I. (1993). The meaning of bad news in HIV disease: Counseling about dreaded issues revisited. *Counseling Psychology Quarterly, 6,* 69–80.

Boyd, J. R. (2001). A process for delivering bad news: Supporting families when a child is diagnosed. *Journal of Neuroscience Nursing, 33,* 14–20.

Brandtstadter, J., Dirk, W., & Werner, G. (1993). Adaptive resources of the aging self: Outlines of emergent perspectives. *International Journal of Behavioral Development, 16,* 323–349.

Brewin, T. B. (1991). Three ways of giving bad news. *The Lancet, 337,* 1207–1209.

Bruhn, J. G. (1984). Therapeutic value of hope. *Southern Medical Journal, 77,* 215–219.

Buckman, R. (1984). Breaking bad news: Why is it still so difficult? *British Medical Journal, 288,* 1597–1599.

Butow, P. N., Kazemi, J. N., Beeney, L. J., Griffin, A., Dunn, S. M., & Tattersall, M. H. N. (1996). When the diagnosis is cancer: Patient communication experiences and preferences. *Cancer, 77,* 2630–2637.

Carroll, P. J., Sweeny, K., & Shepperd, J. A. (2006). Forsaking Optimism. *Review of General Psychology, 10,* 56–73.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56,* 267–283.

Charlton, R. C. (1992). Breaking bad news. *Medical Journal of Australia, 157,* 615–621.

Clark, R. E., & LaBeff, E. E. (1982). Death telling: Managing the delivery of bad news. *Journal of Health and Social Behavior, 23,* 366–380.

Clayton, J. M., Butow, P. N., Arnold, R. M., & Tattersall, M. H. N. (2005). Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer, 103,* 1965–1975.

Cleary, T. (2001). *The wisdom of the prophet: Sayings of Muhammad, selections from the Hadith.* Boston: Shambhala.

Crocker, J. (1982). Biased questions in judgment of covariation studies. *Personality and Social Psychology Bulletin, 8,* 214–220.

Croyle, R. T., Loftus, E. F., Klinger, M. R., & Smith, K. D. (1993). In J. R. Schement & B. D. Ruben (Eds.), *Between communication and information. Information and behavior* (Vol. 4, pp. 255–268). New Brunswick, NJ: Transaction Publishers.

Croyle, R. T., & Williams, K. D. (1991). Reaction to medical diagnosis: The role of illness stereotypes. *Basic and Applied Social Psychology, 12,* 227–241.

Damian, D., & Tattersall, M. H. N. (1991). Letters to patients: Improving communication in cancer care. *Lancet, 338,* 923–926.

Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefiting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology, 75,* 561–574.

Dean, A. (2002). Talking to dying patients of their hopes and needs. *Nursing Times, 98,* 34–35.

De Haes, H., & Koedoot, N. (2003). Patient centered decision making in palliative cancer treatment: A world of paradoxes. *Patient Education and Counseling, 50,* 43–49.

Derdiarian, A. K. (1989). Effects of information on recently diagnosed cancer patients' and spouses' satisfaction with care. *Cancer Nursing, 12,* 285–292.

Dias, L., Chabner, B. A., Lynch, T. J., & Penson, R. T. (2003). Breaking bad news: A patient's perspective. *The Oncologist, 8,* 587–596.

Doyle, D., & O'Connell, S. (1996). Breaking bad news: Starting palliative care. *Journal of the Royal Society of Medicine, 89,* 590–591.

Dunn, S. M., Butow, P. N., Tattersall, M. H., Jones, Q. J., Sheldon, J. S., Taylor, J. J., et al. (1993). General information tapes inhibit recall of the cancer consultation. *Journal of Clinical Oncology, 11,* 2279–2285.

Edwards, W. (1954). The theory of decision making. *Psychological Bulletin, 51,* 380–417.

Eggly, S., Afonso, N., Rojas, G., Baker, M., Cardoza, L., & Robertson, R. S. (1997). An assessment of residents' competence in the delivery of bad news to patients. *Academic Medicine, 72,* 397–399.

Ellis, P. M., & Tattersall, M. H. N. (1999). How should doctors communicate the diagnosis of cancer to patients? *Annals of Medicine, 31,* 336–341.

Epstein, R. M., Alper, B. S., & Quill, T. E. (2006). Communicating evidence for participatory decision making. *Journal of the American Medical Association, 291,* 2359–2366.

Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. *The Lancet, 363,* 312–319.

Fallowfield, L., Jenkins, V., & Beveridge, H. A. (2002). Truth may hurt but deceit hurts more: Communication in palliative care. *Palliative Medicine, 16,* 297–303.

Faulkner, A. (1998). ABC of palliative care: Communication with patients, families, and other professionals. *British Medical Journal, 316,* 130–132.

Floyd, D., Prentice-Dunn, S., & Rogers, R. (2000). A meta-analysis of research on protection motivation theory. *Journal of Applied Social Psychology, 30,* 407–429.

Fogarty, L. A., Curbow, B. A., Wingard, J. R., McDonnell, K., & Somerfield, M. R. (1999). Can 40 seconds of compassion reduce patient anxiety? *Journal of Clinical Oncology, 17,* 371–379.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior, 21,* 219–239.

Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: A study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48,* 150–170.

Freedman, B. (1993). Offering truth: One ethical approach to the uniformed cancer patient. *Archive of Internal Medicine, 153,* 572–576.

Gamliel, T. (2000). The lobby as an arena in the confrontation between acceptance and denial of old age. *Journal of Aging Studies, 14,* 251–271.

Gillotti, C., Thompson, T., & McNeilis, K. (2002). Communicative competence in the delivery of bad news. *Social Science and Medicine, 52,* 1011–1023.

Girgis, A., Sanson-Fisher, R. W., & Schofield, M. J. (1999). Is there consensus between breast cancer patients and providers on guidelines for breaking bad news? *Journal of Behavioral Medicine, 25,* 69–77.

Goldie, L. (1982). The ethics of telling the patient. *Journal of Medical Ethics, 8,* 128–133.

Greer, S., Morris, T., & Pettingale, K. W. (1979). Psychological response to breast cancer: Effect on outcome. *Lancet, 2,* 785–787.

Groopman, J. (2004). *The anatomy of hope: How people prevail in the face of illness*. New York: Random House.

Hagerty, R. G., Butow, P. N., Ellis, P. M., Lobb, E. A., Pendlebury, S. C., Leighl, N., et al. (2005). Communicating with realism and hope: Cancer patients' views on the disclosure of prognosis. *Journal of Clinical Oncology, 23,* 1278–1288.

Harber, K. D., & Pennebaker, J. W. (1992). Overcoming traumatic memories. In S. A. Christianson (Ed.), *The handbook of emotion and memory* (pp. 359–388). Hillsdale, NJ: Erlbaum.

Hogbin, B., Jenkins, V. A., & Parkin, A. J. (1992). Remembering "bad news" consultations: An evaluation of tape-recorded consultations. *Psychooncology, 1,* 147–154.

Holland, J. C. (1989). Now we tell, but how well? *Journal of Clinical Oncology, 7,* 557–559.

Hurwitz, C. A., Duncan, J., & Wolfe, J. (2004). Caring for the child with cancer at the close of life: "There are people who make it, and I'm hoping I'm one of them." *Journal of the American Medical Association, 292,* 2141–2149.

Inhelder, B., & Piaget, J. (1958). *The growth of logical thinking: From childhood to adolescence.* New York: Basic Books, Inc.

Janz, N., & Becker, M. (1984). The health belief model: A decade later. *Health Education Quarterly, 11,* 1–47.

Jemmot, J. B., Ditto, P. H., & Croyle, R. T. (1986). Judging health status: Effects of perceived prevalence and personal relevance. *Journal of Personality and Social Psychology, 50,* 899–905.

Kübler-Ross, E. (1969). *On death and dying.* New York: Macmillan.

Kahneman, D., & Tversky, A. (1982). On the study of statistical intuitions. *Cognition, 11,* 123–141.

Kelly, A. E., & McKillop, K. J. (1996). Consequences of revealing personal secrets. *Psychological Bulletin, 120,* 450–465.

Kirscht, J. (1988). The health belief model and predictions of health actions. In D. S. Gochman (Ed.), *Health behavior: Emerging research perspectives* (pp. 27–41). New York: Plenum Press.

Lalos, A. (1999). Breaking bad news concerning fertility. *Human Reproduction, 14,* 581–585.

Lamont, E. B., & Christakis, N. A. (2001). Prognostic disclosure to patients with cancer near the end of life. *Annals of Internal Medicine, 134,* 1096–1105.

Langer, E. J. (1975). The illusion of control. *Journal of Personality and Social Psychology, 32,* 311–328.

Langer, E. J., & Roth, J. (1975). Heads I win, tails it's chance: The illusion of control as a function of the sequence of outcomes in a purely chance task. *Journal of Personality and Social Psychology, 32,* 951–955.

Lazarus, R. S. (1966). *Psychological stress and the coping process.* New York: McGraw-Hill.

Lazarus, R. S. (1981). The stress and coping paradigm. In C. Eisdorfer, D. Cohen, A. Kleinman, & P. Maxim (Eds.), *Models for clinical psychopathology* (pp. 177–214). New York: Spectrum.

Lazarus, R. S. (1985). The costs and benefits of denial. In A. Monat & R. S. Lazarus (Eds.), *Stress and coping* (2nd ed., pp. 154–173). New York: Columbia University Press.

Lazarus, R. S., & Launier, R. (1978). Stress-related transactions between person and environment. In L. A. Pervin & M. Lewis (Eds.), *Perspectives in interactional psychology* (pp. 287–327). New York: Plenum Press.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lerman, C., Daly, M., Walsh, W. P., Resch, N., Seay, J., Barsevick, A., et al. (1993). Communication between patients with breast cancer and health care providers: Determinants and implications. *Cancer, 72,* 2612–2620.

Links, M., & Kramer, J. (1994). Breaking bad news: Realistic versus unrealistic hopes. *Supportive Care in Cancer, 2,* 91–93.

Loge, J. H., Kaasa, S., & Hytten, K. (1997). Disclosing the cancer diagnosis: The patients' experiences. *European Journal of Cancer, 33,* 878–882.

Lubinsky, M. S. (1994). Bearing bad news: Dealing with the mimics of denial. *Journal of Genetic Counseling, 3,* 5–12.

MacLeod, C., & Campbell, L. (1992). Memory accessibility and probability judgments: An experimental evaluation of the availability heuristic. *Journal of Personality and Social Psychology, 63,* 890–902.

Maddux, J., & Rogers, R. (1983). Protection motivation and self-efficacy: A revised theory of fear appeals and attitude change. *Journal of Experimental Social Psychology, 19,* 469–479.

Mager, W. M., & Andrykowski, M. A. (2002). Communication in the cancer "bad news" consultation: Patient perceptions and psychological adjustment. *Psycho-Oncology, 11,* 35–46.

Maguire, P. (1998). Breaking bad news. *European Journal of Surgical Oncology, 24,* 188–199.

Mast, M. S., Kindlimann, A., & Langewitz, W. (2005). Recipients' perspectives on breaking bad news: How you put it really makes a difference. *Patient Education and Counseling, 58,* 244–251.

McClenahen, L., & Lofland, J. (1976). Bearing bad news: Tactics of the Deputy U.S. Marshal. *Sociology of Work and Occupations, 3,* 251–272.

McHugh, P., Lewis, S., Ford, S., Newlands, E., Rustin, G., Coombes, C., et al. (1995). General information tapes inhibit recall of the cancer consultation. *British Journal of Cancer, 71,* 388–392.

Michaels, E. (1983). Deliver bad news tactfully. *Canadian Medical Association, 129,* 1307–1308.

Myers, B. A. (1983). The informing interview: Enabling patients to "hear" and cope with bad news. *American Journal of Disabled Children, 137,* 572–577.

Newall, D. J., Gadd, E. M., & Priestman, T. J. (1987). Presentation of information to cancer patients: A comparison of two centres in the UK and USA. *British Journal of Medical Psychology, 60,* 127–131.

Nisbett, R. E., & Wilson, T. D. (1977). Telling more than we can know: Verbal reports on mental processes. *Psychological Review, 84,* 231–259.

Parathian, A. R., & Taylor, F. (1993). Can we insulate trainee nurses from exposure to bad practice? A study of role play in communicating bad news to patients. *Journal of Advanced Nursing, 18,* 801–807.

Park, C. L., Armeli, S., & Tennen, H. (2004). Appraisal-coping goodness of fit: A daily internet study. *Personality and Social Psychology Bulletin, 30,* 558–569.

Park, C. L., Folkman, S., & Bostrom, A. (2001). Appraisals of controllability and coping in caregivers and HIV+ men: Testing the goodness-of-fit hypothesis. *Journal of Consulting and Clinical Psychology, 69,* 481–488.

Parkes, K. R. (1986). Coping in stressful episodes: The role of individual differences, environmental factors, and situational characteristics. *Journal of Personality and Social Psychology, 51,* 1277–1292.

Pennebaker, J. W. (1988). Confiding traumatic experiences and health. In S. Fisher & J. Reason (Eds.), *Handbook of life stress, cognition and health* (pp. 669–682). Oxford, England: Wiley.

Pennebaker, J. W., Colder, M., & Sharp, L. K. (1990). Accelerating the coping process. *Journal of Personality and Social Psychology, 58,* 528–537.

Pennebaker, J. W., & O'Heeron, R. C. (1984). Confiding in others and illness rate among spouses of suicide and accidental-death victims. *Journal of Abnormal Psychology, 93,* 473–476.

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

Penson, R. T., Partridge, R. A., Shah, Muhammad, A., Giansiracusa, D., Chabner, B. A., & Lynch, T. A., Jr. (2005). Fear of death. *The Oncologist, 10,* 160–169.

Peteet, J. R., Abrams, H. E., Ross, D. M., & Sterns, N. M. (1991). Presenting a diagnosis of cancer: Patients' views. *Journal of Family Practice, 32,* 577–581.

Ptacek, J. T., & Eberhardt, T. L. (1996). Breaking bad news: A review of the literature. *Journal of the American Medical Association, 276,* 496–502.

Ptacek, J. T., & Ptacek, J. J. (2001). Patients' perceptions of receiving bad news about cancer. *Journal of Clinical Oncology, 19,* 4160–4164.

Quill, T. E. (1991). Bad news: Delivery, dialogue, and dilemmas. *Archive of Internal Medicine, 151,* 463–468.

Rabow, M. W., & McPhee, S. J. (1999). Beyond breaking bad news: How to help patients who suffer. *Western Journal of Medicine, 171,* 260–263.

Radziewicz, R., & Baile, W. F. (2001). Communication skills: Breaking bad news in the clinical setting. *Oncology Nursing Forum, 28,* 951–953.

Ramirez, A. J., Graham, J., Richards, M. A., Cull, A., Gregory, W. M., Leaning, M. S., et al. (1995). Burnout and psychiatric disorder among cancer clinicians. *British Journal of Cancer, 71,* 1263–1269.

Randall, T. C., & Wearn, A. M. (2005). Receiving bad news: Patients with haematological cancer reflect upon their experience. *Palliative Medicine, 19,* 594–601.

Reed, J. M., Kemeny, M. E., Taylor, S. E., Wang, H. J., & Visscher, B. R. (1994). Realistic acceptance as a predictor of decreased survival time in gay men with AIDS. *Health Psychology, 13,* 299–307.

Reynolds, P. M., Sanson-Fisher, R. W., Poole, A. D., Harker, J., & Byrne, M. J. (1981). Cancer and communication: Information-giving in an oncology clinic. *British Medical Journal, 282,* 1449–1451.

Richman, L. S., Kubzansky, L., Maselko, J., Kawachi, I., Choo, P., & Bauer, M. (2005). Positive emotion and health: Going beyond the negative. *Heath Psychology, 24,* 422–429.

Roberts, C. S., Cox, C. E., Reintgen, C. S., Baile, W. F., & Gibertini, M. (1994). Influence of physician communication on newly diagnosed breast cancer patients' psychologic adjustment and decision-making. *Cancer, 74,* 336–341.

Rogers, R. W. (1983). Cognitive and psychological processes in fear appeals and attitude change: A revised theory of protection motivation. In J. T. Cacioppo & R. E. Petty (Eds.), *Social psychophysiology* (pp. 153–176). New York: Guilford Press.

Rosen, S., & Tesser, A. (1970). On reluctance to communicate undesirable information: The MUM effect. *Sociometry, 33,* 253–263.

Rothbaum, F., Weisz, J. R., Snyder, S. S. (1982). Changing the world and changing the self: A two-process model of perceived control. *Journal of Personality and Social Psychology, 42,* 5–37.

Sabbioni, M. E. (1997). Informing cancer patients: Whose truth matters? *Annals of the New York Academy of Sciences, 809,* 508–513.

Salander, P. (2002). Bad news from the patient's perspective: An analysis of the written narratives of newly diagnosed cancer patients. *Social Science & Medicine, 55,* 721–732.

Sardell, A. N., & Trierweiler, S. J. (1993). Disclosing the cancer diagnosis: Procedures that influence patient hopefulness. *Cancer, 72,* 3355–3365.

Schofield, P. E., Butow, P. N., Thompson, J. F., Tattersall, M. H. N., Beeney, L. J., & Dunn, S. M. (2003). Psychological responses of patients receiving a diagnosis of cancer. *Annals of Oncology, 14,* 48–56.

Searight, H. R., Gafford, J. (2005). Cultural diversity at the end of life: Issues and guidelines for family physicians. *American Family Physician, 71,* 515–522.

Segerstrom, S., Taylor, S., Kemeny, M., & Fahey, J. (1998). Optimism is associated with mood, coping and immune change in response to stress. *Journal of Personality and Social Psychology, 74,* 1646–1655.

Shepperd, J. A., Findley-Klein, C., Kwavnick, K. D., Walker, D., & Perez, S. (2000). Bracing for loss. *Journal of Personality and Social Psychology, 78,* 620–634.

Shepperd, J. A., & McNulty, J. K. (2002). The affective consequences of expected and unexpected outcomes. *Psychological Science, 13,* 85–88.

Shields, C. E. (1998). Giving patients bad news. *Primary Care, 25,* 381–390.

Silliman, R. A., Dukes, K. A., Sullivan, L. M., & Kaplan, S. H. (1998). Breast cancer care in older women: Sources of information, social support, and emotional health outcomes. *Cancer, 83,* 706–711.

Simpson, C. (2004). When hope makes us vulnerable: A discussion of the patient-healthcare provider interactions in the context of hope. *Bioethics, 18,* 428–447.

Slovic, P., Fischoff, B., & Lichtenstein, S. (1982). Facts versus fears: Understanding perceived risk. In D. Kahneman, P., Slovic, & A. Tversky (Eds.), *Judgment under uncertainty: Heuristics and biases* (pp. 463–489). New York: Cambridge University Press.

Snyder, C. R. (1999). *Coping: The psychology of what works.* New York: Oxford University Press.

Spera, S. P., Buhrfeind, E. D., & *Pennebaker,* J. W. (1994). Expressive writing and coping with job loss. *Academy of Management Journal, 37,* 722–733.

Sweeney, K., & Shepperd, J. A. (2007). Do people brace sensibly? Risk judgments and event likelihood. *Personality and Social Psychology Bulletin, 33,* 1064–1075.

Taylor, K. M., & Shepperd, J. A. (1998). Bracing for the worst: Severity, testing and feedback as moderators of the optimistic bias. *Personality and Social Psychology Bulletin, 24,* 915–926.

Taylor, S., Lichtman, R., & Wood, J. (1984). Attributions, beliefs about control, and adjustment to breast cancer. *Journal of Personality and Social Psychology, 46,* 489–502.

Terry, D. J. (1991). Coping resources and situational appraisals as predictors of coping behavior. *Per-*

sonality and Individual Differences, 12, 1031–1047.

Tse, C. Y., Chong, A., & Fok, S. Y. (2003). Breaking bad news: A Chinese perspective. *Palliative Medicine, 17,* 339–343.

Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science, 185,* 1124–1131.

Ungar, L., Alperin, M., Amiel, G. E., Beharier, Z., & Reis, S. (2002). Breaking bad news: Structured training for family medicine residents. *Patient Education and Counseling, 48,* 63–68.

van Dijk, W., Zeelenberg, M., & van der Pligt, J. (1999). Not having what you want versus having what you do not want: The impact of type of negative outcome on the experience of disappointment and related emotions. *Cognition & Emotion, 13,* 129–148.

van Dijk, W. W., & van der Pligt, J. (1997). The impact of probability and magnitude of outcome on disappointment and elation. *Organizational Behavior and Human Decision Processes, 69,* 277–284.

Ward, C. G. (1992). "The die is cast": Telling patients they are going to die. *Journal of Burn Care and Rehabilitation, 13,* 272–274.

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

Yates, P. (1993). Toward a reconceptualization of hope for patients with a diagnosis of cancer. *Journal of Advanced Nursing, 18,* 701–706.

Received August 31, 2006
Accepted December 20, 2006 ■

E-Mail Notification of Your Latest Issue Online!

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at http://watson.apa.org/notify/ and you will be notified by e-mail when issues of interest to you become available!