

## Understanding and working with the concept of denial and its role as a coping strategy

An exploration of what denial is, why nurses should accept it as normal and how patients use it in the process of finding ways of coping with a difficult prognosis

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**ABSTRACT Hardy, R., Kell, C. (2009) Understanding and working with the concept of denial and its role as a coping strategy. *Nursing Times*; 105: 32, 22–24. We are psychological therapists working as part of a specialist palliative care team, and receive referrals for patients who are psychologically distressed and frequently described as being 'in denial'. In this article, we explain what denial is and how patients use this process as they try to find different ways of coping with their prognosis.**

As psychological therapists involved in supporting patients needing palliative care, we have noticed that the normal defence of denial is often a process of disavowal.

This means that patients adopt dual thinking as their way of coping with their diagnosis and prognosis. They appear to be able to have a rational discussion with healthcare professionals about their future, while at the same time maintaining a set of beliefs that appear to be irrational.

Numerous clinicians have noted that the concept of 'denial' is complex (Vos and de Haes, 2007; Salander and Windahl, 1999). Freud identified two different defences against unbearable reality:

- **Denial:** The repudiation of reality – an entirely unconscious process of repressing or forgetting information that we have been given;
- **Disavowal:** Allows individuals to accept the information they have been given, while

finding ways to minimise its impact (Freud, 1927).

Nurses are usually familiar with the term 'in denial', but may not be familiar with the term 'disavowal'.

Basch (1983) called disavowal 'self-deception in the face of accurate perception'. Patients create a more bearable story of what is happening to them, and move between the medical story (which nurses might feel is the *real* story) and their own version of events (which might well be a *healthy* story) depending on what they can face at any particular time.

This is illustrated in the following comment from a patient: 'You think you'd want to know everything but, when it comes to it, you find you don't.'

We have found it useful to use the term 'two-track thinking' to describe disavowal. It is helpful to imagine the patient's mind being like two trains going along parallel tracks at the same time, conscious of the other track but not in two places at the same time.

For example, a nurse has a conversation with a patient about their prognosis being 'weeks rather than months'. A few hours later, the nurse overhears the same patient talking about planning a cruise. It is not uncommon for nurses to refer patients to the psychological therapy team at this stage, because they feel such patients are in denial.

### WHY DOES DISAVOWAL MATTER?

The use of the term 'in denial' can have an impact on how patients are treated. It is tempting to be dismissive of those who seem not to have taken in information and to pathologise their behaviour, rather than grapple with our own understanding of it.

### PRACTICE POINTS

- There are different forms of denial.
- Denial is a normal coping mechanism.
- Listen to patients' irrational as well as rational thoughts.
- Denial is not always a problem.
- Give difficult information in small chunks.

Nurses are well placed to work alongside patients who are struggling with their prognosis, especially if they know the 'denial' that patients are experiencing is disavowal and is normal for their condition.

This view is supported by NICE guidelines, which encourage nurses to take on some of the psychological care of patients in palliative care (NICE, 2004).

### NICE GUIDANCE

NICE (2004) guidance on *Improving Supportive and Palliative Care for Adults with Cancer* includes psychological support services and a potential model for service delivery.

This divides psychological assessment and interventions into a four-level model. Psychological support at levels 1 and 2 should be provided by health and social care professionals who are directly responsible for the care of people with cancer. Psychological therapists should manage those with more severe psychological distress at levels 3 and 4.

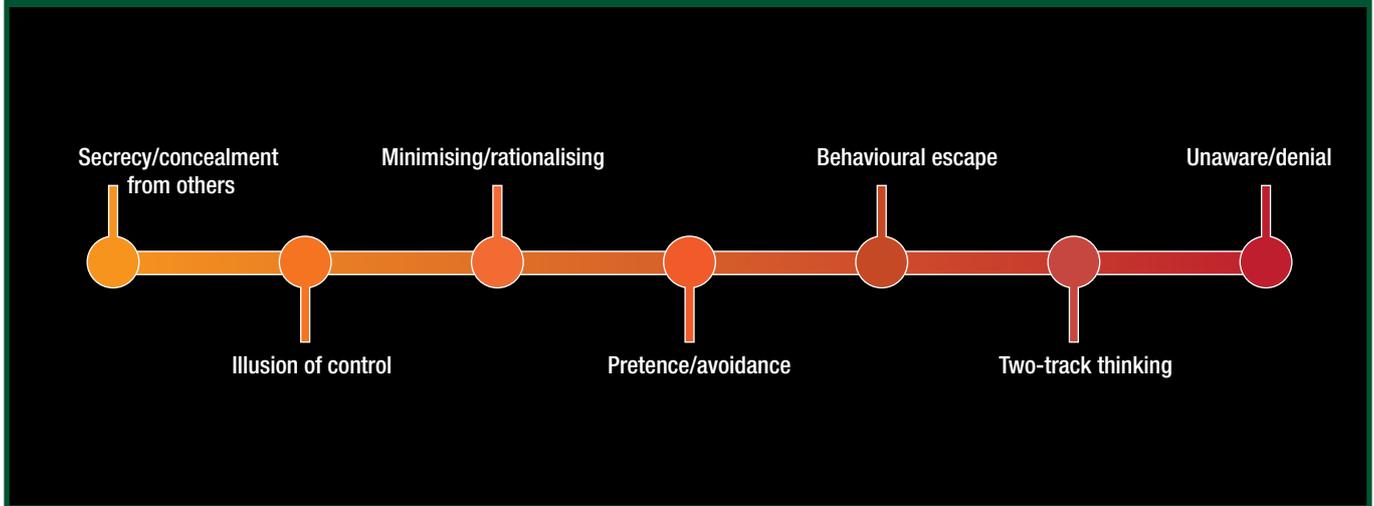
The guidance says nurses should be working at level 2 and able to 'elicit worries and other feelings by establishing trust and listening in a permissive and non-judgemental manner'.

### UNDERSTANDING THE PROCESS OF DENIAL

If nurses understand the process of denial, they will be able to intervene. They can encourage patients to talk, and listen to their responses if they are aware that this is only one aspect of their mental outlook and that, on another day, in another mood, patients will be able to talk about 'reality'.

Mechanisms such as avoidance, two-track thinking and denial are normal and reasonable reactions to a life-threatening condition.

FIG 1. THE SPECTRUM OF DENIAL



Patients adopt a continuum of coping styles and all of these have been documented (Vos and de Haes, 2007).

At one end of the spectrum, patients are fully conscious of facts and of what they are doing; at the other end, they have no conscious control of their reactions at all, which is Freud's classic definition of denial.

This is not a process that patients tend to move through, or have any conscious control of, but is a way of locating how someone might be managing unbearable thoughts and feelings. Fig 1 sets out our idea of what this spectrum might look like and Box 1 shows different coping styles.

One way of bringing these ideas closer to home is for nurses to try this test out on themselves.

Locate a part of your body which is showing signs of ageing, such as grey hair, freckles on your hands, lines on your face or slackness in your skin. Look at it and see how long it takes before you have to remove your gaze and stop yourself thinking about getting older and dying. Notice which of the defences you use yourself so as not to notice the everyday living and dying of your own body.

## NURSING A PATIENT IN DENIAL

Denial in a palliative or critical setting is a complex process, which may involve an unsteady process in coming to terms with a frightening prognosis.

If we understand that these defences are normal for all of us, then perhaps the process

of identifying them will enable us to be more understanding of our patients' behaviour.

The relationship we have with patients needs to be based on trust and understanding. They need time to take on information or accept a poor prognosis or death. It is likely that the slow process will be punctuated by periods of investment in a parallel 'well' story that offers them temporary relief from feelings of distress and anxiety.

It is important that professionals do not push patients towards 'acceptance' or measure success by their immediate reaction. This

involves taking cues from patients and listening to what they are saying, so that we understand what track they are on.

When patients are ready to talk about their diagnosis or death, nurses need to have the courage and the belief that they can manage the difficult thoughts and feelings that can arise in themselves as well as in patients.

The patient quoted at the beginning of this article also said: 'When it comes to how you feel, how you deal with things on a day-to-day basis, it's the nurses who matter.'

There are times when a persistent

### BOX 1. COPING STYLES

Patients may exhibit the following coping styles:

- **Secrecy/concealment from others:** 'I want to keep this to myself. There's no need for others to know.' May be accompanied by isolation and distancing from others.
- **Illusion of control:** 'I'll have all the treatments, go to the best doctors, change my diet, read everything....' A frantic search for facts and treatments which prevents an emotional reaction.
- **Minimising/rationalising:** 'Lots of people get cancer and most survive it these days. Others are worse off than me.'

May be accompanied by exhorting others to think positively and an unrealistic outlook.

- **Pretence/avoidance:** 'I just don't want to think about it. There's no point in dwelling on something you can't do anything about.' May be accompanied by talking about everyday, mundane things but avoiding any talk about illness.
- **Behavioural escape:** 'There's no reason to give up smoking and drinking now: I'm off to the pub.' May make heroic efforts to complete a task but seem obsessed with

activity rather than making realistic plans.

- **Two-track thinking (disavowal):** 'Sometimes I can cope with it; sometimes I have to escape into hope, even if it is a fantasy.' Switches between rationality and being unduly optimistic.
- **Unaware/denial:** 'I don't know what you're talking about – I haven't got cancer.' The patient cannot let terrifying information into the conscious mind at all. This is very rare. All these mechanisms are 'normal', in the sense that they are part of a range of everyday defences against reality.

# Practice in depth

non-acceptance of a painful reality merits further scrutiny and thought. At these times, we need to ask:

- Is this a problem?
- Who is it a problem for?
- If it is a problem, why is it a problem?

When considering these questions it could be useful to think about the following points:

- If individual patients persistently talk about their 'healthy' story and do not seem to be taking in the medical information about their disease, even over time, do they need to know their prognosis?

There may be situations where it will not make any difference to what individual patients do or do not do, and it is all right for them not to know.

Sometimes patients may want to leave the knowledge with the doctors/nurses, as this makes them feel more secure.

There are situations in which patients may need to be involved in plans relating to the future, such as custody of children or financial and social provisions for the family.

- Is a particular patient distressed by not knowing? Do they seem anxious or depressed as a consequence of not knowing?

Sometimes the patient may not want to

know, but the family can cope with reality better. In these situations, permission may need to be sought from the patient for information to be disclosed to the family.

Even if this permission cannot be obtained, the family or other carers can still be supported by the professional team who can help them care for their relative or friend.

- Is it harmful for the patient not to know? Are there key treatment decisions that need to be made that require individual patients to have full knowledge of their condition, or issues around adherence to treatment that should be addressed?

- What are the costs of not knowing? This could be understood in terms of the cost of not having an open and honest communication with family and friends that would allow for an exchange of social and emotional support. What is right for one family may not be right for another.

If it is necessary to confront patients' denial, then information should be communicated respectfully and gently in small manageable chunks, allowing space for them to process and reflect on what they are being told.

Patients will look to nurses to understand and support them.

## CONCLUSION

Patients with challenging and life-threatening conditions change their perceptions over time, and need to come to terms with difficult information at their own pace and in their own way.

Nurses are well placed to manage this process alongside their patients, and to recognise a range of behaviours within the concept of normal 'denial'. ●

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