Understanding the theoretical process of denial gives the nurse a framework within which to assist patients.

DENIAL

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The common theme in the Case Reports (page 10) is "denial." The nurses in these situations might look to the literature on denial to explore possible nursing interventions. Reading the literature on denial, however, is reminiscent of reading about the story of the blind men trying to assess and describe an elephant. Many people have described a part of the denial process, but conceptualizing the whole process with its clinical implications is difficult.

Denial was first described by Sigmund Freud in 1923 (Freud, 1961a) when he theorized that young boys would rather believe they had seen a penis on a female than accept its absence. As with many other terms, the meaning of denial has evolved and has lost specificity. The word "denial" frequently occurs in everyday language and therefore gives the illusion that its meaning is understood. Different schools of thought within psychiatry and psychology understand the concept differently, which further contributes to confusion.

Denial is a very broad concept that at times may seem to overlap with other terms such as avoidance, negation, allusion, self-deception, minimization, or even positive thinking (Lazarus & Folkman, 1984). Agreement is reflected in the definition of denial as consisting "of an attempt to disown the existence of unpleasant reality" (Campbell, 1981). The looseness with which the word is used in general conversation may interfere with its clarity in the clinical setting. At times, any "no" will be labelled as denial and the underlying dynamics are obscured. In this article an attempt will be made to clarify the process of denial and discuss appropriate nursing interventions.

Frameworks in Which to View Denial

Denial can be viewed from within several frameworks. Denial will be examined as both a defense mechanism and a cognitive process. The model the nurse uses has direct implications for nursing practice.

Denial as a Defense Mechanism

Defense mechanisms alter a person's perception of reality (Vaillant, 1971). This function is in direct conflict with another ego function—to determine reality. The process of how the defense mechanism denial operates, although simplified, is based on the four phases described by Dorpat (1983) and is illustrated in Figure 1.

The first phase of the process of denial is the "preconscious appraising of danger or trauma." This phase is similar to what Freud described in 1926 as "signal anxiety" (Freud, 1961b) and what Lazarus and Folkman called primary appraisal, although Lazarus and Folkman would also include the possibility of the event being viewed as a challenge. Signal anxiety occurs at an unconscious or preconscious level and primary appraisal can occur at any level of consciousness. Dorpat believes that the appraisal of danger or trauma is usually carried out at a preconscious level, but states that conscious appraisals may also occur.

The second phase is called "painful affects and defensive actions." The individual has already determined that danger or trauma may be present; therefore defensive action is initiated to avoid the unpleasant affects. At each stage of cognition there is an affective component that will determine whether a given stage of thinking will become conscious. Certain stimuli may register at the unconscious level, but will be blocked from conscious awareness.

During the third phase, "cognitive arrest," threatening information is actively excluded from conscious awareness. Attention is refocused elsewhere. Dorpat likens this process to what Sullivan (1953) called
CASE REPORTS
Denial as a Defense Mechanism

Case 1
Ms. A was seven months pregnant when she was admitted via the Emergency Department in premature labor. She delivered a stillborn baby, but seemed to be coping well. "I'm fine... everything will be all right." On the day of planned discharge she was observed stuffing tissue paper into her ears, nose, and later into her vagina and rectum. When questioned about this behavior she would respond by asking staff to feel the baby kick and ask to have the fetal heart rate monitored.

Case 2
Mr. B was a self-employed businessman who had always prided himself on his good health despite smoking two packages of cigarettes daily. When informed he has terminal lung cancer he stated simply, "I know there has been a mistake... I'm just tired. There's nothing wrong with me." He proceeded to "tidy up" his business and personal affairs so he could take a "long vacation." Mr. B's wife called the public health unit to ask a nurse to visit her dying husband and help him talk about his impending death. On the day of the visit Mrs. B apologized profusely for her husband, who had left saying he saw no need to talk to a nurse as he had no problems.

Case 3
Ms. C was a registered nurse with three young children. She had been having increasing difficulties in sleeping at night. A physician friend had ordered lorazepam 2 mg b.i.d., but she had gradually increased this to 8 mg b.i.d. "I'm not an addict... I'm just going through a difficult time with work and the kids and need some extra help, but I have the situation under control." A nursing colleague was concerned and called the nurses' "addiction hotline." Ms. C agreed to a confidential meeting with a nurse counselor to "get them off my back."

Dorpat views the process of excluding this material from conscious awareness as occurring in primary process thought. He states that the individual who is using denial unconsciously fantasizes about actively destroying that which is causing the unpleasant affect. These attacks prevent conscious awareness of the painful object; therefore, conscious cognition is prevented. "Denial... is like a jury that renders a verdict before the evidence is presented. The 'verdict' in denial is pre-emptory, arbitrary, and prereflective" (Dorpat).

The cognitive arrest phase is usually followed by the fourth phase, screen behavior. "Screen behavior refers to the ideas, fantasies, affects, and overt behaviors activated by the... (individual's) need to fill the gaps formed in the cognitive arrest phase and to support its defensive aims" (Dorpat). In other words, screen behavior provides a cover story, which will make the information credible and internally consistent. This is illustrated in Figure 1 by the subject perceiving the sharp edges of danger to be more obtuse.

Denial as a Cognitive Process
Denial can also be conceptualized as a cognitive process. The works of Lazarus and Festinger will be discussed.

The Appraisal Process. Lazarus views denial as a cognitive process that may be used as a valuable first step in coping with stress (Goleman, 1979; Lazarus, 1981; Lazarus & Folkman). Within Lazarus' framework, stress is viewed as occurring in the transaction between the environment and the person. The individual's appraisal of an event and perception of her/his ability to cope determines how stressful the event will be for the individual. For example, Westwell (1983) found that women perceive a wide variation in the degrees of stress encountered during the early postpartum period. While some women experience great stress interpreting and responding to their infants' needs and behaviors, other women experience little stress and feel they responded intuitively and with ease.

Two ways of coping with stress are problem-focused and emotion-focused strategies (Lazarus & Folkman). Denial is an example of an emotion-focused way of coping. Emotion-focused strategies do not alter the relationship between the person and the environment. In other words, they do not change the situation but act to change how a person feels about the situation. Lazarus and Folkman state that there are many stresses where the individual cannot alter the situation. Therefore the effective strategies, which include denial, may be helpful, providing they do not prevent adaptive action.

Cognitive Dissonance. Denial can be viewed within a framework of cognitive dissonance (Festinger, 1957). Cognitions are described as "any knowledge, opinion, or belief about the environment, about oneself, or about one's behavior." Dissonance occurs when there are inconsistencies or conflicts among an individual's cognitions. Festinger hypothesizes that the existence of dissonance is psychologically uncomfortable (similar to Dorpat's concept painful affect). This discomfort will motivate the person to reduce the dissonance between cog-
nitions. Festinger states that the individual who experiences dissonance will also avoid situations and information that might be likely to increase the dissonance. Dissonance can be reduced by rejecting or altering an inconsistent cognition or adding a new cognition. This rejection of a cognition may be observed as “denial.” For example, according to Forchuk (1984), a person who has alcoholism may experience dissonance if attempting to accept all three cognitions:
- “You are alcoholic”;
- “You are worthwhile”;
- “Alcoholics are not worthwhile.”
The individual may reduce the dissonance by denying their alcoholism. A person given a psychiatric patient label may experience similar difficulty and deny the label due to psychiatric stigma (O'Mahony, 1982). An example of steps to be used within this framework is illustrated in Figure 2.

Is Denial Normal?
Denial has been described as both a pathological and normal ego defense mechanism. Anna Freud (1980) viewed denial as a normal, accepted mechanism for children, except when the child was unable to make the transformation from fantasy to reality readily or tried to shape his/her actual behavior according to the fantasy. Denial seems less likely to be perceived as a normal process as the person matures. Historically, denial “is usually ranked toward the bottom of ego hierarchies as indicating disorganization, primitivism, or distortion of reality and is considered inherently maladaptive” (Lazarus & Folkman). Kübler-Ross (1969) viewed denial as one of the normal stages of coping with a terminal illness. “Denial functions as a buffer after unexpected shocking news, allows the patient to collect himself and, with time, mobilize other, less radical defenses.” Denial was seen as a temporary defense usually replaced by partial acceptance. Lazarus and Folkman view denial as a potentially helpful coping strategy.

Integrating Theory and Practice
The nurse may have difficulty translating theories related to denial into nursing interventions. For example, the nurse may have difficulty determining if what is being observed is actually denial. Con-
Denial

Fusing denial with lying or refusing to acknowledge the nurse’s truth/reality are common pitfalls. However, when the nurse focuses on whether or not what she is seeing is “true” denial (as opposed to lying) the nurse’s focus is on collecting the “proof” rather than enhancing an understanding of the patient’s experience. Labelling every “no” as denial is as untherapeutic as forcing the patient to “prove” denial. For example, a person refusing to discuss an issue may not be using denial, but may consciously be deciding not to discuss the issue.

Part of comprehending the patient’s experience involves understanding how the denial maintains the patient’s sense of well-being. The nurse needs to keep in mind that denial protects the ego from having to acknowledge unpleasant realities.

Anxiety is implicitly or explicitly an important component of all the models described. Anxiety is an indication or symptom of perceived anger, threat, challenge, or conflict. It is not always readily apparent, however, what it is that the patient perceives as the danger, threat, challenge, or conflict. Peplau (1971) described the unpleasant experience of anxiety and how individuals may use specific behaviors in order to reduce their anxiety. Denial may be viewed as an example of an anxiety-reducing behavior. The nurse needs to listen to what the patient is saying about his or her experience and perceptions. The patient’s behavioral and situational factors also require consideration. In Case Report 1, this understanding was very important for the nurses caring for Ms. A, who had delivered a stillborn baby. Ms. A was diagnosed as having a postpartum psychosis with her major defensive style being denial. Staff recognized the symbolism of her actions, but did not verbalize these with her or confront her. Instead they discussed her feelings around wanting the baby.

Understanding that denial serves a protective function makes it clear why confronting denial directly can be viewed as ineffective and untherapeutic. Not only would direct confrontation serve to increase the individual’s anxiety, causing the need for denial to increase, it may undermine the nurse-patient relationship. Some models of therapy have suggested channelling this increase in anxiety to either weaken the individual’s defensive structure and focus directly on the conflict or induce a cathartic effect. Examples of where this may occur include flooding/implosive therapy (Campbell) and psychodrama (Moreno, 1972). Anyone attempting to use such an approach must have a thorough understanding of these models and be prepared to deal with the extreme anxiety that may be generated.

Because a direct confrontive approach is not generally indicated with the models described, the nurse needs an alternative approach. Denial serves a protective function and sometimes the alternative is to do nothing or at least to delay action. The patient’s interpretation of the nurse’s actions and the nurse’s understanding of the patient’s situation will vary according to the stage of the relationship. Another facet in considering what, if any, action should take place is how fixed or how temporary the denial may be. Because denial may be temporary, time may be all that is needed. This is illustrated in the nursing intervention planned for Mr. B, the businessman denying his illness. The nurse helped Mrs. B ventilate her feelings of concern and frustration and did health teaching around normal stages of grief and dying. Neither Mrs. B nor the public health nurse confronted Mr. B with his illness or his denial.

Another possible intervention is to find a “back door” approach. The “back door” approach enables the patient to work on a less anxiety-producing part of the issue rather than dealing with the more anxiety-producing parts. An example is the situation described earlier where the cognition “Alcoholics are not worthwhile” was dealt with rather than directly confronting the denial.
reflected in “I am not alcoholic.” A similar cognitive approach was used with Ms. C, the nurse who abused lorazepam. The nurse counselor discussed with Ms. C her interpretations of “addict” and gave some brief nonjudgmental health teaching related to addiction. The “label” issue was put aside and nonpharmacological strategies to help her cope were explored over several outpatient visits.

Nurses frequently describe feelings of frustration and fear that they are being manipulated when caring for patients who are using denial. It is difficult for the nurse to experience these feelings and not assume a judgmental attitude and project blame onto the patient. Awareness of one’s own defensive structure, which includes denial, may help the nurse in avoiding this common pitfall. Recognizing the interpersonal and intrapersonal dynamics may help the nurse to have an intellectual and affective understanding. This understanding allows the nurse to remain emotionally available to the patient.

Nurses may be concerned that they will be reinforcing the patient’s denial unless they confront the patient with “reality.” A helpful technique (drawn from the assertiveness literature) is “fogging” or “agreeing with truth” (Smith, 1975). The nurse can agree with the part of the denial that is based in reality. For example, a statement such as “It sounds like you believe you are not abusing your medication” could be used with Ms. C without direct confrontation (“It sure sounds to me like you’ve been abusing your medication”) or reinforcement of denial (“You’re not abusing your medication”).

The myriad of emotions generated within both patient and nurse make denial a very complex and difficult issue. There is no easy solution to assist patients with denial, but understanding the theoretical process of denial gives the nurse a framework within which alternatives can be found.

References
Campbell, R.J. Psychiatric Dictionary, ed. 5.


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KEY POINTS


1. Denial can be described as a defense mechanism and as a cognitive process. A common theme of both theoretical views is the presence of conflict/dissonance with its inherent anxiety and the role of denial in reducing the anxiety.

2. The nurse needs to understand the meaning of the denial for the patient, for example, what issues are causing conflict and how does denial reduce anxiety for the individual?

3. The nurse should avoid a direct confrontation. The nurse may use a “back door” approach (dealing with a less anxiety-producing part of the issue) or postpone action related to the denial.

4. Awareness of the underlying mechanisms and one’s own defensive structure can help the nurse deal with feelings of frustration and fear of manipulation.