Journal of BUON **13:** 559-563, 2008

ORIGINAL ARTICLE

Using the denial mechanism to inform the cancer patient

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Summary

Denial is a defense mechanism found in interpersonal relationships and behaviors, when a person finds it hard to cope with an unpleasant event or situation and accept that it is true. The success of disclosing information to a patient and indeed its individualization lies on the right use of the patient's character traits. This approach supplies an answer in issues such as when, how much, how we give information and what words we use. We can address these questions more fully, if we combine the approach and use of the denial degree of each patient along with personality traits.

Therefore, it is obvious that there is a relationship between characteristics and the expression of the denial mechanism, hence denial per se. It is worth stressing on how family and relatives react to the bad news. In fact, in some cases not only preserve but also exacerbate denial in their patient, whereas many times they press the physician not to disclose the patient's illness. The hardest difficulty in understanding the denial mechanism by therapists is to establish to which extent these denial-induced reactions are conscious or not. As much as this defense mechanism is simple to put down in words, it is difficult to understand it completely and assess how deeply rooted it is. Therefore, the concepts of the denial mechanism should be the subject of training. The best way to understand the denial mechanism is through Consulting-Liaison Psychiatry.

Key words: cancer patient, denial, informing

Introduction

The ability to assess the degree of *denial* is an important tool in answering the questions about informing and even more so about when we should inform the patient and how much information should be revealed (including how serious it is). We would also argue that - to a certain extent - it is the *key* that will guide us through the right approach to inform the patient [1-8].

Denial is a defense mechanism found in interpersonal relationships and behaviors, when a person finds it hard to cope with an unpleasant event or situation and accept that it is true. Except the *external reality*, the denial mechanism also has an impact on the *internal reality*, namely thoughts, emotions, desires or needs [1,7,9-11].

To put it differently, the person *is unable to face the truth and acts as if it does not exist.* Indeed, when an individual is dealing with a life-threatening disease, he is in denial, which is manifested in various ways. For instance, he will carry on living as if this problem does not concern him, and refuse medical help. For instance, a woman, whose mammography showed an indication of suspected malignancy, delayed seeking medical help for 10 months at which point the signs of the disease were evident [1,5,6,12-14].

On other instances, despite knowing the diagnosis, the patient expresses himself like he cannot believe that this could be happening to him. He would usually say something like: "I can't believe that this is happening to me", "I never thought that this could actually happen to me, I always thought it would never touch me" or say in a dramatic tone "I can't believe that this could be happening to me!" On other occasions, the patient would think aloud "why would this happen to me, it's unbelievable. But then again, why wouldn't it? After all, I'm not God's favorite…" [15].

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Received 14-04-2008; Accepted 03-06-2008

Many times the patient reacts to the news with acute stress or even panic and visits one doctor after another in the hope of listening that it isn't so. In an effort to rationalize the situation, he places everything in doubt: doctors, the accuracy of examinations, hospitals and lab tests. Special care should be placed on patients who doubt and accuse colleagues they had previously visited. We should not accept their reasoning nor agree with them. We should always bear in mind that this is an unconscious need rooted in the denial mechanism. A good approach, even when the patient prefers to be treated by another doctor, would eventually benefit him and also contribute to reducing his degree of denial [15].

Psychiatrist Kübler-Ross, who worked with cancer patients, has accurately described the denial mechanism. She reports the stages a patient goes through to cope with a life-threatening disease. After the initial shock, one is faced with the stage of denial that is accurately characterized by the denial defense mechanism. The following stages are anger, negotiation, depression, and lastly acceptance of reality that must be coped with [16].

As demonstrated in the studies carried out by Kübler-Ross, the stage of denial is treated by the therapist at the beginning of the therapeutic relationship, where a therapy plan is drawn with the patient's necessary consent.

The denial mechanism works at the unconscious level and, like any other defense mechanism, it aims at shielding the individual's ego from an unbearable reality, from something he can't believe it's happening to him. The object of our discussion here is an important loss of health caused by a serious disease. The largest body of research on this mechanism has been focused on cancer patients. Nevertheless, it is also present in a number of other important medical problems, such as coronary disease, renal failure, diabetes mellitus etc [17-21]. This mechanism is manifested perhaps a little differently there [15].

The denial mechanism is also manifested in stressful life events, which are perceived as a crisis by the individual concerned. We could argue that the denial mechanism is brought into play on every major loss crisis.

The degree of denial can be normal or abnormal. All individuals feel a small degree of denial when experiencing a certain problem. Expressions like "I can't believe it" are common, yet they do not interfere with the individual's desire to accept painful realizations.

One has probably witnessed people's first reactions upon learning about some disastrous fact or hearing that someone important or close to them has died. They usually say "no", "but how did this happen?", "it can't be…" etc.

How denial is manifested

1) Denial triggered by a major problem accompanies the thought that "this has not happened to me" which is usually expressed as if the person is afraid that his "inner false reality" will be disrupted. 2) When the degree of denial becomes less intense, then the person begins to say things like "why should this happen to me?, "I can't believe it". 3) He tries to explain it, rationalize it by saying "what have I done to be punished by God like that?" or to put it down to a minor injury or accident (i.e. I fell down the stairs and hit my chest) 4) Lastly, the patient is asking for explanations and poses questions to the therapist. The patient who avoids asking perhaps wishes to retain his denial. Very often patients attribute their own non-information to their therapist. But when asked if they specifically asked to be informed, they reply negatively and sometimes they blame doctors for being always busy or in a hurry etc. The truth of the matter is that this haste is well-received by them and the therapist rather sensed their denial [15].

The degree and the progression of denial varies according to the patient's personality characteristics i.e. a controlling personality usually presents a low degree of denial and prefers to face the truth. On the other hand, the dependent patient, who exhibits a high degree of denial, would rather leave the therapist use the approach he considers most appropriate. A patient who had undergone a mastectomy and had been living with denial for 3 years thanked her therapist for "respecting her wish" not to speak to her about her illness. After 3 years, when one of her relatives told her that she had cancer, she approached the drawer, had a look at the exams and passed out. Despite knowing that the exams had been in her drawer the whole time, she never went to have a look at them. The relative who told her the bad news happened to be working as a healthcare provider too and he thought that the doctor was wrong in not informing her. The patient thought that her relative acted out of spite and not genuine interest.

Another form of denial is when the patient avoids or "forgets" to do the tests needed from time to time i.e. for gynecological cancer, as if, by ignoring the tests, she could avoid the possibility of becoming ill. The expression "I'm not doing any tests because I'm afraid that they will show I've got something bad" is said very often.

Denial mechanism and the family

It is worth stressing on how family and relatives react to the bad news. In fact, in some cases not only

preserve but also exacerbate denial in their patient, whereas many times they press the physician not to disclose the patient's illness. This attitude can be explained by the belief that "negating danger could save his life" or that simply the disavowal of their illness could make it disappear like magic. In other words, the patients, being in denial, can give a heroic fight against the disease. On a number of occasions, stories of individuals have been reported who, in times of hardship, namely in wartime, not only they kept control but also saved their comrades and themselves. There is also an expression we hear over the news or read on the newspapers: "*In defiance of* danger, he saved etc." Heroism can also be explained in such extreme circumstances.

Thus, relatives believe that, by denying the truth, the patient can find more courage to cope with his medical problems. We often hear patients complaining about the pressure exercised by their relatives and their urge to ignore the illness. Lately, one of my patients mentioned his relative's advise to "put it off your mind completely, carry on living like before and this will help you …" It may be that some times this attitude makes them more courageous. But most of the times, patients feel not only that they are not understood but also that a burden is placed upon them. They suspect that their relatives avoid the problem or get the message that "there is something more that patients can do but they aren't doing it".

Clinical staff is usually angry with the relatives because patients communicate this pressure exercised on them or they are asked - sometimes quite persistently - by the relatives not to reveal anything to the ill person about his condition. This gap between relatives and the patient and the dead-end associated with it has been often solved through a therapeutic intervention.

The denial mechanism and disclosure of information

Deepening on the denial mechanism and assessing its degree enables to disclose information and contributes to individualized information and indeed to honest disclosure of information. The disclosure of information, in turn, will assist the patient in his fight to recover his health and his well-being in general [8]. Only when a good therapeutic relationship is based on the right amount of information tailored to each individual patient can the goals set by the patient and therapist be met.

The success of disclosing information to a patient and indeed its individualization lies on the right use of the patient's character traits. This approach supplies an answer in issues such as when, how much, how we give information and what words we use.

We can address these questions more fully, if we combine the approach and use of the denial degree of each patient along with personality traits.

Overall, the way each individual faces a loss of health has a lot to do with his character structure. Therefore, it is obvious that there is a relationship between characteristics and the expression of denial mechanism, hence denial *per se* [15].

The Controlling - Organized patient tends to cope with his denial; therefore, its effect is short-lived. Usually, Controlling – Organized personalities appear to be more realists, they search for the truth (sometimes the whole truth) so that they can control it and counter doubt which seems tormenting to them. This low degree of denial enables the individual to want to learn about his disease; sometimes he addresses the therapist directly, sometimes he is less demanding but he would never give up asking.

The denial mechanism in the Depending personality is manifested in the entirely opposite way from the Controlling - Organized personality. The individual is usually in great denial and, as a result, avoids asking about his medical problem. Overall, these character types do not wish to know at all and they prefer not to be informed of crisis situations in their lives. Therefore, we should reveal to this type of patient almost nothing. In this case, confidence in the therapist will allow the patient to rely on him and follow treatment.

The Emotional-Hyperthymic patient manifests a high degree of denial. Usually, therapists underestimate its degree, being deceived by the image portrayed by the person; an image of the expressive person, who knows how to give his fights almost heroically. Therapists should be tolerant until the impact of denial subsides, because, even if the patient seems to want to know (like a hero) about his disease, at the same time he is afraid to learn the painful truth.

The Emotional-Hypothymic individual does not usually exhibit a high degree of denial. He tends to be more realistic than the Hyperthymic person, and he does make an attempt to accept reality.

The denial mechanism in the Arrogant patient could get out of proportion. This personality type cannot accept that it is *him* facing a serious medical problem, and not the others "who are so worthless…" for society. Generally, all individuals to a certain degree feel that they are important and useful to society and others; therefore, they cannot accept the narcissistic blow inflicted by a serious disease. But this feeling in the Arrogant patient is many times higher making him feel almost untouchable.

Assessing the degree of denial in the Avoidant personality can present difficulties, as he could easily be mistaken for being realistic like the Controlling - Organized personality. It is likely that because of this introversion, he will not communicate with his internal reality and may show signs of not needing anyone. The Avoidant type is the introvert side of the Arrogant type, therefore, the feeling of the narcissistic blow is similar. During the interview one should be a little more tolerant to allow the patient communicate better the elements of denial.

The Arrogant and Avoidant patients would appreciate gradual disclosure of information when it is targeted to the deeper vulnerability and the blow they are experiencing. It should be noted that these patients are more at a risk of a major depression episode and increased suicidal ideation and face a similar risk to committing suicide.

The denial mechanism in the Suspicious - Irritating personality has a certain difficulty to assess as it is assisted by the projection mechanism, distrust and subsequent quarrelsomeness. Experience has shown that they ascribe omissions, possible deceit etc too easily to the therapist, saying things like "he doesn't want to give me proper medication", or "he doesn't inform me of the right medication to take." Unfortunately, this pathology is also fuelled by thoughtless, exaggerated expressions used in the media like "Despite the fact that pharmaceutical companies have drug stock, they insist on keeping them off the shelves." The tension could be mitigated if information supplied by the therapist about the strategy to be followed in terms of diagnosis and treatment is given as early as possible. This patient should be kept at a safe distance.

The Giving - Self-sacrificing person has a difficulty in assessing the degree of denial. Indeed, assessment is difficult for an individual who perceives illness as a punishment and propitiation. Despite the realistic front, the therapist senses confusion behind it. God is usually responsible for what is happening to him and this may be a way of dealing with denial. To put it differently, "I don't know why, but God surely does". The therapist has a hard time deciphering the messages and he should control his counter transfer, this sense he gets from the patient. If the therapist senses that the patient is just being coolheaded, he will inform him as he would a Controlling - Organized person. If he is embarrassed, then he should inform him in the same manner as a Dependant type. Usually, the degree of information given varies between the two above-mentioned characters.

The Distant - Isolated character finds it harder than the rest to assess denial. His great introversion does not let him give away his feelings; therefore the therapist must use his countertransfer in the best way, as in the Giving -Self-sacrificing type.

Conclusion

Understanding and diagnosing the degree of denial in a patient seems to be greatly associated with the approach adopted to inform the patient, since it appears in the initial stage of the therapeutic relationship.

It has an impact on the communication with the patient, the information disclosed to him, if precious time will be won or lost, how the therapeutic process will evolve. Therefore, it is critical to understand the denial mechanism in depth, the degree of denial, when and how much this can be useful for the patient, how it should be handled, as well as to respect and find how to gradually break down this mechanism.

We should never forget that this is an unconscious defense mechanism aiming at fending off the patient, at least initially, from the shock of health loss, the possible loss of life. Therefore, in the initial stage, it is a very useful mechanism. But if it persists, it can actually harm the individual and almost destroy him.

Understanding and adopting a sound approach for the denial mechanism lays the foundation for a patient's positive attitude and the establishment of trust within the therapeutic relationship.

The hardest difficulty in understanding the denial mechanism by therapists is to establish to which extent these denial-induced reactions are conscious or not. On many occasions, they suspect that the patient knows or on other occasions it's the therapist who discloses the illness. Nonetheless, the patient acts more or less as if such an uncomfortable reality does not exist.

As much as this defense mechanism is simple to put down in words, it is difficult to understand it completely and assess how deeply rooted it is.

Therefore, the concepts of the denial mechanism should be the subject of training. The best way to understand the denial mechanism is through Consulting - Liaison Psychiatry.

Another helpful way for therapists is to study and understand their own denial mechanism in the face of various life events. Gaining a deeper and better understanding of denial, for the sake of the patient, can also give us the opportunity to learn ourselves better.

References

1. Hughes J. Denial in cancer patients. In: Stoll B (Ed): Coping with cancer stress. Martinus Nijhoff Publishers, Netherlands, 1986, pp 63-69.

2. Goldbeck R. Denial in physical illness. J Psychosom Res 1997; 43: 575-593.
3. Muskin PR, Feldhammer T, Gelfand JL, Strauss DH. Maladaptive denial of physical illness: a useful new "diagnosis". Int J Psychiatry Med 1998; 28: 463-477.
4. Croyle RT, Ditto PH. Illness cognition and behavior: an experimental approach. J Behav Med 1990; 13: 31-52.
5. Kreitler S. Denial in cancer patients. Cancer Invest 1999; 17: 514-534.
6. Rabinowitz T, Peirson R. "Nothing is wrong, doctor": understanding and managing denial in patients with cancer. Cancer Invest 2006; 24: 68-76.
7. Wool MS. Understanding Denial in Cancer Patients. In: Wise TN (Ed): Psychiatric Aspects of Cancer. Advances in Psychosomatic Medicine. Karger, 1988, pp 37-53.
8. Holland J. Understanding the Cancer Patient. CA Cancer J Clin 1980; 30: 103-112.
9. Strauss DH, Spitzer RL, Muskin PR. Maladaptive denial of physical illness: a proposal for DSM-IV. Am J Psychiatry 1990; 147: 1168-1172.
10. Fricchione GL, Howanitz E, Jandorf L, Kroessler D, Zervas I, Woznicki RM. Psychological adjustment to end-stage renal disease and the implications of denial. Psychosomatics 1992; 33: 85-91.
11. Laplanche J, Pontalis JB (Eds). Vocabulaire de la Psychanalyse. Presser Universitaires de France, Paris, 1981.
12. Moyer A, Levine EG. Clarification of the conceptualization and measurement of denial in psychosocial oncology research. Ann Behav Med 1998; 20: 149-160.
13. Buckman R, McGuire P. Why won't they talk to me? An introductory course in communication (5 tapes). Linkward Productions, Shepperton, Herts, England, 1989.
14. Buckman R. Communicating with the patient. In: Stoll B (Ed): Coping with cancer stress. Martinus Nijhoff Publishers, Dordrecht, Netherlands, 1986, pp 165-173.
15. Kallergis G (Ed). Information and communication guide with the patient. Medical Graphics, Piraeus, Greece, 2003 (in Greek).
16. Kübler-Ross El (Ed). On death and dying. Routledge, London, 1973.
17. Young L, Schweiger J, Beitzingen S, Manus M. Denial in heart transplant candidates. Psychother Psychosom 1991; 55: 141-144.
18. Livneh H, Martz E. Reactions to diabetes and their relationship to time orientation. Int J Rehabil Res 2007; 30: 127-136.
19. Worrall-Carter L, Jones T, Driscoll A. The experiences and adjustments of women following their first acute myocardial infarction. Contemp Nurse 2005; 19: 211-221.
20. Anees M, Mumtaz A, Nazir M, Ibrahim M, Rizwan SM, Kausar T. Referral pattern for hemodialysis patients to nephrologists. J Coll Physicians Surg Pak 2007; 17: 671-674.
21. Curtis BM, Barrett BJ, Djurdjev O, Singer J, Levin A. Evaluation and treatment of CKD patients before and at their first nephrologist encounter in Canada. Am J Kidney Dis 2007; 50: 733-742.