

Understanding Denial

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Purpose/Objectives: To explore the adaptive and maladaptive uses of denial while developing a clearer understanding of denial.

Data Sources: Nursing and psychological periodicals and textbooks.

Data Synthesis: Oncology nurses tend to have too broad a definition of denial because they overgeneralize similar patient responses and label them as denial. Because of the uncertainty as to its value, denial is viewed as a negative, fixed response to a crisis and can strain the nurse-patient relationship.

Conclusion: Denial is a fluid, interpersonal experience that can affect patients during many points of the cancer experience. By experiencing a clearer understanding of denial and recognizing its adaptive value, nurses can provide more effective patient care.

Implications for Nursing: Clinicians should not underestimate the value of the nurse-patient relationship when a patient is in denial. Patience, understanding, and self-awareness are crucial for providing a safe, trusting environment for patients who are experiencing denial.

Key Points . . .

- Denial, which often is viewed as a negative, fixed state, is actually a fluid, interpersonal process with adaptive and maladaptive qualities.
- Patients may use denial subconsciously when their physical health, important relationships, or sense of control is threatened.
- By understanding denial, clinicians will be able to identify windows of opportunity to discuss patients' situations while respecting patients' right to cope at their own pace.
- By understanding the interpersonal qualities of denial, clinicians will understand how their attitudes about denial affect the nurse-patient relationship and, ultimately, patients' abilities to confide in clinicians.

Many people diagnosed with cancer fear that it is a death sentence. The perceived threat to life brought about by a cancer diagnosis can lead to a denial response in some patients. Denial is a coping mechanism used in response to a psychological trauma and often is viewed by nurses as a maladaptive and undesirable by-product of crisis (Burgess, 1994). Clinicians have uncertainty about the role of denial in adaptation to cancer. Many believe that once a cancer diagnosis is made, a patient and family must acknowledge the illness immediately so they can make decisions related to treatment (Morley, 1997; Smith, 1993). This belief is reinforced by Kübler-Ross's (1969) stages of grief, which are viewed by many to be an accurate reflection of the dying process. Smith explained that because denial is regarded as the first stage of grief in Kübler-Ross's framework, it also is presumed to be the least mature. Clinicians often assume that moving through the stages of grief quickly is healthy; therefore, they tend to criticize those who linger in the denial stage (Ingebrigsten & Smith, 1997).

Denial sometimes is necessary for the preservation of well-being during crisis (Jones, 1999; Murray & Neilson, 1994). It is a coping mechanism that provides protection from stressors that are too overwhelming (Moyer & Levine, 1998). Denial buys an individual time to mobilize the resources needed to cope with the situation (Murray & Zentner, 1979) and, if used temporarily, can be a healthy coping mechanism (Kadlec-Fuller, 1997). Weisman (1972) explained that not only does the use of denial allow an individual to reject the threat to the physical self but also can safeguard important relationships that a patient believes are too fragile to withstand the truth of the diagnosis. This explains the transient nature of some cases of denial: Some patients perceive a need to employ a more rigorous measure of denial around some people than they do with others.

The struggle to maintain control is another reason patients use denial. The diagnosis of a devastating or terminal illness

can precipitate a loss of control over virtually every aspect of a person's existence. If the loss of control is perceived as unacceptable, a patient can take on a denial response subconsciously. By denying the precipitating event, control is restored and integrity maintained. Giving these individuals choices throughout their cancer experience may help to restore their sense of control, allowing them to view their illness honestly (Burgess, 1994). Considering the protective role of denial, individuals who use denial have the right to do so and should not be labeled negatively (Smith, 1993).

Denial may have adaptive value by protecting an individual from devastating, life-threatening information, or it can be maladaptive by preventing an individual from participating in informed consent, closing important relationships, and reconciling final affairs. Understanding denial can be a source of frustration for many healthcare professionals who have difficulty distinguishing between adaptive and maladaptive processes. This article will review the literature to explore the definition of denial. As nurses develop a clearer understanding of denial, they can better determine if and when intervention is necessary, thus enhancing patient care.

Dimensions of Denial

Salander and Windahl (1999) argued that denial lacks a clear conceptual definition, which prevents clinicians from sharing a

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