

## Review Article

# Denial in Medical Conditions: A Synopsis of its Components

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## Abstract

This paper offers the reader an abbreviated overview of denial within the context of life threatening and severe medical conditions. Included in this brief review are the definitions, clinical types, various indicators, measuring tools, and finally costs and benefits of denial.

## INTRODUCTION

The conceptualization, identification, and assessment of denial have been regarded as one of the thorniest issues faced by community and hospital-based psychiatrists and other mental health professionals. Yet, the concept of denial has been intimately interwoven into much of the psychiatric and psychological literature since the early 1900's [1,2]. In this brief paper I will: (a) review the leading definitions of denial, (b) briefly discuss the major clinical types of it, (c) outline the presence of denial in various medical conditions, (d) present the primary indicators and measurement tools used to assess denial in medical patients, and (e) indicate denial's costs and benefits.

## Definitions of Denial

A wide range of definitions of denial, at times conflicting in nature, have been reported in the literature. This state of confusion is partially reflective of the fact that denial has been regarded as: a psychological defense mechanism, a coping strategy, a psychotic-like reality distortion, anosognostic neurological deficit, and a stage of psychological adaptation to the onset of medical condition [3-6].

Two often used definitions of denial include: (a) "an intra psychic, unconscious process that relieves the individual of emotional conflict and anxiety" [2], and (b) a process through which the individual uses verbal, cognitive, behavioral, and/or fantasy-linked attempts to ward off painful reality [7]. Denial, therefore, is regarded as a mostly unconscious defense mechanism whose primary function is to distort, disavow, repudiate or refute, painful stimuli or threatening reality. In this capacity denial functions as a defensive "gate" to prevent both internal and external stressful stimuli and traumatic experiences from entering one's conscious psyche [4,8,9]. Within the context of life threatening medical conditions, denial has been regarded mostly as indicative of efforts to adhere to the belief in the integrity of the body and self. More specifically, denial has been seen as an unconscious (but, at times, also conscious) repudiation of the meaning, magnitude, long-term consequences, and life

threatening implications of the injury or illness, with the purpose of reducing emotional distress [10,11].

## Clinical Types of Denial

Several types of denial have been observed in the psychiatric and, more specifically, disease and disability literatures. These types of denial have been typically observed mostly in patients with life threatening conditions such as cardiac and neoplastic diseases, but also among survivors of traumatic head injuries, spinal cord injuries and amputations. They are viewed as spanning, in severity level, from minimal, to partial, and to complete denial [1,4,9]. The most commonly encountered types of denial include: denial of facts (e.g., seriousness, diagnosis); denial of future implications and consequences of the medical impairment (e.g., the requirement of extended medical and rehabilitation interventions); denial of emotional impact (e.g., anxiety, depression, fear); and denial of the meaning of the information and medical-related facts associated with the condition.

Another form of denial is termed anosognosia. It is considered a variant yet distinct form of denial. Whereas traditional denial is regarded as an automatic reaction (or defense) to ward off both internally- and externally-triggered anxiety and stress to psychological traumas, anosognosia reflects impaired self-awareness often associated with neurological conditions such as traumatic brain injuries and strokes that affect mostly right hemispheric dysfunction of the parietal lobe and basal ganglia [9,12]. Furthermore, following the onset of a disabling condition, such as head injury, patients with anosognosia typically exhibit indifference to their physical and social surroundings, poor understanding of their behavior and functional restrictions, and pervasive cognitive perplexity. In contrast, those with "denial-only" clinical features exhibit some (e.g., partial) knowledge of their limitations, resist medical advice, treatment, and feedback, and more actively exhibit distress (e.g., depression, anger, frustration) [9,12].

## Clinical Indicators of Denial

Numerous, and often inconsistent, perspectives have been advanced on what constitute a reliable and valid diagnostic indicator, or marker, of denial among patients with medical conditions. Obviously, most clinicians and researchers of this vast field offer different opinions. Yet, it appears that most agree that the following indicators are highly suggestive of the presence of denial [4,13-15]. Among cognitive indicators one often finds the following: unrealistic optimism and hope, exaggerated self-image, underestimation of condition's seriousness, rejection of any threatening information, and maintenance of improbable future goals and plans. Among the affective indicators of denial one typically finds the following: feelings of detachment, indifference and self-contentment, as well as more troubling signs of inappropriate cheerfulness and euphoria. Finally, behavioral indicators of denial are best exemplified when patients: (a) discount the impact of the seriousness of experienced symptoms on their work or daily routines; (b) reject any mention, by others, of their emotional aloofness or unpredictability; (c) delay seeking treatment; (d) refuse to comply with medical advice and treatment regimen; (e) exhibit anger and frustration when being confronted on their functional limitations; (f) refuse to participate in rehabilitation activities; (g) avoid "failure-prone" situations which may ignite recognition of limitations; (h) resist help attempts from others; (i) refuse to associate with other people exhibiting similar symptoms and medical conditions; and (j) manifest discrepancy between verbal denial of personal distress and body language that suggests physiological arousal and defensiveness.

## Measurement of Denial

Numerous open-ended and (semi)structured clinical interviews and self-report measure of anxiety exist [16]. It is beyond the scope of this paper to address them all. Among the more frequently cited semi-structured clinical interviews are those by [14]. The Levine Denial of Illness Scale [LDIS] and by Hackett and Cassem [17]; The Hackett-Cassem Rating Scale of Denial). Both were originally geared towards assessing denial among cardiac patients, but their use has been extended to people with medical conditions, such as cancer and cerebrovascular accidents. Another frequently used measure, assessing denial among head injury survivors, is The Impaired Self-Awareness and Denial of Disability after Brain Injury Scale.

Among the self-report measures, for people with chronic illnesses and disabilities, one can find the following denial specific measures: (a) The Mental Adjustment to Cancer Scale [18], which includes among its 40 items and 5 subscales, an Avoidance/Denial subscale of 4 items; (b) The Cardiac Denial of Impact Scale [19], which consists of 8 denial-linked items; (c) The COPE Inventory, [20], a generic 15-subscale, 60-item measure frequently used for people with a wide range of chronic illnesses and disabilities that includes a 4-item Denial subscale; and (d) The Reactions to Impairment and Disability Inventory (RID) [21], a generic 8-subscale, 60-item measure, broadly used for people with a wide range of physical impairments and medical conditions that includes a 7-item Denial subscale [12]. These and other measures have yielded hundreds of empirical findings

on the nature, structure, and use of denial among people with numerous medical conditions.

## Benefits and Costs of Denial

Clinical and empirical findings on the use of denial among medical patients have demonstrated that although denial is mostly equated with poor medical and psychosocial outcomes, under certain circumstances denial can result in temporary beneficial outcomes [1,6,16]. The use of denial, under certain, mostly short-term, circumstances culminates in several positive outcomes (benefits). Denial could offer a "cushioning touch", such that immediately following the onset or diagnosis of an injury or chronic illness it provides for gradual internalization of any overwhelming implications. In addition, denial could reduce stress when the medical condition is unmanageable or untreatable, and allows the individual to retain a positive self-regard and hope for the future. Finally, when used only partially and for a limited time, it may create opportunities for the future use of more adaptive coping modes and changes in life style. Indeed, the concepts of "positive illusions" and "perceived hope" (even if not always realistic), strongly suggest that these types of mellowed-down forms of denial could fuel the patient's energy level and pave the way to more adaptive and realistic future coping efforts [22,23]. In contrast, among the negative outcomes (costs) of denial use, the available literature suggests that it could: (a) lead to life-threatening consequences if symptoms are not addressed promptly; (b) prevent mastery of other future traumatic and stressful situations; (c) endanger the lives of others (e.g., if consciousness impairment is involved); (d) jeopardize future learning of coping with stressful life events; and (e) interfere with interpersonal, including family and professional, relationships.

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