Intractable denial

Ann J. Brady, MSN, RN-BC

We care for patients by helping fix what is bothering them. But is denial really a problem that needs fixing?

"Wow, she is really in denial."

"How can he be in denial after all he has been through?"

"They just don't get it. They are in denial."

"Can't she see how bad it is? I've never seen such denial."

I don't know how many times I have heard some variation of these statements from countless sources—nurses, doctors, social workers, family members. "Denial" seems to be the one psychological symptom everyone feels comfortable identifying. We throw the label around as a definitive diagnosis, rolling our eyes as we roll out denial as an excuse or explanation or as a statement of fact made with a sigh of exasperation. We say "denial" with conviction, as sure of its veracity as we are of vital signs or lab values. Our work caring for oncology patients would be easier if the barrier of denial did not exist. As a coping mechanism, it is viewed as only slightly higher in the pecking order than someone who whines or complains excessively. But it is no less disparaged. We want to fix it.

I don't want denial to determine my method of interaction with patients or families. Denial can be a tremendous barrier to communication. It makes me uncomfortable because it draws me into its web of deception. If I go along with it I feel complicit, as if I am lying. But I worry that if I punch holes in it, I risk being cruel to someone in a difficult situation. I run around the edges of it with my hair on fire saying, "He is in denial, he is in denial," uncertain of what to do.

Once I identify a problem, I look for a way to solve it. I know how to address intractable pain or intractable nausea. I think of them as things I, as a nurse, can fix. I look at other "intractable" issues and at the issue of denial and I immediately focus on what I can do to correct it. Often, as nurses, that is what we do, what we are comfortable doing. We care for patients by helping fix what is bothering them. But is denial really a problem that needs fixing?

My youngest son believed in Santa Claus longer than most kids, or so I thought. Each fall when the Christmas ads started on TV he would make his list for Santa. I encouraged his two older brothers not to spoil it for him. "He'll figure it out," I said. What none of us knew was that he had already figured out there was no Santa, but he thought the only way to keep getting presents was to act like you still believed. Eventually he put it all together. But it was when he was ready, when it made sense to him. A transitional time.

Continued on page 44

What has this got to do with denial and patient care? For some patients denial is a transitional phase. But for some patients there is almost an internal mandate to hold onto a level of denial, that it must be there for hope to exist. If they embrace the reality of their diagnosis, they may be left with nothing. They go along, just as my son did, because they think they need a certain level of denial to maintain a level of hope. They cling to it, rebutting any statistics by saying things like, "He is a fighter." Or the one I find most unsettling, "We are praying for a miracle." I believe in miracles but a connection is made between the two. A miracle can only happen if they maintain hope, and the fear is that hope will be lost if they accept reality.

DISCUSSION

I have believed that denial is something good nursing can fix. I thought I needed to break down the barrier to reach the patient. But denial is not something I have to save my patients from. The barrier is there for a reason. Intractable denial is not like Holocaust denial, something that must be corrected. In her book *On Death and Dying*, Elisabeth Kübler-Ross doesn't only classify denial as a stage in the dying process.[1] She identifies how necessary denial can be for some patients. Something the patient needs as a defense.[1]

I had a patient, Suzie, who was dying of metastatic breast cancer. I felt that her denial was a huge barricade. Each conversation about how we would treat her symptoms was mitigated by her pronouncement, "I am not going to die from cancer." Then followed by, "I have my daughter to raise." Suzie had a job she wanted to get back to, things she wanted to accomplish. Dying was not an option. What I came to realize was that Suzie's denial was a struggle *for me*. Her psychologist, a member of our team, helped me to understand the importance of Suzie's denial by telling me that removing Suzie's protective coping mechanism would likely do more harm than good.

One of the radiation therapists asked me what I said to Suzie when she made such a blatant statement of denial. I told her that sometimes I said nothing, that I gave a partial nod to indicate I was listening, not a full nod, that would indicate I was in agreement. I asked Suzie what her doctor had told her. Surprisingly, as patients often do, she readily admitted that her doctor had given her a poor prognosis, but then she affirmed her denial, "But I can beat it." I recognized that her denial was intentional.

I live in Southern California. I like where I live. But when I meet people who are not from here or who only know of California from things they have seen on TV, I get comments like, "I would hate not to have four seasons," or "Earthquakes!" But where I live is home for me. I accept it with the good and the bad. There are many places where I know I could not live, but where others happily live their lives. Maybe denial is like that, an environment that suits us individually. It is a place where the person is most comfortable. When the patient is ready, he or she may choose to move to a different place. I can be there to greet them. But I don't have to pack their bags for them. ■

Denial is not something I have to save my patient from. The barrier is there for a reason.

JOIN THE CONVERSATION

- What is your reaction to a patient who is in denial? Do you feel like you need to correct them?
- Do you think there is a place for denial in patient care? How do you reconcile your personal feelings about it?

ON THE WEB

Go to www.OncologyNurseAdvisor.com/challenges-intractable-denial to join the conversation in the Comments section.

Ann Brady is the symptom management care coordinator at the Cancer Center, Huntington Hospital, Pasadena, California.

REFERENCE

1. Kübler-Ross E. *On Death and Dying*. New York, NY: Scribner; 1969.