Denial

NB: The function of denial is to protect the patient from something which would cause intolerable pain, and could lead to psychological disorganisation or suicide.

It is ***NOT*** our job to prevent patients coping in this way but to tentativeiy explore underlying fears and concerns to see if they can be addressed, or to help those for whom denial is no longer complete or working as a coping mechanism.

Why is denial a problem ?
Denial itself is a very adaptive coping mechanism (Moorey & Greer 1997). However, persistent denial may prevent the patient or relative facing and dealing with important practical and emotional issues. This can lead to problems impacting on the closeness of the patient and relative, problems in implementing care packages in end stages of life, and bereavement problems.

Working with denial
Complete denial is a strong coping mechanism. Sensitive assessment, negotiated exploration and gentle probing is unlikely to break it.

There are however times when denial is **not complete.** This is often shown by the patient starting to doubt and question things in their own mind, even if they have not voiced it to family or carers. This may be manifested by sleeplessness, agitation or even nightmares.

Here are two ways of checking the strength of denial.

- Challenging any inconsistencies in the patient or relative's story:
  Example: "You say it couldn't have been serious, yet you tell me you had an intensive course of chemotherapy?"

- Check if denial is total by looking for a 'window' on the denial, this is often at night:
  Example: "Is there ever a moment when you don't think things are going to work out?"
  "Can you bear to talk about it?"
  "Can you bear to go any further?"