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Nursing & Healthcare International Journal
ISSN: 2575-9981

Symptom Denial: A Concept Analysis

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Conceptual

Volume 2 Issue 6

Received Date: December 13, 2018

Published Date: December 27, 2018

DOI: 10.23880/nhij-16000168

Keywords: Nursing; Symptoms; Analysis

Abbreviations: MI: Myocardial Infarction; MMPI: Minnesota Multiphasic Personality Inventory.

Aim of Concept Analysis

Denial is a primary response to a life-threatening illness, and can significantly affect the outcomes of diseases. Patients may manifest denial by delaying in seeking medical help, minimizing the symptoms of illness or not accepting its complications, failing to cooperate with medical treatments, or by failing to pursue recommended self-care [1].

Denial is a concept that has been defined by different disciplines, which resulted in a lack of consistency in the definition [2,3]. For example in medicine and nursing, when patients deny cardiac symptoms related to myocardial infarction (MI) and delay admission to a hospital, this will lead to a serious implications for myocardial injury in cases where "time is muscle" [4-7].

Description of the Concept

Denial is an abstract and intricate psychological concept [1], and has been used to explain both adaptive and maladaptive responses of individuals to a disease or perceived health risks [8]. According to Robinson, (1993) [9] adaptive denial occurs when the person is consciously aware of using denial to keep control of an immediate danger. Most individuals employ some form of adaptive denials at stressful or catastrophic times. In these occasions, the defense mechanism of denial function as the preserving of well-being, protecting the person from stressors that are too overwhelming, buying time to mobilize the resources needed to cope and safeguarding important relationships that are too fragile to withstand the truth [10].

Denial is a highly prevalent health problem. However, the prevalence rate of denial can be significantly different based on the type of disease, the stage of illness and definitions [11,12]. For example, in a recent review of denial in cancer, the prevalence of different type of denial (denial of diagnosis, denial of Impact and denial of affect) ranges from 4% to 70%) [1].

Denial can play an important role in coping response to diseases or it can result in behavior that continually jeopardizes health [13]. An example of maladaptive coping is smokers who deny the health risks of smoking, and therefore, are considerably less ready to quit smoking [14]. Individuals with Myocardial Infarction (MI) who have greater denial scores, will have longer delays in visiting a hospital [6].

The definition of denial may be different based on the theoretical framework that defines it. The word denial was initially applied to Psychoanalytical Theory [15]. Denial was defined as "a defense mechanism whose aim was to decline unpleasant affects by means of rejecting the reality" [15]. According to this definition, denial has been considered as a pathological problem for years. Later, according to the Cognitive, Stress and Coping theories, denial was recognized as a mechanism to escape stressful events either consciously or unconsciously [1].

Denial has a multidimensional structure. Jacobsen, et al. (1992) [16], who have been working on the denial of heart attack patients, stated several factors of denial that clearly show the multidimensional features of this concept a) cognitive denial of illness; b) denial of impact of illness on the future; c) unrealistic optimism; d) unrealistic expectations from the health care providers; e) denial for need of care; e) affective denial or denial of feelings. f) denial of grief, depression, anxiety, and fear of death.

Cognitive denial of illness refers to denial of diagnosis, misattribution of symptoms and minimization of illness [1]. Denial of impact on the future involves denying susceptibility. For example, a patient says: "I will be fine very soon". They may also have improbable planning and say: I'll go mountain climbing soon after the discharge. Unrealistic expectations from the health care providers include lack of confidence in the physician, nurses and unhappiness with care and/or extreme dependency. Denial for need of care is perhaps the most important feature of denial. Finally, affective denial or denial of feelings that is related to the illness [1].

Denial consists of different components; several authors have classified denial in various dimensions, such as primary, secondary or tertiary [1]. A refusal of illness or the diagnosis is seen as primary denial; however a rejection of treatment or implication of symptoms and treatment is seen as secondary denial. Finally, in tertiary denial, people reject the long-term prognosis and outcomes of their diseases, including the possibility of death [1]. In my population of interest, I will focus on the secondary denial that women with MI often experience with regard to their symptoms.

Concept Analysis Approach

A literature review of nursing, medicine and psychology was conducted using CINAHL, Scopus and PsyINFO. A keyword search was conducted by using the keywords denial, cardiovascular diseases, CVD, Myocardial Infarction, MI and symptoms. This concept analysis was performed based on the eight-step method of Walker, et al. [17]. The reason for choosing Walker and Avant's method is because the steps of this approach are clear and easy to follow, which makes it useful to explore the attributes of different concepts and distinguish them from other similar concepts. Walker and Avant's steps of concept analysis include a) Selecting a concept; b) Determining the purpose of the analysis; c) Identifying all uses of the concept that can be discovered; d) Determining the defining attributes; e) Constructing a model case; f) Constructing borderline, related, contrary, invented, or illegitimate cases (although it is recommended not to include these last two cases); g) Identifying antecedents and consequences; h) Defining empirical referents [17].

Several factors can influence delay in seeking medical help after the onset of MI and denying MI-related symptoms is one of those important factor [18,19]. Denial as psychological factors, can affect particularly, the responses of women experiencing MI related symptoms. Denial of MI symptoms by women can leads to delay in seeking medical help, and consequently, higher mortality and morbidity [19].

Uses of the Concept

According to Webster's Ninth New Collegiate Dictionary (1987) [20], the word denial originated in 1528. Sigmund Freud (1923) first described the concept of denial in psychiatry as disavowing the existence of an unpleasant reality.

The concept of denial is a common word frequently using in our everyday life. In fact, denial is one of the most common reasons for referral to psychiatric consultation [1]. It is also used in many nursing, medicine, psychology and other related health care texts and papers [21]. To identify the scientific usage of the concept, an integrative literature review was performed. This review identified that denial has been vastly used in several subjects, including heart attack, substance abuse, HIV/AIDS, child abuse, renal diseases, heart transplantation, cancer, sex offenders, death, clinical practice, anorexia nervosa, type 2 diabetes mellitus, physical disabilities/rehabilitations, learning difficulties and aging.

Defining Attributes of Denial

Defining attributes are characteristics of the concept that appear repeatedly in the literature [17]. According to Miceli, et al. (1998) [22] denial does not have a univocal and standard definition. Therefore, there are several definitions of denial. Mainly, denial is "Unconscious avoidance process" [23], "a form of repression where stressful thoughts are banned from memory" [24] "a kind of optimism" [3], a defense mechanism, an intrapsychic, unconscious process that relieves the individual of emotional conflict and anxiety [23,25-29], adaptive or maladaptive process or dynamic coping, and finally response used as a form of self-deception to protect the individual from threat [9,30].

Denial is a maladaptive unconscious response among women experiencing MI symptoms. MI patients' may have unrealistic optimism about symptoms, ignore symptoms or refuse to accept that symptoms are related to a life-threatening disease such as MI.

A Model Case

According to Walker, et al. (2011) [17], a model case includes all the defining attributes of the concept, and is an actual and realistic example of the use of the concept. The following case is an example of this type of cases: Mrs. G, a 62-year-old widow with no history of CVD, suddenly

developed sub-sternal heaviness and a pain that radiated to her jaw, left arm and scapula while driving home from a baby shower with one of her friends. When profuse sweating, weakness and nausea developed, Mrs. G's friend suggested that Mrs. G should give control of the car to the friend to drive them to the emergency department. Mrs. G did not realize the seriousness of her symptoms and instead went home, and tried some herbal medication since she believed that it was a simple digestion problem, and that it would be resolved very soon after drinking the herbal medicine. She spent all night alone with these continued serious symptoms. The next morning, when the symptoms were worse, she finally called 911. Her primary EKG revealed extensive MI. Because of the long delay, Mrs. G was not a good candidate to receive any thrombolytic therapy or angioplasty for treatment.

Borderline Case

Borderline are cases that contain some but not all of the critical attributes of the concept [17]. One such case is the following: Mrs. B, a 58-year old teacher, has been a known case of MI for about 6 years. She did not go to the doctor after her angioplasty the year before, and did not take her medication regularly. Last week when she experienced a severe chest pain during her brother's grave ceremony, she went home and tried to take rest and some medication, stating that "I think my heart is used to this pain and there is a kind of protection in my heart. Nobody can understand this, but I believe in it. I would say: Some day we all have to die." After two hour, her chest pain accelerated and was intolerable. She was scared about the seriousness of the problem and called 911 for help. She went under thrombolytic therapy because of extensive MI but survived.

Related Cases

Related cases are instances of concepts that are related to the concept being studies but that do not contain all the defining attributes [17]. Some instances of concepts that are related to the present concept include: avoidance; ignorance, disbelief, negation or disavowal of reality, repression; delusion; projection and non-compliance [3,21,23,24,28,31]. As an example, denial, illusion and unrealistic hope are similar terms that involve the judging of one person's perceptions as either unrealistic or inaccurate by another [3].

Contrary Cases

To show the contrary case of denial, which contains none of the defining attributes of the concept, the following example is presented: In the spring of 2010, Julia A, a 45 year-old women, was working as an editor by day; painting, teaching and trying to finish her doctoral dissertation by night; and getting by on about four hours of sleep. One evening, as she was driving home from school, she experienced an extremely strange, severe pain in her left hand. Julia knew it was not the flu, so she looked online for the symptoms of a heart attack, and she had every one of them. She was in total shock. She had no family history of heart disease and she had been a vegetarian for more than 20 years. She couldn't believe that's what had happened to her. However, at that time, she faced the truth, walked inside and told her husband, "I'm having a heart attack." At the hospital, Julia learned that she had had a heart attack and received angioplasty very quickly. The procedure was successful and after 1 week, she was discharged from the hospital with a very good prognosis.

Antecedents of Denial

Walker, et al. (2011) [17] defined antecedents as events that must occur before the incidence of the concept. Antecedents of denial are based in feelings of anxiety or perceived danger to the individual. Anxiety may initiate with alleged loss, such as: loss of self-esteem; loss of control; fear of retaliation; and loss of love, help, or protection [3]. Other acknowledged antecedents denial include threats to people's health, approaching death, dependency, disability [30], unexpected information, sudden changes, or rapid unexpected happenings [3].

Consequences of Denial

Denial is a coping mechanism that gives us time to adjust to distressing situations. Adaptive consequences of denial are: better adjustment to illness; faster return to work; enhanced physical functioning; prolonged survival; decreased anxiety or depression; enhanced self- esteem [23,31]. Still, denial has a dark side. Being in denial for too long prevents patients from effectively dealing with issues that require immediate action. For example, when patients deny MI-related symptoms and delay admission to a hospital, serious complications such as extensive myocardial injury or death may result [4-7,32-35].

Empirical Referents

According to Walker, et al. (2011) [17], the final step of concept analysis is determining the empirical referents for critical attributes. Empirical referents are classes or categories of actual phenomena that, by their existence or presence, demonstrate the occurrence of the concept itself.

Various quantitative and qualitative instruments have been adopted to measure denial such as: Levine Denial of Illness Scale, semi-structured interview tool in MI patients [13], the Hackett-Cassem Denial Scale (primarily used for cardiac patients); Watson and Colleagues Denial Scale in patients with breast cancer, Minnesota Multiphasic Personality Inventory (MMPI) in patients with psychiatric and medical problems (e.g. chronic pain), and Marlowe-Crowne Social Desirability Scale as a measure of denial in renal patients.

Conclusion

Denial is a multidimensional, adaptive and maladaptive response and the use of the term in the literature refers to a wide range of psychotic, neurotic, and normal processes. Denial has several features, and depending on people's theoretical attitude, it can have different meanings to different people. Clinical practice however, has been maintaining the view that denial is fundamentally maladaptive and should be tackled. This may cause more anxiety, depression, and increase denial [3]. Various definitions and measurement tools of denial are available in the literature, because of the widespread use of the concept in different subjects.

A good understanding of the definition of denial and how denial works in patients, such as women with MI, is vital for health educators because knowledge about this process can lead to more effective ways of encouraging attention to relevant health threats and engagement in health protective behavior. More research is needed to determine effective strategies in working with clients who use denial as a maladaptive defense mechanism.

In the end, I can conclude that ME women who experience MI- related symptoms, use denial as a maladaptive response to lessen the psychological distress of their perceived health risk. Although women use this as a coping strategy, since prompt admission to Emergency Department is necessary after the occurrence of MI, this should be considered as an inappropriate health behavior that needs consideration of expert and education of patients.

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