Denial and Minimization in Telephone Contacts with Patients

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This paper defines and demonstrates mechanisms of denial, disavowal, and minimization as they operate in telephone contacts between patient or family member and the physician. The physician needs to be cognizant that such mechanisms, operating in both physicians and patients, distort patient's reports of their observations of their illnesses or those of family members. These distorted diagnoses affect proposed treatment plans and ultimate outcome. Examples of situations in which distortions contribute to dangerous consequences are developed in the paper. Specific techniques are elaborated to deal with patients who deny, including expert questioning, direct confrontation, and/or interpretation of the hidden motives leading to the denial. Physicians need to be alert to their own tendency to deny or block out crucial factors secondary to conflicting personal and professional priorities, fear of loss of self-esteem, and unresolved psychological conflicts regarding particular medical syndromes.

Although the primary care physician spends the larger portion of his/her time with patients in the office or hospital setting, at least one to two hours daily may be taken up with telephone calls from patients and family. Important information giving and gathering processes are exchanged, via telephone, between physician and patient. Both patients and their physicians use telephone contact with varying degrees of ease, clarity of communication, and satisfactory outcome.

The purpose of this paper is threefold: (1) to elucidate the particular psychologic mechanisms of denial, disavowal, and minimization as tendencies which, although they protect the patient and the physician from psychological conflict, may have potentially dangerous medical-surgical ramifications; (2) to demonstrate how these mechanisms operate in telephone contacts; and (3) to suggest how physicians can respond to patients using these mechanisms.

Not included in this discussion are situations where the lack of clinical training of patients or family members makes it impossible for them to know what they were observing.[1] They would be

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unable to synthesize bits of important information to come up with a worrisome finding. Instead the focus is on situations where patients and/or family members did, in fact, make important clinical observations. It is the fate of this observation which is affected by the psychological defense of denial. The observers in these instances want to protect or defend themselves from the potential meaning of the observations.

All physicians encounter this mechanism. The most glaring example in the experience of one of the authors occurred when a most attractive, stylish woman in her forties came to the Breast Cancer Clinic at Sloan-Kettering Memorial Hospital for an initial examination. While she was immaculately dressed, she emitted a powerful odor. The examination revealed a far advanced, exposed, inflammatory breast carcinoma which had destroyed soft tissue, fat, muscle, and even bone. In commenting about her state she related that she had first noticed the tumor a few days earlier, an impossibility from the amount of tissue destruction evident. According to the patient, it was apparently the odor which had finally broken through her denial.

Patient Denial Mechanisms

With the exception of a paper by Clyne in 1961,[2] none of the recent literature deals with patients whose anxieties prevent them from adequately reporting their symptoms. The physician's problem is further compounded by those patients who telephone with an adequate and clear report of symptoms but who, upon hearing the diagnosis and course of treatment, insist that little or nothing is wrong with them. The presence of clearly perceived symptomatology on the part of the patient is no guarantee for the success of physician intervention, as some patients become acutely distressed and develop a strong resistance to accepting treatment.[3] When an office visit is urged, such patients will often minimize their symptoms to the point of not following through on the physician's recommendation. In several interesting studies,[4-6] it has been found that mothers' cooperation in following medical advice was directly related to their own perceptions of the seriousness of their children's illnesses. If someone does not perceive a serious illness, the physician's diagnosis of severity and his proposed treatment plan will go unheard by the patient or family member.

Although Clyne[2] offers numerous examples of patients and family members who disavow, trivialize, or displace symptoms, these descriptive data are not organized interpretively around the mechanism of patient denial. It appears that from Clyne's data one can discern at least two kinds of mechanisms at work. For a certain group of patients, the telephone call is motivated by a great deal of anxiety which is apparently immediately relieved by making contact with the physician. When the physician then proceeds to ask a variety of questions, the patient "backs off" and begins to downplay his complaint: "I was silly to have bothered about this"; "The cough seemed so bad an hour ago, now it's really better." Sometimes the patient will report only one symptom but deny the importance of others, for example, "I threw up a few times"—but not include the crucial, "I threw up blood." Following these kinds of calls for immediate help, the physician is left wondering why the patient called.

There is a second group of patients in whom denial operates to the point of not calling the physician at the appropriate time. With these patients, a potentially dangerous situation can ensue, leaving the physician to wonder why the patient did not call sooner. Paradoxically, these are often the patients described as "good patients": with the exception of some calls, they are otherwise of no bother to the physician. These are the patients who "carry on," without medical help, until they can bear their symptoms no longer.[2] In the ensuing situation of heightened distress, the patient may block out certain perceptions which, at an earlier stage, might have been properly conveyed to the physician. The danger in these situations, of course, is that the patient may become seriously ill or die. Clyne[2] describes a patient with severe abdominal pain who made "contact" with her physician initially by walking up and down in front of his closed office at night for two hours. Two days later she appeared at his office at a scheduled time with her complaint. Emery[7] studied the epidemiology of 249 deaths of young children both at home and in the hospital over a seven-year period. There was a significantly greater tendency for deaths to occur at home over the weekend, when the family

physician was not available. Emery reports, ". . . it seems that the parents knew the child was ill. They did not realize that it was severely ill and thought that they would wait until the doctor was back on duty again on Monday." While these results have been interpreted in terms of the disinclination of some families to turn to a new physician in a crisis,[2] nevertheless the data suggest an alternative interpretation, namely that the parents of these very ill children wished to protect themselves against the knowledge and did so, by minimizing the severity of illness and hence the need to telephone for help.

Physician Denial Mechanisms

There are obstacles inherent in telephone contact for physicians as well. Without benefit of the senses of sight, smell, hearing, and touch, the physician feels at a loss for the kinds of information he would otherwise have in a clinical setting. Experimental studies appear to corroborate these intuitive feelings.[8,9] When the physician is unable to establish rapport, the effect on patient behavior may be unfortunate. In a follow-up of patients treated over the telephone vs those seen in the office (as measured by later office visits), the response of the former group was significantly poorer than the latter.[10] The authors recommend face-to-face contact and treatment, and avoidance of telephone contact as much as possible.

The physician himself can well understand these frustrations, inherent in using the telephone, and has many times wished that he did not have to respond under such constraint. The literature on breadth of information obtained, accuracy of clinical judgment, and adequacy of patient management indicates that physician feelings of frustration may be substantiated by some experimental data.[10-12] For example, in one study potentially life threatening information was sometimes overlooked, and critical questions associated with common complaints were asked less than 50 percent of the time.[12]

Through repeated experience, the physician intuitively knows these drawbacks in using the telephone to communicate with patients. He comes to the telephone with a particular "set" or expectation which also, and importantly, includes his own emotions. Clyne[13] has described the situation in which, at the ring of the telephone, the physician has two conflicting impulses; the wish and need to attend to the patient *and* the wish not to be bothered. Telephone calls are often felt as intrusive, especially when they come after-hours. With these conflicting feelings and the knowledge of limited time and information available, the physician is likely to proceed with a physical diagnosis approach, ignoring any tendency to deny on his own part and/or on the part of the patient. There is a tendency to alter communication in the direction of reciprocal exchange, so that any inherent mechanism of denial operating within the physician may be intensified in his communications with a disavowing patient.

The literature review has turned up nothing in the way of a description or explanation of normal physician denial mechanisms. The authors do know that if the patient has a propensity for denial and the physician uses a similar mechanism, the arrangement becomes collusive and unsatisfactory. The situation is unintentionally misleading to the physician. His task is made easier by understanding the dynamics of denial and disavowal, so that identifying the patient's problems and engaging the patient's cooperation become possible.

Interest in exploring these matters was encouraged following a report to the authors of a telephone contact by a family medicine resident. The telephone call was received by the resident at his home at 11:45 PM on New Year's Eve. The caller was a middle-aged woman who identified herself as the daughter of a patient unknown to the resident.

The caller reported that her mother, an elderly woman, had been ill for a day with nausea, vomiting, and low back pain. She described the symptoms in a calm, coherent manner. The resident felt that her manner of describing the mother's symptoms belied any ominous implications. The resident's impression was that the patient was suffering from the flu which had been making the rounds at the time; and when he advised medication but expressed some uncertainty about its availability at that hour of the night, the daughter confidently reported that she would locate a pharmacy to handle that. The resident advised the daughter to call him back should things become worse with her mother. The daughter agreed to this, and im-

pressed the resident as being an exceedingly conscientious person.

Early the following morning, the patient's husband telephoned to say that his wife was no better and that he was awaiting his daughter's arrival. She telephoned shortly thereafter to report that her mother was "pale and weak, she doesn't look very good." The resident asked her to bring her mother to the Family Practice Center, a trip which would have taken 15 minutes. The resident arrived at the center and waited 45 minutes for the family before telephoning them. The daughter said, "My mother is dying. I have called the Life Squad." The resident went immediately to the home, and found the mother dead.

In reflecting on this series of telephone encounters, the resident was impressed by two things. The first was that the clinical picture, in his mind, fit almost precisely the symptoms of a flu syndrome. He himself counted on certain cues which would alert him to a dangerous situation—but none of these were forthcoming from the daughter. The second inescapable impression was his feeling about the patient's daughter: that she was "very confident, she had things under control, particularly knowing how to get the medicine, she would handle that." He found himself essentially relying upon her control and good judgment.

But the outcome of the telephone contacts was entirely unexpected, and the death of the patient caught the resident by surprise. He felt deceived by the daughter who had in some way misinformed him. He felt that if only the daughter had told him what was *really* happening, he would have handled the situation differently. Retrospectively, he was aware that something was operating to obscure the seriousness of the problem, but at the time of contact was unable to raise the feeling of being misled to a conscious level. If the physician can detect the operation of a tendency to distort, he then has an opportunity to deal more directly with the patient or family member who is denying the seriousness of an illness.

Motives for Denial

As mentioned earlier, patients unconsciously wish to protect themselves from the potential meanings that various clinical observations have. These tendencies operate in various contacts, not only on the telephone. If we had talked at length with the woman with the advanced inflammatory breast carcinoma, we would have discovered that her body was most important to her and particularly her breast. To have something wrong with her breast and to begin to imagine a mutilating procedure which would, by her estimation, leave her maimed, ugly, and unattractive was more than she could bear. Added to this was her sure knowledge that even after such surgery there was the possibility of further complications and finally death. Better to disavow the first apparent evidence—ie, a small, easily palpated lump.

There are many such potential motives for blocking out or denying crucial observations. In the other example, the patient's daughter may have minimized the significance of her mother's distress to avoid having to feel guilty about recurring wishes that her elderly mother, a burden for many years, would actually develop a terminal illness. She would avoid this by making a case that the obviously severe symptoms were not so serious after all.

In still another case, the detailed motives for "missing the obvious" became well established in long-term psychotherapy. This individual was in psychotherapy with one of the authors. She was extremely well versed with symptoms of neurologic illness and had for a number of weeks missed obvious signs in her father, eg, ataxia, inability to gauge distance, confusion, and mental deterioration, attributing these to her father's drinking. The father collapsed suddenly at work and a large brain tumor was discovered. At this point, the patient was able to recall, in detail, the specific (neurological) symptoms which the father had demonstrated over a period of several weeks. This woman's reaction to her father's illness was very much influenced by the illness and death of her mother, 15 years previously. The reason for the denial ultimately became clear when it was discovered that the patient had made an irrational link between her murderous rage towards her sick mother and the mother's death after a long, complicated downhill course with cancer between the young girl's 8th and 15th year. The irrational link caused the patient to feel that her murderous rage toward the mother had caused her mother's death. She thus disavowed what she saw in her father

knowing full well from her work with similar patients that the symptoms might be secondary to intracranial disease. She protected herself from getting in touch with a multitude of unpleasant feelings that she had had during the mother's illness. These had been repressed and only came to light when she began to see her motives for denying her father's symptoms. There are many similar motives for disavowing current information. Needless to say, such variable motives operate in many other individuals who have a tendency to deny illness or its severity.

Manifestations of Denial

Another question needs to be raised at this point. How does denial manifest itself? At one extreme, the individual giving the information fails to elaborate on the important observations. Or the situation is presented, but in a vague or confused manner with distortion of pertinent clinical facts. Presenting crucial observations in such a way is a manifestation of a psychological mechanism which is one step towards total disavowal, denial, or obliteration of the known facts. At the other extreme, the informant is circumstantial (going on and on about each detail without ever getting to the significant information).

Sometimes an informant does not respond to clearly stated questions. This is a clue to anxiety and discomfort bordering on a tendency to deny or distort. Even if the patient or family member states, "I don't think it's anything," the physician should become suspicious of an attempt to minimize or deny and be alert to the possibility that the reporter tends to leave out or obscure something important. However, stating too often "It's nothing!" does not necessarily mean it is something. It only means that the individual does not want to see what is happening as serious for whatever personal, often unconscious, reasons. In the resident's case, the daughter was too emphatic in making the mother's symptoms into the flu. In retrospect the resident felt that he was vaguely aware of this possibility. The previously mentioned psychotherapy patient focused heavily on her father's drinking problem. The therapist understood this to represent an expression of disappointment in and hostility towards the father, when, in fact, the disappointment and hostility were being used by the daughter to protect herself from facing the potential seriousness of the situation. In addition, the symptoms were noted but their meaning was changed and tied to symptoms of mild intoxication. This distortion reinforced the denial.

The same tendencies in patients mentioned above also operate in the physician who minimizes or denies the meaning and importance of what the patient or family member reports. The physician, in order to protect himself from feelings of frustration and loss of self-esteem, allows a vaguely presented clinical picture to cloud his clinical judgment. In other instances, the physician minimizes the importance of what he/she hears if it suggests a syndrome that the physician feels uncomfortable about; that is, he may not understand the particular syndrome, is uncomfortable in his knowledge of treatment approaches, or has had some past unresolved difficulty over a similar case. These physicians, like the knowledgeable young woman who missed evidence of her father's brain tumor, can overlook symptoms related to experience with illnesses of key figures from their own past.

Another group of physicians ignore or deny important observations in order to rebel against a part of their personality which unrelentlessly demands that "no stone be left unturned." Ordinarily, physicians feel that leaving no stone unturned ensures the best possible outcome; however, at times they slavishly "turn more stones" than necessary, anticipating depreciation and humiliation if they make a mistake. The above group does not deny, but goes to this opposite extreme.

Conflicting priorities affect physician judgment and promote tendencies to minimize or deny crucial factors. A conflict is stirred in the physician as to whether he meets personal or family needs, eg, rest or recreation, or whether he meets the demands of patients.

Physician Management of Denial

First and foremost, physicians should be able to examine themselves. They should be alert to unusual factors which would make them even less

receptive to telephone intrusions. Conscious acknowledgement of such factors will diminish a tendency in the physician to distort the communication from the caller. An unconscious wish that the telephone call entail no further interruption in the physician's life most likely affects the way the physician hears and synthesizes clinical information.

Secondly, physicians must be ready to either bypass the denial through expert questioning or to confront the individual who is utilizing such mechanisms, exploring motives underlying the denial. A family physician recently told of such a situation in which the wife's motives for minimizing the significance of her husband's symptomatology had to do with the fact that she was in the process of poisoning him. The fact that the wife seemed upset and nervous with the physician over his attempts to be thorough made the physician suspicious. This led to further questioning and finding a blood arsenic level.

The physician must be ready to say to the reporter, "You seem to want not to be alarmed about your husband's problem," having picked up this fact from the interview. Or the physician might say, "I can tell that you do not want this spell to represent anything serious," or "Maybe the fact that you had so much looked forward to this vacation has you hoping that this illness won't interfere with your plans." In cases where the physician senses vagueness and confusion, the physician might confront this directly, eg, "This seems vague to me" or "You aren't being clear for some reason." In a recent case presented by a resident, the resident became suspicious that the patient's husband was hiding something in emphasizing insignificant details surrounding his wife's acute illness. The resident correctly cut through this tendency by saying in an empathic manner, "Now something is going on there, what is it?" The husband became tearful, expressed his serious concern for his wife, and then gave a very accurate description of an "acute abdomen," necessitating immediate attention.

Most physicians have done this very thing many times. The intent of this paper is to help the physician conceptualize how this problem presents itself so that such interventions are conscious and planned rather than intuitive and spontaneous. The physician must be prepared to utilize a psychotherapeutic concept, that is, to take a moment to work through a protective device. More specifically, the following questions undermine the denial and lead to fresh information, eg, "How is your mother's illness affecting you?" or "You seem upset by the fact that your mother is ill," or "I think you are afraid to be in touch with feelings you have about your symptoms," or "Maybe you would rather not confront the fact that your mother is quite ill?" Questions similar to these should be fruitful in telephone contacts between physician and patient, and will enhance their satisfactory outcome.

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