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Commentary

Issues Related to the Association between Denial-like Coping Strategies and Psychosocial Adaptation to Chronic Illness and Disability

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Commentary

Denial, as a psychological construct, refers to both a coping strategy and a defense mechanism mobilized in the face of impending stressful situations and potentially traumatic life experiences [1]. Reported empirical data, obtained from research on the relationship between the use of denial-type coping and psychosocial adaptation to chronic illness and disability (CID), have typically shown that individuals who rely mostly on denial, as a coping strategy to reduce the impact of their CID (e.g. functional limitations, pain), largely demonstrate, although not exclusively, poor adaptation to their medical conditions [2-5]. More specifically, for people who have sustained traumatic injuries, such as spinal cord injuries, traumatic head injuries, stroke, and limb amputations [6-8], and those who were diagnosed with life threatening diseases, such as heart conditions, cancer, and multiple sclerosis (Kershaw, Northouse, [9-11] the use of denial, or avoidant-type coping, in the aftermath of their trauma or diagnosis, results in increased levels of depression, anxiety, and psychological distress. They have been also found to experience lower levels of psychological well-being, life satisfaction, and in general, poorer quality of life Findings of negative relationships between the use of denial coping and adaptation to CID must, however, be interpreted with extreme caution due to several conceptual, procedural, and psychometric weaknesses inherent in many of the reported studies. These weaknesses include, but are not restricted to, the following:

A. The conceptualization and measurement of denial (and denial-like processes) is inconsistent across studies. Scales that purport to measure denial-like coping are often reflective of psychological constructs that are only tangentially associated with denial, including these of avoidance, wishful thinking, distancing, escape, (social) withdrawal, and mental (and behavioral) disengagement. These constructs may differ in both theoretical (e.g. conscious vs. unconscious motivation) and empirical (e.g. type and wording of items used) underpinnings.

B. Outcome criteria employed to investigate the influence of denial-like coping on psychosocial functioning (as the outcomes) span a wide range of constructs. Some of these outcomes are positively-valanced (e.g. life-satisfaction, acceptance, subjective well-being), while others are negatively-valanced (e.g. depression, anxiety, psychological distress). Empirical studies have consistently demonstrated that positively- and negatively-measured psychological constructs are independent of each other and are, therefore, differentially linked to predictors such as coping strategies.

C. The types of disabling conditions, and their associated functional limitations, vary greatly in the reported studies, and accordingly, necessitate the use of different coping strategies to reduce condition impact. Whereas the use of denial-like coping has been periodically linked to the reporting of better psychosocial adjustment in the early stages of bodily losses incurred in conditions such as SCI and amputation, it has been found to be often correlated with poor adaptation in the long run. Therefore, the use of extended denial and avoidance coping may not only be masked by the nature of the medical condition, it could also aggravate prognosis associated with, and treatment prescribed for, life-threatening diseases such as cancer and heart failure.

D. Length of measured time since CID onset (duration of condition) varies substantially in the reported studies. More specifically, whereas in some studies participants provided data obtained only days following CID onset, in other studies data were collected many years (as long as 40-50 years) following CID onset. The relationships of Denial-like coping and psychosocial outcomes, as well as the interaction of coping with numerous socio demographic, medical and personality variables, are certain to change in the course of such an extended time period.

E. The coping instruments used to measure denial-like processes and stress-reducing efforts differ substantially in their conceptualization and definition of denial and of other avoidant-type coping strategies. Relatedly, the instructions given to respondents on how to address each question (i.e. encountered stressful situation) and the time frames they should consider for

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their responses (for a review, refer to [12] are also discrepant among scales. The most frequently adopted measures such as the Ways of Coping Questionnaire (WOQ; [13], the COPE Inventory (and the Brief COPE; Carver, [14], the Coping Responses Inventory (CRI; [15], and the Coping Strategies Inventory (CSI; [16], were normed on samples of individuals who were coping with generic life stressors (e.g. unemployment, natural disasters) rather than with the onset of severe or chronic CIDs. These differences between coping with non-medically-linked situations and life-threatening conditions are likely to result in dissimilar adoption rates of denial coping.

F. Many of the reported studies lack sound psychometric properties. Three glaring weaknesses include:

i. low internal reliability (Cronbach's α coefficients) of denial-like coping measures that have been measured, at times, to be as low as α=27, and often below the recommended α=70 criterion for acceptable internal reliability.

ii. Unreported psychometric properties for current studies, with sole reliance on values reported in the original scale-constructing study.

iii. Reliance on sample-specific data reduction methods (e.g. factor analysis, cluster analysis) that typically yield unstable and ungeneralizable indicators of denial, avoidance, and disengagement.

In conclusion, the use of denial, as a coping strategy to ward off stressful life events, has been generally linked to poorer psychosocial adaptation to CID. However, the veracity of these findings must be viewed with caution, since many of the studies have been hampered by conceptual, procedural and psychometric limitations.

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