A Closer Look at Denial

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Introductions

- Bob Carty
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- Participants’ Poll
Learning Objectives

- Explain key concepts related to denial
- Describe the progressive and expansive nature of denial
- Examine denial patterns listed by Gorski
- Discuss what happens to denial in treatment and early recovery if left unaddressed
- Identify clinical strategies and interventions to help clients’ to recognize and reduce their denial
What Is Denial?

- “Refusal to admit the truth or reality” (Webster’s Dictionary)
- Patients often initially describe it as “lying to oneself and others”
- Both descriptions seem to imply a conscious process
- Denial is also an unconscious, psychological defense that activates certain thoughts and behaviors
Key Concepts

- Psychological defenses are activated automatically when a person feels threatened and/or experiences certain emotions – especially FEAR, GUILT, and SHAME.

- Frequently, these reactions are triggered in the brain by the mere anticipation of a threat, not an actual threat.
The D’s of Denial

- Numerous d-words related to denial
  - Disbelief
  - Distortions
  - Deception
  - Distractions
  - Discrepancies
  - Delusion

It's not denial.
I'm just very selective about the reality I accept.
If you believe that addiction is progressive (escalating symptoms over time), consider that denial is also progressive.

Greater denial is needed to block out greater devastation caused by one’s condition (lost jobs, divorces, incarcerations, etc.).

The more that one’s life is out of control, the more one needs to “prove” to oneself and others that everything is OK.
As one’s denial increases, it also expands to areas other than one’s substance use.

Any perceived criticism and judgment may trigger defenses within the person with advanced addiction.

Numerous patients admit that they found themselves lying about unimportant things – fear that any disclosed info about oneself can become evidence for future attacks on their use.
Denial in Treatment

- Entering treatment does not end denial; but may actually enhance this unconscious, psychological defense

- This leads to:
  - Minimizing amount used and symptoms experienced
  - Hiding behind a false sense of still being in control
  - Comparing oneself to patients who may have greater physical deterioration
Gorski’s Denial Patterns

- Avoidance
- Absolute denial
- Minimizing
- Rationalizing
- Blaming
- Comparing

- Compliance
- Manipulating
- Flight into health
- Recovery by fear
- Strategic hopelessness
- Democratic disease state
Avoidance

- Focusing on things other than one’s substance use disorder is a primary form of denial

- When others try to raise this issue, the person will typically respond by changing the subject or by getting angry to shut down the discussion

- Avoidance can occur even in response to direct questions during intake sessions
Absolute Denial

- **May be the simplest form of denial**
  - “I didn’t drink”
  - “I don’t use drugs”
  - “I don’t have a problem”

- Frequently seen in the pre-contemplation stage

- People may deny with such force that they come to believe their own story
Minimizing

- This pattern is not as “black and white” as absolute denial
- This may be conscious or unconscious
- Individual tends to lessen his/her report regarding
  - Frequency of use
  - Amounts used
  - Consequences of use
Rationalizing

- Finding reasons for one’s substance use and its consequences serves to protect the person from facing the irrational behaviors that one maintains throughout his/her addiction.

- Thinking can be a way to keep from feeling the fears, confusion, and desperation.

- This pattern can also be seen in treatment as the client expresses considerable self-awareness, but cannot seem to apply this to staying sober.
Blaming

- This defense allows the individual to avoid responsibility for one’s substance use disorder
- Others are the “reason” for one’s use and its consequences
  - “If you had a wife/husband like mine, you would drink too”
  - “My boss is always on my case, so I need to take something to relax”
  - “I got a DUI again because the cops are out to get me”
Comparing

- Concept here is that identifying others with more severe substance use disorders is used as evidence to “prove” that one’s own problem is not that bad.

- Considerable opportunity to do this when one hangs out with heavy users.

- This one is also common in treatment as a client usually can find someone who seems sicker than him/her.
  - Greater physical impairment
  - More previous treatment episodes
Compliance

- In this pattern, the individual seems to “go along” with what is requested of him/her, but shows no real change.
- Promises to stop drug use are made to family members, yet the person simply tries to hide the drug use better.
- These promises also get the “heat” off for a while.
- Some clients are “stars” in treatment and end up relapsing shortly after discharge.
Many people with substance use disorders may admit to get help only if others do certain things for them:

- One would enter treatment if his/her spouse stops divorce proceedings.
- 35-year-old daughter would enter treatment if her parents pay for a residential facility in California.
- In such cases, the individual tends to do less work than those around him/her.
Flight into Health

- Some alcoholics and addicts are pleased to feel better physically and emotionally in early recovery.

- As they feel better, they begin to think that they do not need to...
  - Continue counseling
  - Attend meetings
  - Maintain contact with supportive peers in recovery

- This thinking tends to lead to isolation and thoughts of controlled substance use.
Recovery by Fear

- This is the “scared straight” defense
- People may recognize how they threatened their lives (and others) with such out-of-control behavior that they swear to never use again so that everything will be fine
- Problem lies in the self-deception that they do not have to change anything, just not use substances
- If nothing changes, nothing changes
People with multiple treatment episodes and recovery attempts may begin to conclude that their situation is hopeless, instead of trying new ways to get and stay sober.

This belief may lead to fighting off the efforts of others to help them.

They may even ask others to simply leave them alone.
This defense is built on the premise that people have the right to drink and drug even to the point of their self-destruction.

A related premise is that they are not hurting anyone but themselves.

This fails to recognize the impact that one’s substance use does have upon family, friends, and frequently public safety.
Unaddressed Denial

Discussion Question: If denial is not addressed in treatment, how does that impact early recovery following discharge?
Denial by Family and Friends

- Complicating the progressive and expansive denial of addict is the denial of family and friends.
- Most family and friends rarely recognize the early signs of this disease and may even continue their disbelief as the disease progresses.
- Once aware, their attempts to control the problem reflect their own denial patterns, such as:
  - Minimizing
  - Rationalizing
  - Comparison
  - Flight into health
Unfortunately, counselors are not immune to denial

- We may fall into various traps
  - We may believe the minimizing by addict and family
  - We may fail to recognize the compliance of our “star clients”
  - In our efforts to motivate clients toward feeling better, we may promote flight into health
  - In working with clients with many previous treatment episodes, we may unconsciously see them as hopeless
Small Group Exercise

- Form groups of 3-6 participants; one person will serve as recorder/reporter
- Select one of the two clinical summaries (Annie and Joe)

Discuss these questions:

- Which of Gorski’s denial patterns are present?
- What clinical interventions do you recommend to address these forms of denial?
Clinical Strategies and Interventions

- Good start is educating patients on both the conscious and unconscious elements of denial
- Encourage patients to decrease their conscious forms of denial, especially times when they catch themselves lying
- Help patients to identify which ones of Gorski’s denial patterns they use, thus increasing self-awareness
Johari Window

- Useful tool to reduce “blind spots” and hidden areas of oneself
Motivational Interviewing

- Its techniques include (but not limited to)
  - Open-ended questions
  - Affirmations
  - Reflective listening
  - Summarizing

- These help to
  - Promote clinical engagement, thus increasing trust
  - Develop discrepancy, which reduces denial
  - Enhance motivation to change
Other Tools to Use

- **Worksheets**
  - Worksheets on the First Step are helpful in encouraging clients to identify specifics on their own sense of being powerless over alcohol and other drugs as well as the unmanageability of their lives.

- **Interviews with peers in recovery**
  - Assign clients the task of interviewing those with more recovery.
    - Ask how they faced their denial patterns.
    - Ask how past denial may have triggered relapse.
And More

- To decrease unconscious forms of denial, clients can...
  - Ask for and use feedback from others in group (others often can see in us what we cannot)
  - Identify specific fears that may trigger denial
    - Fear of becoming vulnerability (trusting)
    - Fear of losing friends
    - Fear of change
    - Fear of failing at recovery
    - Fear of succeeding at recovery
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Denial is much more than lying to oneself and others. It can be an unconscious defense that is triggered by perceived threats. Such defenses do not end simply by entering treatment. Clients require help in chipping away at their denial.