

How denial can lead to anger and aggression

In this second of a series on communication, Clare Morris explains how the psychological mechanism of denial operates for a person with dementia; how anger and aggression can result if a person is confronted with something they understandably find too painful to acknowledge.

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In the first part of this series (JDC July/Aug 1999), the reader was invited to step into the shoes of the person with dementia in order to gain some insight into the experience of dementia. An experimental approach to communicating was advocated, where there are no hard and fast rules to follow, but only guidelines, your own courage to try things out, and the need to establish a network of support where you can discuss problems and possible solutions.

Denial is a psychological coping mechanism we all use to some extent. We tend to deny things that don't fit in with our view of things, things that are too painful to acknowledge, things we are uncomfortable with, or things for whatever reason we feel we need to lie about. Anger and aggression often accompany denial; this implies that there is something very important at stake.

Meeting someone who seems to recognise us when we have no recollection of meeting them often leads us to roundabout means of trying to establish their identity. It is not uncommon for people to part without becoming any the wiser; it seems it is not easy to admit that you have forgotten. When we can't find something we are sure we have put in a safe place, we may well accuse others of moving it or taking it. When our sense of competence is challenged in this way, we certainly feel very uncomfortable, but we may also behave defensively or aggressively.

Insight expressed subconsciously

People with dementia, with failing memory and altered visual perception, are likely to respond along similar lines but possibly in a more extreme way. There is the most important thing at stake: a sense of being a person who is able to make sense of the world around them. It is possible that it is better to deny something ever existed than to admit that you are failing to make sense of events at a very basic level. Trying to convince such a person that they are mistaken often only makes matters worse. The person with dementia may be unaware of seeing things differently. What we see is real to us: perhaps the realisation that something is amiss comes primarily from the reactions of those around us. There are different levels of realisation or insight: it can be expressed non-verbally and perhaps subconsciously through anxiety, defensiveness, anger and denial; or it can be experienced and expressed openly.

Take, for example, a family situation where one member of the family is untidy and always losing things and another is more organised and gets fed up with repeatedly looking for their belongings. Then there comes a time when the scattier of the two is sure that they haven't lost the item, and the more organised person has this niggling feeling that they might know something about it but does not or cannot

own up to it. It may be that this person does not even consciously admit this to themselves, let alone anyone else, but they may well express it non-verbally by being more critical or more irritated than usual. People with dementia also appear to "know" at some level that things are not right. Some choose to deny this, and others may show "insight" and talk openly about their condition. Some examples follow:

Elvira was admitted to a psychogeriatric ward because of aggressive outbursts in the residential home. This 75-year-old woman, a mother and a school matron, had become doubly incontinent but hit out when anyone tried to clean and change her. Unable to allow her to walk around dropping faeces, several nurses would have to hold her down, causing bruising. This situation was probably experienced by Elvira as assault. Attempts to toilet her regularly were not accepted by Elvira, and she would barge out of the toilet with "I don't need to", and "Bloody check". Elvira, her son and all the nursing staff were understandably considerably distressed.

Gerry, who suffered from frontal lobe degeneration, was constantly trying to leave the ward (and often successful). When asked to stay, he would say that he was only going down the road to buy some tobacco. If prevented from leaving he would hit out with his stick and get very angry.

Maira, a younger person with as yet undiagnosed memory difficulties, personality change and extreme anxiety, was refusing to stay overnight in hospital for tests. She claimed her problems were due to stress, redundancy and the menopause. She was persuaded to stay as a day patient and tolerated all but the neuropsychological testing. She emerged from nearly two hours of testing red-faced and furious, refusing ever to return to the hospital and blaming her husband for bringing her.

Francesca, a young woman with an inherited dementia, refused to attend clinic appointments or allow any involvement from statutory or voluntary services. She refused to acknowledge anything was wrong with her, despite significant difficulties with language, memory, caring for herself or her family and the increasing tendency to fall. Her denial and refusal to accept help added to the strain for her husband who was caring for her and their two young children as well as doing a demanding full time job. →

Listening for clues

By listening carefully both to the actual content of what people with dementia say, and the possible underlying messages, many clues as to the ways to approach a particular person can be found.

For example, **Elvira's** comment when taken to the toilet was "Bloody cheek". This possibly implied that she felt it was degrading and undignified for a mature lady with a high standard of personal hygiene. Perhaps she felt it was a more fitting activity for a toddler learning to gain control over their bladder and bowels. Such a hypothesis had important implications for managing this woman's incontinence. Instead of behavioural management by regular toileting, and drawing her attention to having been incontinent, she was approached with the information: "It's time for your morning wash Elvira. Would you like me to help you?" This was accepted readily, and Elvira co-operated entirely with getting undressed. When she saw that she had been incontinent she would cry and cry, but there was no aggression.

Maira, when explaining her memory problems as due to the menopause, redundancy and stress, seemed to be conveying an important underlying message: "I cannot and will not entertain any other explanation of my difficulties. I do not have the same problem as my mother." She had however agreed to come to the hospital, and was still prepared to undergo all investigations provided she did not have to stay overnight. By asking for more information about her problems as she saw them and taking them seriously, by arranging investigations according to her wishes, perhaps Maira felt more in control of the situation.

All the investigations she agreed to were completed without any problem, with the exception of neuropsychology. This tends to confront the person with their difficulties and in many cases makes people very angry or very sad. It is not always possible to avoid upsetting people, as investigations are central to diagnosis, and diagnosis is the key to accessing appropriate services. However, there are strategies which can be used to cope with the very strong feelings that may surface for the person with dementia – some of which are discussed later in this article.

Francesca was walking to the local shop with me, talking of her work as a colour technician, and how she intended to return to work when the children were older. Currently her children were the priority, despite the fact they were in full time nursery care as she could not be left alone with them. When we arrived at the shop and she had selected what she needed, she handed her purse to the shopkeeper in

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order to pay for her shopping. This seems to illustrate that she fully anticipates her difficulty making sense of money, and probably also that she is unable to look after her children or go back to work.

However, she was not prepared to admit this openly, let alone talk about it, needing above all else to maintain a "normal facade". She had watched her mother deteriorate with this disease when she was growing up, and must be very frightened indeed. Denial could be seen as the most important mechanism she has for coping with her situation.

Compensate for deficits

Given that the person with dementia has difficulty modifying their behaviour, strategies to alter the experience of events may be more effective in changing behaviour. The following suggestions of strategies to compensate for neurological problems aim to help facilitate communication, allow the outward appearance of normality, and therefore preserve the person's dignity by not making the difficulties they are facing public. It is difficult to test for some of the difficulties that arise in the dementias, but if we start from the assumption that a person's behaviour makes sense in light of their view of the world, we can ask ourselves the question: *Under what circumstances would this behaviour make sense?*

Touch and non-verbal communication

So much of the way we communicate is automatic and is acquired from birth over our lifetime. We get a sense of what someone is like, how they are feeling, whether we trust them, without necessarily exchanging a word. Non-verbal communication through touch, facial expression, use of colour and style of dressing, posture and positioning, tone of voice are just some of the ways we communicate all the time. When communicating with people with dementia we need to bring non-verbal communication more within our conscious

awareness in order to use it to facilitate contact with people with dementia.

Denial is often described as a feature of the early stages of dementia, along with defensiveness and blame, anger and aggression. These kinds of behaviours are likely to keep people at a distance, at a time when people with dementia are very frightened and uneasy. The person with dementia often shares the widely held view that dementia is synonymous with stupidity, and loss of respect and dignity. In my experience the use of formality, such as handshakes and use of titles or asking the person if it is all right to use their first name, goes a long way towards helping the person retain their dignity. In some cases people hold on to your hand, others drop it quickly. In either case dignity is preserved and for some comfort is gained.

Reminiscence

Remembering new information is the difficulty facing most people with dementia. In contrast, expressing opinions, talking about the distant past and commenting on the here and now is relatively unaffected, and is often possible even for people with more advanced dementia. For people who are in denial, encouraging reminiscence or asking their opinion about something important to them avoids confronting them with their difficulty, will make them feel good, and can serve as useful safe ground when the situation is difficult to deal with.

Reality orientation

Up to this point I have suggested that correcting someone and confronting them with their deficits is something to be avoided, particularly when the person with dementia is not acknowledging any difficulty. However, there are ways of orienting someone in a subtle manner without pointing out a "mistake". Supplying information in your conversation – "Hello it's Clare from... it is time for..." – is very helpful. When people are unsure where they have met someone, they will "fish for clues". We can help people with memory/orientation/perceptual problems by littering our communications with clues in a natural way.

It is, however, possible to overdo this, as was the case for one man whose wife has dementia. They attended a club regularly on a Wednesday morning, and he would call and say "Are you ready?" which always ended in an argument. When he said "Are you ready? It's time to go to the club", his wife could get her coat without being reminded that she couldn't remember what it was they were doing, without getting flustered and irritable.

However, at times he took this to extremes; for example, in the supermarket he identified each item aloud as he moved

them from the basket to the checkout: "Here's the bread, the milk... the butter..." Apparently his wife nearly hit him!

Communicating is something we have learned over a lifetime, and we don't, as a rule, need to stop to think too carefully about how and what we say. It is difficult to change the way we communicate and even more difficult to do so without making it obvious. It is important not to be discouraged when it goes wrong, but to reflect, discuss, even laugh, and then try things differently. It is nearly always appreciated.

Sometimes the person with dementia will ask directly for information. There is a natural tendency to seek out and become aware of things only to the extent that can be dealt with at the time. It may be that the person with dementia will do the same, and seek an understanding for some of the difficulties that they cannot ignore. I would contend that it is important to be honest and open about that which is asked about. This does not necessarily mean a formal diagnosis, but an acknowledgement of the difficulties the person is facing and why. What is the person actually asking? What have they been told? What do they acknowledge of their condition? People who do not acknowledge their diagnosis will not generally want to discuss it, but they will want to put their experience in context in order to make sense of it.

For example **Francesca**, while refusing to acknowledge her illness and prognosis, would sometimes ask her husband about her difficulties. She often repeated things and asked the same question endlessly, but when he explained that this was part of the problem of her "brain shrinking" she never asked about the same symptom again. She developed a problem with feeling excessively hot all the time, took her clothes off, turned off the heating, opened windows, was aware no one else felt like this, and became very agitated. When the problem was explained as a feature of her condition, she shrieked and left the room, was heard to be crying next door, but then returned much calmer and more able to focus on other things. In the long run she gained more comfort from being able to understand that she is not ill, but that the symptom is part of her condition.

Respond to feelings

For those people who are not able to acknowledge their condition, it is impor-



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tant to exercise caution in asking how they are feeling. We tend to deny things when there is a very good reason to; feelings are likely to be strong and perhaps not easily controlled. Their position is that there is absolutely nothing wrong, and perhaps this is the only stance the person can take and retain their composure. As a general rule, therefore, it is better to avoid discussion of feelings or problems unless invited.

Elvira broke down in tears each time she discovered her incontinence. At this time it was entirely appropriate to talk about her feelings, how awful it must be for her, while offering to help her clean up and choose some clean clothes.

Gerry regularly tried to leave the ward, "just to go and buy some baccy, I'll be right back". If it was suggested he might not be able to do that, or that he might get lost, Gerry would claim this to be nonsense and walk off. If prevented from leaving the ward he would beat the offending person with his stick. While not desirable practice, sometimes the only solution for busy nursing staff was to lock the doors to the ward. Within a group setting, Gerry had described the nurses as "prison officers" and the experience of being on a psychogeriatric ward as like being in prison. Talking of his feelings about not being free to come and go, the difficulty for the staff in that it was their job to make sure no harm came to him but they had other residents to consider, and a promise not to let him run out of tobacco, were met with much more reasonable behaviour.

Distraction

Distracting someone with dementia can be a very useful strategy in the short term, particularly if you have discovered some "safe ground".

For example, **Maira** was very angry when she emerged from neuropsychology, having been brought face to face with tasks she found difficult but on an everyday basis was either unaware of or could ignore. She looked greatly relieved, and her mood switched, when asked for advice about cats. She had a catery and many cats of her own, as well as working as a veterinary nurse for some years. This was safe ground, where she was still an expert, in contrast to the way the tests had made her feel.

It is interesting that for some people this seems to work well, but for others the underlying feeling of distress remains despite the conversation moving on. While it is a very valuable strategy to relieve distress during crises such as these,

there may well be times when addressing the truth will have to be considered, as it was with Francesca.

Collusion

Going along with a person's mistaken beliefs is a tempting strategy, but can cause more difficulty than it will help. People in the early stages of dementia are very challenging to care for, the ground rules always seem to be changing, and you are always wrong. Try to seek more information about the person with dementia's view of the situation. Accept that this is true for them, but you do not have to share this view. Talk in terms of how you would feel if you were in their shoes, rather than talking as if it were the truth. In many cases this will be a question of how you phrase your responses.

For example colluding with Francesca might involve helping her to plan for her future return to work, as if it could actually happen. In contrast reality orientation might encourage her to take a realistic view that this is not going to be possible. However, reminiscing and asking about her expertise and her role does not force her to recognise what you know to be the "truth", nor colludes with the way she wishes things were, but is likely to promote conversation, make her feel good, and allow her to ignore the prospect of her deterioration.

Next issue: Sensory impairment, delusions and hallucinations.