

MIDDLE KNOWLEDGE

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1. Core Definition

Middle Knowledge refers to a distinct cognitive state experienced by individuals, typically patients facing a terminal illness, characterized by the active, yet often intermittent, recognition and realization of their impending mortality. This state is differentiated from absolute, integrated acceptance or complete denial. It represents an oscillating awareness where the patient intellectually grasps the severity of their prognosis--the knowledge is present--but they employ various psychological defense mechanisms to manage the overwhelming emotional and existential threat posed by that knowledge. The knowledge is held "in the middle," acknowledged intellectually but often resisted emotionally or behaviorally.

The concept highlights the dynamic, non-linear way in which human beings process catastrophic information. While the patient may be fully aware of the clinical facts (e.g., metastatic disease, failed treatment), the consistent application of this knowledge to their own existence proves too demanding for the psyche to sustain continuously. Thus, **Middle Knowledge** serves as a psychological buffer, allowing the patient to fluctuate between moments of lucid understanding and periods of strategic protective retreat into disbelief or hopeful fantasy. This fluctuation is not pathological but rather a necessary coping strategy to maintain psychological equilibrium during an incredibly stressful period.

It is crucial to understand that **Middle Knowledge** is primarily a cognitive recognition rather than an emotional stage of grieving. Unlike concepts that describe emotional responses to loss (such as the grief stages), this state focuses on the conscious management of facts pertaining to the self. The patient knows they are dying, but the implementation of this knowledge into daily life--the planning, the goodbyes, the cessation of hope for recovery--is perpetually deferred or resisted through mental gymnastics. This often manifests as a tacit agreement between the patient, family, and medical staff to acknowledge the prognosis while simultaneously focusing on short-term goals or minor improvements that sustain hope, even if unrealistic.

2. Historical and Disciplinary Context

The emergence of the concept of **Middle Knowledge** is rooted deeply in the field of Thanatology, the scientific study of death and dying, which gained significant traction in the mid-20th century. Before this period, medical practice often prioritized shielding patients from terminal diagnoses, believing that hope was paramount and the truth too damaging. As medical ethics evolved toward patient autonomy and informed consent, the reality of communicating fatal prognoses became

common, leading researchers to investigate how patients actually process this information.

The work of researchers like Barney G. Glaser and Anselm L. Strauss in the 1960s, particularly their studies on awareness contexts in dying patients, provided the foundational framework for understanding **Middle Knowledge**. They identified various "awareness contexts" (e.g., closed, suspicion, mutual pretense, open) that characterized the interaction dynamics between the patient, family, and staff regarding the prognosis. **Middle Knowledge** aligns closely with the dynamics observed in mutual pretense contexts, where all parties are aware of the truth but act as if recovery is still possible, thereby allowing the patient the psychological space to engage with or avoid their mortality as needed.

This cognitive state provides a valuable perspective that complements, but does not replace, established models of emotional processing. By detailing the specific mechanisms of oscillating awareness--attention, resistance, and denial--the concept of **Middle Knowledge** offers a practical lens for clinicians, particularly those in palliative care and hospice settings, to interpret seemingly contradictory patient behaviors. It moves beyond simple categorizations of "denial" or "acceptance" to acknowledge the highly complex and often inconsistent psychological landscape of the terminally ill.

3. The Processual Stages of Middle Knowledge

The transition into and through the state of **Middle Knowledge** is often described as cyclical rather than purely linear, involving distinct phases that manage the intake and integration of existential threat. The initial stages involve a heightened state of awareness, followed by defense mechanisms designed to push the knowledge away.

Attention (Initial Recognition): This phase begins when the patient first receives or comprehends the severe prognosis. It involves a moment of intense focus where the reality of the situation breaks through typical defensive barriers. The patient pays acute attention to physical symptoms, medical reports, and non-verbal cues from caregivers. This is the stage where the objective data about mortality is cognitively registered, establishing the "knowledge" component.

Denial and Resistance (Psychological Retreat): Following the initial shock of attention, the mind automatically employs resistance, often manifesting as denial, to protect itself from overwhelming anxiety. Resistance is the active mental struggle against integrating the facts of mortality into the self-concept. The patient may question the diagnosis, seek alternative opinions, or focus intensely on positive anomalies (e.g., one good day) while dismissing overall decline. Denial, in this context, is not a failure to know, but a temporary, strategic retreat from acting upon that knowledge.

Protective Mechanisms and Oscillation: As the illness progresses, the patient enters a stage of oscillation where denial becomes one of several protective mechanisms employed flexibly. These

mechanisms allow the patient to engage in life roles (e.g., parent, friend) without the constant burden of death awareness. Other protective behaviors include selective attention (only hearing positive prognoses), intellectualization (discussing the illness clinically without emotional engagement), and displacement (focusing anxieties onto minor health complaints). The oscillation between attention and resistance is the defining feature of **Middle Knowledge**, demonstrating that the patient is neither wholly unaware nor fully resigned.

This process highlights the psyche's remarkable capacity for self-protection. The mind grants itself temporary respites from the overwhelming truth, allowing the patient to maintain dignity and emotional functionality. Caregivers must recognize these shifts, understanding that resistance today does not preclude a moment of deep, open conversation tomorrow.

4. Clinical Significance and Therapeutic Response

For clinical staff in oncology and hospice settings, recognizing **Middle Knowledge** is essential for effective communication and patient advocacy. If a patient is exhibiting signs of oscillating awareness, staff must avoid confrontation or forced acceptance, which can lead to isolation and distress. Instead, the therapeutic response should be tailored to meet the patient where they are currently situated on the awareness spectrum. When the patient expresses attention (e.g., "Am I getting worse?"), the clinician should respond truthfully and supportively; when the patient retreats into resistance or denial (e.g., "I know I'll beat this; the doctor was wrong"), the clinician should respect that defense mechanism, avoiding challenges that might strip the patient of their necessary coping mechanism.

The realization that **Middle Knowledge** is a common and functional coping strategy changes the goals of communication. The objective shifts from enforcing "the truth" to promoting quality of life, comfort, and psychological safety. Effective communication involves using ambiguous or flexible language that allows the patient to choose their level of engagement with the prognosis. For instance, discussions might focus on preparing for eventual decline without explicitly stating a timeline, thus respecting the patient's need for both hope and preparation.

Furthermore, **Middle Knowledge** impacts the planning of medical interventions. A patient operating in a state of resistance may cling to aggressive, curative treatments long after they cease to be beneficial. The clinical team must navigate this resistance gently, often involving family members in discussions about realistic goals and transition to palliative care without directly undermining the patient's chosen defense structure. The aim is to guide the patient toward comfort measures during moments when attention is high, while understanding that resistance may return when anxiety is overwhelming.

5. Distinction from Related Concepts

While often discussed alongside models of coping with terminal illness, **Middle Knowledge** must be conceptually distinguished from the more widely known stages of grief and dying, such as the framework developed by Elisabeth Kübler-Ross. Kübler-Ross's model--Denial, Anger, Bargaining, Depression, Acceptance--primarily describes the *emotional* and psychological processes involved in grieving a loss, whether that loss is the self or a loved one. The focus is on affective responses to the situation.

In contrast, **Middle Knowledge** is purely a description of the *cognitive management* of information regarding mortality. A patient can be in the cognitive state of **Middle Knowledge** (knowing but resisting the fact) while simultaneously exhibiting emotional stages like bargaining or depression. The two concepts operate on different psychological axes: one detailing the structure of awareness, the other describing the nature of the emotional turmoil. The patient in **Middle Knowledge** has the facts, but the emotional response (grief) is often regulated and modulated by the cognitive defense mechanisms inherent in the oscillating state.

This distinction is important because achieving "Acceptance" (the final stage in Kübler-Ross's model) implies a degree of emotional peace and resignation that moves beyond the oscillatory nature of **Middle Knowledge**. A patient may never reach full, sustained acceptance, but may instead spend the entirety of their terminal phase managing their awareness through **Middle Knowledge**. This recognition validates the patient's struggle and prevents clinicians from viewing continued resistance or denial as a failure to cope correctly. It acknowledges that full, consistent acceptance of one's own death is an incredibly difficult, and sometimes unattainable, psychological endpoint.

6. Ethical and Communicative Challenges

The existence of **Middle Knowledge** presents profound ethical dilemmas for caregivers, particularly regarding the principle of truth-telling (veracity) versus the duty to do no harm (non-maleficence). If a patient appears to grasp the truth intermittently and retreats when overwhelmed, how should healthcare providers modulate their honesty? The professional consensus often leans toward a compassionate flexibility, where the truth is always available, but only delivered at the level and pace the patient indicates they are ready to receive.

A major communicative challenge lies in the "mutual pretense" that often accompanies **Middle Knowledge**. Families and staff frequently engage in this pretense to protect the patient, discussing future plans that are highly unlikely to materialize (e.g., "When you get home," or "Next summer"). While intended to preserve hope, this pretense can also isolate the patient, preventing them from having authentic, final conversations or making necessary preparations (such as updating wills or

reconciling relationships). Caregivers must subtly create opportunities for open communication during the patient's periods of high attention without destroying the protective defenses used during periods of resistance.

Furthermore, managing family dynamics is critical, as family members often have varying levels of acceptance regarding the patient's prognosis. One family member might insist on unrelenting hope (reinforcing the patient's denial), while another might push for immediate acceptance and planning. The healthcare team must educate the family about **Middle Knowledge**, explaining that the patient's oscillation is a normal coping pattern, and coordinate a unified approach that supports the patient's varying needs for both protection and reality checking. The ethical imperative is to support the patient's autonomy in choosing how and when they confront their mortality.

7. Further Reading

[Thanatology \(Wikipedia\)](#)

[Palliative Care \(Wikipedia\)](#)

[Glaser and Strauss Awareness Contexts \(Wikipedia\)](#)