



DEALING WITH DENIAL

About the Speaker

Dr. Mohan Raj has been practicing as a Consultant Psychiatrist since 1995 across a wide range of clinical settings. His primary specialization is in Adult Psychiatry, with additional involvement in Child and Adolescent Psychiatry, Geriatric Psychiatry, and Substance Use Disorders. He has received formal psychotherapy training in Psychodrama through the Moreno Institute, Germany, conducted in Chennai.

He has served in a teaching capacity at a premier national mental health institute in Bangalore between 1992 and 1995 and has contributed extensively to public mental health education through media engagement and peer training programs for medical specialists.



Dr. Mohan Raj

Seminar Overview

The seminar addressed the concept of denial in mental health contexts, focusing not on classical psychoanalytic denial but on practical denial of illness, symptoms, diagnosis, and treatment by patients and caregivers. Dr. Mohan Raj explained that denial is one of the most common barriers to timely psychiatric care and often delays intervention until conditions become severe.

The session examined what people commonly deny, why denial occurs, how it manifests behaviourally, and practical clinical strategies for addressing denial in different psychiatric conditions. The emphasis was on empathetic engagement, staged explanation, and collaborative persuasion rather than confrontation.

Forms of Denial in Mental Health

The seminar outlined several major types of denial observed in clinical practice.

Denial of Problem:

Individuals may insist that nothing is wrong despite clear functional impairment. This is especially common in psychotic disorders, substance use disorders, and mood disorders, where patients may attribute difficulties to external causes rather than internal illness.

Denial of Symptoms:

Patients may conceal hallucinations, suspicious thoughts, depressive feelings, or anxiety symptoms due to fear of labelling, hospitalization, or medication.

Denial of Diagnosis:

Some individuals reject psychiatric diagnoses entirely, believing conditions such as depression

or schizophrenia are artificial constructs or misinterpretations of normal behaviour or creativity.

Denial of Need for Tests:

Both in physical and mental health, individuals may postpone investigations due to fear of discovering illness.

Denial of Treatment:

Even when problems are acknowledged, patients or families may refuse medication or therapy due to fear, stigma, or alternative belief systems.

Reasons Behind Denial

Dr. Mohan Raj explained that denial is rarely simple resistance and usually arises from identifiable psychological and social factors.

Lack of Awareness:

Some individuals do not recognize that their experiences represent treatable symptoms. For example, persons with obsessive thoughts may assume they have a character flaw rather than a disorder.

Superstitious and Cultural Explanations:

Symptoms may be attributed to supernatural or social causes instead of mental health conditions.

Stigma:

Fear of social labelling remains a major driver of denial. Families may avoid diagnosis to protect social image.

Fear Factors:

Common fears include medication side effects, addiction, personality change, and long-term dependency.

Medication as Illness Reminder:

Daily medication may psychologically reinforce the identity of being “ill,” leading to resistance after symptomatic improvement.

Family-Level Denial:

Caregivers may minimize or reinterpret

symptoms, delay tests, or postpone starting prescribed treatment.

Behavioural Patterns of Denial

Denial often appears not as direct refusal but as delay and avoidance. Common patterns include:

- Postponing consultation repeatedly
- Not conducting advised investigations
- Filling prescriptions but not starting medication
- Seeking multiple alternative explanations
- Superficial agreement without actual compliance

Such patterns can significantly delay recovery and increase risk.



Clinical Approaches to Addressing Denial

The seminar emphasized that denial should be addressed through graded engagement rather than forceful confrontation.

Symptom-Focused Entry Approach

In psychotic disorders where insight is low, clinicians may initially focus on distressing symptoms rather than diagnostic labels. For example, treatment may be introduced as help for sleep disturbance or distressing voices rather than immediately naming the disorder. Insight often improves after symptom reduction.

Motivational Framing in Mania

Individuals in manic states frequently reject diagnosis due to perceived high productivity and creativity. Intervention focuses on harm reduction, limiting impulsive decisions, social media activity, and risky behaviour, while gradually introducing treatment rationale.

Transparent Discussion of Medication

Open explanation of benefits, side effects, and limits of medical knowledge increases trust. Patients respond better to honest acknowledgment of uncertainty than exaggerated certainty. Encouraging patients to read, question, and verify information strengthens treatment alliance.

Addressing Fear Directly

Specific fears like addiction, side effects, long-term harm, should be individually addressed with factual clarification and management plans rather than dismissed.

Denial in Substance Use Disorders

Denial is particularly strong in alcohol and substance dependence. Some individuals deny the problem entirely, while others verbally agree but fail to change behaviour. The latter group is often more challenging clinically.

Motivational strategies include:

- Education about long-term cognitive and motivational damage
- Linking substance use to psychiatric symptoms
- Emphasizing functional consequences
- Structured de-addiction and relapse-prevention approaches

Denial in Childhood and Adolescent Conditions

In conditions such as Attention Deficit Hyperactivity Disorder and learning disorders, denial often occurs at the family level. Parents may

resist diagnosis due to guilt or stigma. The recommended approach is collaborative, encouraging independent reading, question listing, and follow-up discussion before starting treatment.

Early recognition prevents later complications such as depression and substance misuse.

Insight Development in Severe Mental Illness

Insight cannot always be forced during acute illness. In psychotic disorders, patients may initially reject diagnostic explanations but accept symptom relief. As improvement occurs, many naturally question prior abnormal experiences, creating an opportunity for insight-oriented education.

In fixed delusional disorders with otherwise preserved functioning, denial is more resistant and sometimes requires structured treatment settings.

Medication Continuation and Discontinuation

The seminar clarified that long-term medication needs vary individually. Some patients with a single episode may eventually taper off under supervision, while others with recurrent illness require maintenance therapy. Dose reduction is attempted cautiously based on course and relapse risk.

Managing Social Withdrawal and Negative Symptoms

When treated patients remain socially withdrawn, evaluation is needed to identify whether the cause is negative symptoms, depression, fear, or low motivation. Interventions include:

- Structured activity scheduling
- Group and occupational therapy

- Exercise programs
- Gradual social exposure
- Motivation-building routines

Conclusion

The seminar highlighted denial as a central barrier in mental health care that operates across patients and families. Dr. Mohan Raj emphasized that denial must be addressed through empathy, staged explanation, collaborative education, and individualized motivational strategies rather than confrontation.

Early recognition, transparent communication, and trust-building significantly improve acceptance of diagnosis and treatment. With informed engagement and supportive intervention, denial can be gradually reduced, enabling timely care and better recovery outcomes.

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