

DEALING WITH DENIAL

Reach through, around, over,
or under denial with strategies for coping
with a loved one's AD/HD symptoms

by Gina Pera

DENIAL OF AD/HD TAKES MANY FORMS. Many teens and adults view both the diagnosis and the possibility that they might have it with skepticism. For some of them, misperceptions about AD/HD and stigma issues, along with defenses built up around receiving lifelong criticism, contribute to their so-called psychological, or defensive, denial.

For many others, though, it's the AD/HD itself that impairs their ability to make the connection between their dysfunctional behavior and dysfunctional work or school situations, relationships, and finances. Core AD/HD symptoms—including difficulties with working memory and a poor ability to understand consequences or learn from mistakes—can obscure one's ability to “see” problems, much less accept that they're AD/HD-related.

Part one of this series explored the biological nature of denial with the leading expert on this topic, Xavier Amador, PhD. An adjunct professor in clinical psychology at Columbia University, former director of research, education, and practice at the National Alliance on Mental Illness (NAMI), and a consultant to the National Institutes of Health, Amador has published more than a hundred peer-reviewed scientific papers and five books, and has served as a forensic expert in famous court cases. His most recent book is *I'm Right, You're Wrong, Now What? Break the Impasse and Get What You Need* (Hyperion, 2008).

Now, in part two, you'll gain some practical strategies for reaching through your loved one's “refusal” to acknowledge AD/HD symptoms.

Gina Pera is an award-winning print journalist and author of *Is It You, Me, or Adult ADD? Stopping the Roller Coaster When Someone You Love Has Attention Deficit Disorder* (2008, 1201 Alarm Press); this article is adapted from the book. For eight years, Pera has researched and written about adult AD/HD while advocating for better awareness and treatment practices. She leads discussion groups in Silicon Valley for the AD/HD community and an Internet-based group for the partners of adults with AD/HD internationally. Pera is a member of the editorial advisory board of *Attention* magazine.

BALDUR TRYGGVASON / ISTOCK





Five guidelines to remember about dealing with denial

Keep these five points in mind as you talk with your loved one about the AD/HD-related issues that are affecting his or her life and your relationship.

1. Brain deficits can be easier to treat than “personality”

“Many people confuse denial or stubbornness about accepting a disorder—or even symptoms of the disorder—as being part of the person’s personality, something that can’t change,” says psychologist Xavier Amador. If you see your loved one’s denial as a negative personality trait rather than a symptom, you risk remaining stuck. That’s why thoroughly educating yourself about AD/HD is the critical first step in breaking through denial.

Sarah apparently understood the difference between symptoms and personality when she only half-jokingly said to her husband, “Look, I think that you act this way because you have AD/HD, and it’s treatable. The alternative is that you’re an insensitive twit, and that’s not treatable. If I were you, I’d get real invested in convincing me that you have AD/HD.”

2. Avoid getting stuck in the gift-or-difference debate

In recent years, some people have touted AD/HD as a gift, not a disorder. Perhaps viewing AD/HD as a gift does make the diagnosis more acceptable for some, and it reminds us to view a person’s challenges in a more balanced context. That’s important. Yet, could this AD/HD-is-a-gift strategy possibly be reinforcing some individuals’ denial or at least minimizing the severity of their symptoms?

For decades, romantic notions about schizophrenia being a gift flourished, too. “It caused a lot of tragedy and missed opportunities,” Amador says. Ultimately, when a behavior is causing real problems, focusing on whether it is a gift, a difference, or a disorder remains beside the point—a seductive distraction sure to keep both of you stuck.

In some ways, the *Diagnostic and Statistical Manual* (DSM), used to diagnose psychiatric disorders, is arbitrary, Amador argues. “There are enough true disorders to convince me we need certain guidelines but there are conditions in the DSM that I truly consider differences, perhaps part of our evolution as humans and perhaps leading us to more complex capacities as a society.” Think of that third X-Men movie, where the government decides that these superheroes whose powers come from genetic mutations require an antidote, a



cure. Are their amazing abilities a disease or difference? Ultimately, that's not the issue. "The issue is how we can all live together and function as a society," he concludes.

3. What really matters are these three questions

To get to the heart of the issue, you only have to ask yourself:

- Is the behavior creating distress for the person?
- Is it impairing them in the important spheres of function—relationships, work, and ability to manage basic needs?
- Is it creating havoc for their loved ones?

If you answer "yes" to any question, who cares whether it's called a disability, a disorder, a difference, or a gift? "If this difference in the way you think and pay attention to the world around you is creating something negative for you, then do something about it," Amador advises.

4. Lose the labels (including AD/HD)

Guess what? You don't have to call it a disorder or anything else to treat the problems. Usually, mental-health professionals preach facing your issues and calling something what it is, but there are exceptions. And for the person you are trying to reach, AD/HD might be one. Whether it's AD/HD, depression, or both, it's okay not to call it by its official name, as long as you start addressing the challenges. (Keep in mind that the physician treating AD/HD with medication will require that diagnosis and most likely the insurance company will, too, but that doesn't mean you and your loved one have to use the term.)

5. Think in terms of "turning down the volume"

Accept that, in some cases, you're just going to lose that argument about whether or not the person has AD/HD. "It's time to unlock horns, stop arguing about disorders and diagnoses, and start talking about something else," Amador recommends.

Many people who are unwilling to be "medicated for a disorder" will agree to "take a little something" for better focus or less anger. (Witness the explosion in "smart" drinks that tout brain-boosting properties. Do they attract buyers by pointing to the buyers' flaws and shortcomings? No, they promote the positive things the drink can do for them.)

Try framing the discussion not in terms of deficits but in terms of increased functioning. You might suggest that a little medication might help your loved one to "turn up the signal on noticing details" or "turn down the signal on interrupting." If the person you're trying to help doesn't realize he or she is overspending, driving like a bat out of hell, or creating a visual cacophony of clutter—or see why it matters—how do you broach that subject? The simple process outlined next can help.

Express feelings without triggering defenses

Practicing the following three steps will improve your ability to communicate your feelings clearly and without sounding accusatory.

1. Point out the problem and how it makes you feel

Let's say that your loved one's driving skills leave you praying that the air bags are in good working order, but he or she thinks you're just a meddling backseat driver. You might begin by saying something like, "When you drive fast, I feel really nervous. Maybe it's my problem, but it really makes me sick to my stomach." In this way, you've left the driver to think about how to solve the problem. You're not saying how to solve the problem or, more important, that he or she is the problem.

The same holds true if your loved one is often irritable. You don't say, "I read that people with low impulse-control yell at their children like you do, so go get an AD/HD evaluation and some medication." You say, "It really hurts me when you do this. It worries me about how it affects the children and their relationship with you. Do you see the fear on their faces when you start in on them?"

The point is to engage the person in adopting a view of his or her problematic behavior. To bring his or her attention to it. But what if the response is, "You're the one with the problem!" Embrace that, Amador says. "Say, 'Maybe I am too

sensitive and I'll work on it, but in the meantime, I need you to work on helping me.'" (Don't get your knickers in a twist just yet about making this admission; keep reading to the third point.)

2. Use "I" statements

Even if you're crystal clear that anyone would consider your partner's driving erratic, it's important to start by saying, "I feel scared when you change lanes that fast." Using what's called an "I" statement is very different than saying "What are you trying to do, kill us?" Typically, "I" statements evoke less of a defensive reaction. If he or she still gets defensive, try "Maybe I'm overreacting, but I still feel scared and must do something about it. Either we drive separately or I'll have to get out of the car when that happens."

The trick, Amador points out, is feeling solid about your position even as you acknowledge you could be wrong. Remember: You're not saying your loved one must do anything; you're saying what you must do to allay your fears. Then do it.

3. Get help in learning to validate your perceptions

Many people have learned to doubt their perceptions and judgment after living too long with a loved one's obfuscations, such as, "I'm fine the way I am; you're just too sensitive/picky/



"It's time to unlock horns, stop arguing about disorders and diagnoses, and start talking about something else," Amador recommends.

controlling/fill-in-the-blank!” How do you know when you really are being normal and reasonable and when you’re trying to impose your personal judgment of what’s normal and reasonable?

“There’s your judgment and there are your feelings,” Amador points out, “and if you stick with your feelings, you’re on more solid ground.” If you’re seeing a therapist who is familiar with AD/HD symptoms, you should be receiving help in anchoring your perceptions. Joining a support group can also help to validate your perceptions. Being clear in your own mind that your concerns are valid gives you mental leeway in saying to your loved one, “Maybe it’s just me, but...” (That is, you can say, “Maybe it’s just me” without risking that you’ll start to believe it really is just you.)

The more you learn about AD/HD and how it manifests, the more clarity you’ll gain. “You’ve got to be rock-solid in your knowledge while realizing that your understanding won’t always be perfect,” Amador explains. “When you’re at that point, you’re going to be nearly invulnerable to blame or feeling guilty for your perceptions.”

LEAP into a denial-dissolving strategy

After twenty years spent studying how to reach patients reluctant to accept treatment, and examining the scientific evidence, Amador developed a four-step plan to change potentially adversarial relationships into alliances. It’s called LEAP: Listen; Empathize; find areas of Agreement; and form a Partnership to achieve mutual goals.

This four-part strategy can help you reach through the fog of denial enveloping the person you care about. Using this strategy, you stop focusing on diagnoses and start zeroing in on problematic behaviors and joint solutions. “Common ground always exists even between the most extreme opposing positions,” Amador stresses, “and it starts with making observations together.”

Listen. Turn off your critical filter as you listen to what your loved one feels, wants, and believes. “But my partner feels, wants, and believes in unlimited spending and little accountability! You want me to listen to that?” you might ask. Okay, chill. At this point, you’re only gathering information.

“When you listen without reacting or contradicting, you avoid creating controversy and building up defenses,” Amador explains. “You want to turn down the heat and keep defenses low, so negotiation can occur.” As you listen, clarify what you’ve heard: “Let me make sure I understand what you’re saying. You’re saying you don’t feel we should discuss purchases together, that it makes you feel like a child. You think I worry too much about money, and the financial future will take care of itself. Is that right?”

As Amador explains, “Listening also involves identifying the cognitive deficits—that is, problems with memory, impulsivity, focusing thoughts—that create barriers not only between you and your loved one but also between him or her and effective treatment.”

Empathize. If you want someone to consider your point of view, first consider that person’s point of view.

Empathizing is not the same as agreeing the belief is true. Instead, your empathy as you listen allows the other person to be more receptive to your opinions and concerns. For example, if he or she expresses entitlement to blaze a credit-card trail, ask, “So how does it make you feel when you ‘win’ that item on eBay?”

It’s asking about a person’s feelings, not interpreting them. (And it’s important to be genuinely curious without oozing veiled criticism or “laying a trap.”) Maybe he or she says, “When I buy something new, I feel calm, like my life is okay. It helps me deal with stress.” And maybe you say, “If I were you, I’d feel the same way.” (Note: You’re not saying it’s how you would feel or how someone should feel.) It’s quite possible that the person never noticed these self-medicating feelings associated with stress and spending money. Notice that you’re now having a conversation about his or her problem dealing with tension instead of fighting about money or a disorder.

Conversations like this pave the way to talking about an AD/HD evaluation or taking medication the doctor has recommended, Amador maintains. Oh, but maybe your partner says, “What problem? We have a credit card and I’m going to use it!” You respond, “Well, the budget can only go so far and then we’re broke. I’ll cut back where I can, but what else can you do, or what else can we do, to deal with it?”

Agree. Find common ground and stake it out. This third step involves acknowledging that we all have personal choices and responsibility for our decisions.

During this step, you are the calm, neutral observer pointing out the various positive and negative consequences of decisions your loved one has made. (Tip: Bite your tongue before saying, “See, if you were taking medication, you wouldn’t have bought those church-organ pipes on eBay that have filled up the garage!”) Instead, you ask questions, such as, “So what happened when you tried to cut back on the spending? How did that work and how did you feel?”

You are helping your loved one to be a detective in his or her own life, Amador says. You’re looking for an opportunity to link a solution to the stated problem that the person now agrees he or she has. She has trouble with paperwork, and it’s jeopardizing her job? You say, “I hear these medications help people stay focused.”

Partnership. Collaborate on mutual goals. Amador calls this last step the most satisfying. Now you’re on the same team against a common opponent, such as the messy house, the scary driving, and this spending-tension-release thing. You’ve stopped the war over “You’re sick” and “No, I’m not”—which amounts to name-calling. Instead, you’re listening, working together to find new ways to view the problem, and learning about how he or she feels. Eventually, you’re going to link the problems you two are now discussing to AD/HD evaluation or treatment. ●



Using the LEAP strategy, you stop focusing on diagnoses and start zeroing in on problematic behaviors and joint solutions.

