ADHD: Support Beyond Medication

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPNs aim is to promote and celebrate interdisciplinary collaborative mental health care.

Emma Ketley (00:19):

Welcome to this episode of MHPN Presents, a conversation about non-pharmacological supports for folks with ADHD. My name is Emma Ketley. I'm an occupational therapist and an ADHD coach over here in Perth, and I'm also the host of today's episode. Joining me today on this episode is my friend, proudly to say that, and fellow ADHD advocate, Amy Green.

Amy Green (00:44):

Hi Emma. Thanks for inviting me.

Emma Ketley (00:46):

Well, thanks for coming in today. As you know today, we are just going to be talking about those non-pharmacological supports, because traditionally in healthcare, we've perhaps always looked at things through a deficit lens or a medication lens, and just looking at those other more human factors that clinicians can bring into their work. Just full disclosure, as I said, Amy is actually a friend. I met her a couple of years ago, and she did a talk at ADHD WA, and I was just struck then, as I've continued to be, by Amy's complete awareness of herself, her needs for accommodations at times, and basically her place in the world as an AuDHDer. Amy, do you want to tell the audience a little bit more about yourself?

Amy Green (01:30):

Sure. And thank you again. You make me blush. You're too kind and ditto back on everything. My name is **Amy Green** and I am a multiple neurodivergent person, ADHD, autism, dyslexia, dyscalculia, all the fun little acronyms that kind of come along with those diagnoses. But me as a human, I'm huge on advocacy, but also advocating for the things that I need. Really big on equity, not equality in terms of how I advocate, I am a community member of my local Shires access and inclusion advisory group in my workplace. I'm a member of my psychosocial work health safety working group, and I'm also a mental health first aider, which is really great, big on that. And I mean, what I do to earn the wage. I currently work within the vocational education training sector, and I'm managing a team of roughly about 30 staff across multiple locations. So on the outside, it really looks like I'm kicking goals to the average Joe who doesn't know me, but very often, pretty much on the daily, the autism, the ADHD, et cetera, all the things often can and does make my life hard. But on the opposite to that, it also makes my life really rich in a lot of ways in the connections that I can make with people such as yourself.

Emma Ketley (03:06):

Yes, and that's the other point I suppose I should really make is that I'm also proudly neurodivergent myself, but I'd been a clinician for very many, many years before I realised that, before I got a very late diagnosis in my late forties. And I have described Amy as a bit of a lighthouse really, because clinically clinicians were not trained very much about lived experience when I trained. And then when we were trained, we were taught very much along the lines of DSM or ICD 10 or 11 criteria, but we were never really taught so much about what those symptoms really mean in everyday life. So when I was able to connect on a personal level with Amy, it was amazing because I realised the flat words on a book, how they actually relate in real life. And I guess what I really value and what I've sought to bring into my practise so much more throughout the years is to be so much more person centred, not as a tokenistic statement, but what does it really truly mean to be person centred in your support for someone with ADHD? So Amy, from on your perspective, what does that mean?

Amy Green (04:15):

That's a loaded question.

Emma Ketley (04:17):

You can handle it.

Amy Green (04:18):

I love it. What does it mean for me and what does it look like? And you're right, I mean, I'm someone who has experienced therapy for a really long time. Over 10 years of my life, I've been in and out as a willing participant wanting to know more about me and just be a better human and know how I relate to the world around me and where I fit. But when it comes to therapy, I didn't always experience a person-centered approach from therapists in the past. And it wasn't until I went through the diagnosis process, formal diagnosis, and found an incredible care team, particularly the psychologists that I work with very closely, that I actually really experienced person-centered support and strategies for the first time in my life.

Emma Ketley (05:10):

Wow.

Amy Green (05:10):

But for me, it's really important that I'm seen as a whole person, not just this diagnosis collective filled with traits. In the DSM, as you touched on earlier, there's this bunch of criteria related to each and a lot of that overlaps. There's so many intersections when you're someone like me with multiple things going on. So the biggest shift for me was when clinicians stopped talking about my ADHD or more broadly neurodivergent traits as problems or issues to be solved and actually started to understand how all of these things exist in context to one another. My strengths, my sensory profile, my chronic pain, the dyslexia as well as my environments, the places that I'm in. So it's a collective of all the things that is person-centered care.

Emma Ketley (06:15):

And like you said, to actually acknowledge the capable person, not the diagnosis, not the deficit, but yourself as a person. I tend to say to clients, it tends to be a situation of you're actually managing much, much more than what we would consider neurotypical. And obviously our folks in the community can do it very, very well, which is where we've got terms like masking and everything.

Amy Green (06:38):

Definitely. And that comes into play within the therapy space as well. Particularly if the clinician isn't coming from that person centred intersectional approach, we may not feel well. I personally have experienced not feeling safe within that therapeutic setting. So I'm going to camouflage, I'm going to try and hide so that those modern neurodivergent traits that I have hidden, even though I don't think I hide them well, I think it's quite obvious. But clearly I have the ability to fool people into thinking I'm normal.

Emma Ketley (07:15):

Which is delicious when it feels like it's your choice. Right?

Amy Green (07:18):

Absolutely.

Emma Ketley (07:19):

I think that's the other thing. I think sometimes people want to go in and fix things, and there seems to be this real big push at the moment to fix masking somehow. But for people that have grown up neurodivergent or recently diagnosed as neurodivergent, it's usually a safety behaviour, isn't it?

Amy Green (07:34):

Absolutely. And to tell someone to unmask in all sorts of environments, it can actually be really dangerous for a lot of people. I mean, I'm a white woman. For me, I have a lot more safety of a female who might be a person of colour as well, and also neurodivergent. So they might have even less safety

than I would both outside, within any environment, but even in a therapeutic setting, sometimes it really isn't safe for them to unmask.

Emma Ketley (08:04):

Absolutely. For my experience, that relational practise, that relational safety, ensuring that someone feels psychologically safe with me, I wasn't trained in that way initially. I was trained to be the different expert in the room, the clinician, and back in the 2000s when I trained, we wouldn't disclose. But actually I've seen over the years, what happens is what you've described is that it creates this illusional, this facade where people, you don't see the authentic or true person if they don't feel safe to disclose with you if they feel any way judged. And I think as a clinician, what I've realised more and more is that starts right at the beginning when they come to see you, because sometimes there is just this natural hierarchy that someone's paying you for your time, and so they kind of recognise you as another someone that's worth paying.

Amy Green (08:56):

And you are!

Emma Ketley (08:56):

And I am. I've been told that, but it's about the clinician's responsibility to make sure that person can bring their whole self, their true self to take their shoes off if they want to do whatever they need to feel comfortable and safe and get the most out of that session.

Amy Green (09:11):

Yeah, I love that.

Emma Ketley (09:12):

So I suppose the next question is, can you give us an example of when a practitioner has actually treated you as a whole person rather than the diagnosis?

Amy Green (09:21):

I can certainly tell you about a time when I wasn't treated like a whole person, and I have historically had clinicians jump straight into interventions, which are really not helpful. I mean, most of the time I don't even know what, what support I need, particularly if I'm at reduced capacity, I can't access the words or even articulate what I might be there for. And the difference between someone just kind of jumping in and wanting to fix me, one of the things that I really appreciate now going into psychology or catching up with my OT is what does support actually feel like for you? Not necessarily what does it look like.

(10:14):

But when you feel supported, what does that feel like? And there are moments, because I do struggle with interoception as well, which is a real challenge as well as alexathymia. So I can't always articulate how I'm feeling, but I know internally what it feels like when I'm in a safe environment, I'm not wanting

to run out the door and go into flight and avoidance mode. And thankfully, since working now with a psychologist who is very affirmative, it's completely life changing to kind of get the support that I need and also the help in me knowing how to implement that in the real world for my life. And that's kind of how I'm being supported. Now.

Emma Ketley (11:06):

You've brought up some really interesting points for me with my clinician hat on things that, again, the traditional training is to come up with treatment goals with the client, and we consider that collaborative, but we look at the measurements usually in terms of assessments or feedback from the clients or behavioural changes or something. But what you are talking about is starting with the feeling of safety. And that aligns really nicely for me when I think about trauma work, that it's always about that safety and stability first before anything else. So it's not about when those clinicians jump in to try and prove that they can fix things or assume what they think that you need fixing. It starts with that person really being able to sit down so you can open up and you can identify what it is.

Amy Green (11:55):

Yeah, yeah. It's that collaborative approach.

Emma Ketley (11:57):

Yeah.

Amy Green (11:58):

Yeah. Rather than, as you say, going back to the perceived hierarchical experience, it's having that clinician, the gp, whoever that person is, who you've gone to for support to actually, instead of just saying, we're going to do this, this, and this, and this is going to make your life better and fix you and magic pill, let's work together and figure out the kind of things that do or don't work.

Emma Ketley (12:25):

Now, obviously in the interests of open market and everything, I can't name the psychologists that you've got what you've described. I would already assume that she's absolutely awesome and she knows who she is, but what is it that she's particularly done, I guess because I know that there is an interest in looking for workable, practical pointers. What is it that she did particularly well, that was, obviously she's a psychologist, but what is it that genuinely has helped you?

Amy Green (12:56):

I'm sure that I've said this to you before, but just therapy in general. I'm really huge on advocating therapy for everyone. Everyone. And I know that's really privileged of me to say, but the world would be so much better if everyone just went to therapy at least once. But there is that stigma, the unknown, I guess for me, it's a little bit different. I have been in and out of therapy for so long, but with her, yes, it's therapy, but she doesn't necessarily make it feel so clinical. She provides me with options, the different modalities of do I want to see her in person? Do I want to have telehealth? There's an online portal available to rearrange sessions and those sorts of things. So there's a lot of wriggle room, whatever kind

of makes me feel safe in what I need at the time. And what I really enjoyed is when I do choose to do those face-to-face sessions, which I genuinely enjoy, her space is just so comfy.

(13:59):

It makes my brain, my whole nervous system just really relaxed. And I remember the very first time that I went to meet with her for my first session years ago, and I walked in and she was lovely and welcoming and said, you want to sit on the couch? Go for it. You want to lay on the floor? Go for it. There's colouring books, there's sensory support tools, and do whatever you want. Take your shoes off, jump on the couch, whatever it is that you want. And already it was just this sense of, oh wow, this is a really safe space. I can stand, I can pace. I can roll around on the floor and it's not going to be perceived negatively by them, which was so important. And I'd never experienced that before, ever in my life. So that was really important in cultivating a safe environment for me, wanting to actually open up and not therapize my mask, but actually therapize me.

Emma Ketley (14:53):

Yeah. Yeah, absolutely. And I think that there is this kind of myth around therapy that it has to be delivered in a certain way.

(15:01):

And while you're talking, you mentioned the word privilege, but obviously in a different framework. But I've worked in governments for quite a long time, so mainstream, very, almost conveyor belt style kind of delivery. But even in them, I think sometimes the therapist, the psychologist, whoever it is, still has certain principles or certain factors as they can change in an environment. For example, even in government, I used to tell people, if you want to take off your shoes, you can. If in groups you want to stand at the back and you do stretches, you can. And that was my take on how I could work the environment for the good of the group or the good of the client. And I think it becomes almost a challenge sometimes when you are in these really cookie cutter kind of environments that it's basically the therapist and the client going, well, how can we change this space for us I suppose to be comfortable?

Amy Green (15:49):

Yeah, that's right. Because doubly important that the therapist or the person providing the supports is comfortable as well. Even though yes, it should be about the client. That's why they're there. Maybe that's just my empathetic streak coming through there in thinking if my therapist isn't comfortable in their environment, then how are we going to build this trust that's required for me to really open up and share the real raw experience.

Emma Ketley (16:17):

That's a lovely point, Amy. So you are actually talking about that. You go in to see the healthcare professional, but there's part of the way that you feel empathy that you need your person in the room to be comfortable as well.

Amy Green (16:29):

Absolutely.

Emma Ketley (16:30):

We've talked before about that dynamic quality of these types of disabilities day to day. What kind of strategies need to change based on your burnout, your pain, your sensory loading, what kind of things changed for you?

Amy Green (16:44):

So much. My support strategies change, as you said, based on my level of burnout, pain, sensory loading, all of the things. So what works one day might not work tomorrow. My support requirements are really dynamic, like so many others. But what I have found really great, which are things that I've explored while working with my care team and clinicians, one of the best things actually is body doubling, particularly with someone who, usually my friend circle as well as my husband, we are neurodivergent. We've all kind of gravitated to one another, which is amazing. So a lot of the time body doubling with a friend who's also neurodivergent, externalising that accountability. We're helping one another co-regulate, and this might be one of us needs to do grocery shopping, which is just sensory hell for anyone who is neurodivergent.

(17:50):

But really I find the only way that I can get there is if I am body doubling. So it's helpful to know that that's an option that I can message a friend who might live close by and say, I need to go get bread or whatever. Can you please be that person for me so we can do it together and we can survive. That's one of the best strategies that really, really helps when I kind of have to do really any task that perhaps I really don't want to. Another thing that my therapist has really helped me to explore is assistive technology. So the chat GPTs of the world, and I am a tech girly, I love tech, and I really wasn't using it for the longest time until my psychologist told me or walked me through how they use it in creating templates and scripts and all sorts of things that they might use really regularly throughout the day.

(18:52):

Particularly in my work, if I'm doing some project management, it's really helpful for me to use that as a tool to create templates and email scripts even that I might use quite regularly, but so useful at those particular times where I'm low on capacity, low on spoons as we like to say, and rather than trying to dig for access to words, it's there. It's ready for me to go. I don't have to think too hard on it, which really, really helps. As well as other assistive tech, like noise cancelling headphones is a big one. I also wear sunglasses a lot. So really anything that can kind of help reduce the sensory input is really important as well as the somatic and regulation strategies that I've learned along the way as well.

(19:47):

So particularly with having a couple of pain conditions, realising that I do need to take movement breaks, and I'm not saying go for a walk around the block, but just standing and doing gentle stretches. I mean, we both do this when we go out. We'll just kind of get up and go to the back of the room and do a little bit of a yoga -

Emma Ketley (20:08):

- because you have to.

Amy Green (20:11):

Exactly right. Just to kind of stretch out, and I'm a classic hand flapper. If I'm at the back of the room, I can participate in my hand flapping. I love weighted blankets. Having that proprioception, the input, it's fantastic. But these are things that I would've never have thought of if I hadn't have gone to the right therapist.

Emma Ketley (20:34):

Absolutely. And again, from my part, what I'm seeing and what I'm learning more and more is that you can have a room set up in a certain way. You can have the sensory fidgets, you can have whatever. But until the client feels safe, until they feel like they have the right, the permission, whatever, the accessibility to those, they won't be used. So what I see from my part is basically that normalising of, if you have to do it, that's fine. I've got a trait, I'm English. I usually ask for permission. But quite frankly, if someone's going to say no, I'm probably still going to need to do it right? Because if we want the best out of our client, that's what we are there for. We want our clients to be comfortable to be able to make use of the space.

Amy Green (21:19):

I mean, I've rattled off a lot of non pharmacological strategies that are available, and I mean, it's limitless. There's so much, and these are things that specifically work for me that might not work for others. So for you as a clinician, how do you help clients to sort through the misinformation or overwhelming online advice in particular that they might come to you with? How do you deal with that to get to providing strategies that actually work?

Emma Ketley (21:53):

Yeah, I knew you were going to throw questions back at me. It means that we are both safe and here. Yeah. I think that there is a lot of misinformation. There's a huge amount. In fact, there has been a study done on how much is in social media that is inaccurate. And I quite often find myself guiding people to further resources that are more credible because there are a lot of damaging myths out there about things. I think one of the things is the subheading for today could really be like pills don't teach skills. Right?

Amy Green (22:26):

Yeah. I love that. I wish they did. It would make things easier.

Emma Ketley (22:31):

Exactly. And I think maybe this is a kind of a throwback from maybe medical model. My psychiatrist who diagnosed me was fantastic, but he basically said, you've done everything you can, you need medication. And I thought medication will help because medication can help, but there's so much more that an individual can explore and find for themselves. So I think first of all, it's about maybe having an open conversation, creating that safe space so the person can actually fact check with you so we can

have a bit of a curiosity. If someone's bringing something into the space as a question that tells me that they're implicitly interested about it, they directly relate to it. So having an open conversation around that. And then I think second of all, once they've taken medication and it may or may not work to the full kind of whatever they expect it to be, I think from there, it's that there is no magic handbook of strategies.

Amy Green (23:29):

I was kind of hoping that you said that you were going to say that there was.

Emma Ketley (23:32):

Yes. When people come to me either as a mental health OT or as an ICF ADHD coach, and they say they want strategies, my job is really for that person to explore what they're already doing, because quite often the stuff that they're already doing are amazing innovations that can be working. So we can build upon those strengths of what they're already doing.

(23:56):

And then we can just rifle through, explore some of the other ways, little tweaks of what they're doing or perhaps bring in new ways of doing things. But I think that would be a red flag. If you walk in and someone gives you a handbook of do this and you won't be X anymore. That's not the point. We're not working to fix neurodivergence. We're accepting it and working inclusively and collaboratively with an individual that has human experiences plus maybe a bit more because of the way the throne is wiring some of these additional sensory sensitivities, for example, different ways of communication. There isn't a one size fits all type world, really. Everyone's just doing the best that they can. So I think that's how I work, is that I will help co-design or explore strategies with clients, but I don't see myself as being a teacher to provide those things.

Amy Green (24:53):

I love that.

Emma Ketley (24:54):

We have covered a lot of territory today, which I'm hoping is a value to the audience. Thank you for joining us for part 1, this conversation about non-pharmacological supports for ADHD. Make sure you don't miss out, and we look forward for you joining us for part two, of this continued conversation. We'd love to hear what you thought of this episode. And on the landing page with MHPN, you'll find there's a link to supportive resources and a feedback survey. Be honest, because we're all here to learn, fill out the survey to let us know whether you got what you needed from this conversation today and provide any comments or suggestions about how MHPN might better meet your listening needs. In the meantime, if you want to stay up to date with MHPN podcasts, make sure you subscribe to the MHPN podcast. Thank you for your commitment to ongoing learning and to multidisciplinary mental healthcare.

Host (25:50):

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