What makes ADHD burnout so different?

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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 back to MHPN Presents part two of my conversation with Amy Green that focuses on non-pharmacological supports for working with people with ADHD. My name is Emma Ketley. Delighted to have Amy back again, just to be able to talk. Hello, Amy.

Amy Green (00:36):

Hello. And I'm delighted to be back. Thank you.

Emma Ketley (00:38):

So, as you know, picking up from our conversation previously, we're just exploring the pills don't teach skills concept, working out how clinicians can work collaboratively in partnership with people. There is a lot of talk, and in fact, MHPN did a panel discussion about burnout, that I was very proud to be part of. But there's a lot of talk about burnout, neurodivergent burnout. What does that feel like? What is that? What's that experience like?

Amy Green (01:08):

Not fun. And it differs greatly to what people would typically think of occupational burnout. Neurodivergent burnout is completely different. We're talking about chalk and cheese. Although in saying that as someone who does participate in employment, I get the joys of both.

Emma Ketley (01:36):

Lucky you.

Amy Green (01:37):

Which I mean, to be fair, I don't think that I can untangle for me specifically the difference, but what does burnout feel like to me, specifically, the systems that keep me functioning literally shut down. It's not tiredness. It's a collapse of my cognitive, emotional, sensory and executive functioning all at once. It's a complete shutdown. It's the point where my brain can't keep masking, compensating, or pushing through anymore. I cannot do any of that. For me, it affects my executive functioning, my sensory tolerance emotional regulation, which is very rare for me because I like to think I'm pretty level-headed, mellow. It affects my access to words and speech, and it also affects my motor skills. The last big burnout that I had, I was walking one moment and down on the floor the next moment. So it really short circuits everything. So it's not solved unfortunately, by a good night's sleep. It can take me and it has taken me weeks, months, and honestly probably years to even come out of some periods of burnout. So it's huge.

Emma Ketley (03:12):

Yeah, absolutely. And for me, again, from my perspective, I have been working with people, divergent people consciously seeking to work with this population since 2019. And I think I'm really aware that there's just the presentation of something like depression and something like burnout from the external, looking at the individual client, can look very similar, but the internal experience of what depression or burnout is can feel sometimes different.

Amy Green (03:44):

Absolutely.

Emma Ketley (03:45):

I mean, depression can be a factor of it because as you just described, you literally see some of your capacity dropping away.

Amy Green (03:52):

Right. And it can be quite distressing. So it seems logical that I would become depressed.

Emma Ketley (03:57):

Absolutely. Absolutely. But it's not depression. It's depression is a symptom of that burnout.

Amy Green (04:02):

Absolutely.

Emma Ketley (04:04):

You said about their sensory profile, can you talk a little bit more about that? What happens sensorily when you were in burnout?

Amy Green (04:12):

Oh, wow. Already on the day to day, all of the sensors, they're kind of already on high alert, but when I am in a period of burnout and full disclosure, I am in a period of burnout at this very moment, but my window of tolerance, it's there, but we haven't quite pushed through. So I am trying to mitigate that from happening internally, doing all I can. But the sensory experience when I'm in burnout is if we're already at level 12 every single day, it's cranked up to 15, 20, a hundred, 150. We're shattering windows basically at this point. And it can be if my husband might be listening to a song at home, and I would typically love that song, I essentially flip my lid. And I am not a screamer, I'm not a yeller, I'm not a shouter. That's just not in my nature.

(05:11):

But because he is a safe human for me, and because he has experienced me for years dip in and out of periods of burnout, it's unfortunate that he does experience that side of me where I've literally yelled, turn it off. And when we didn't know that I was neurodivergent, of course it would spark fights. But now, because we both have that understanding and he himself is neurodivergent, he'll turn it off straight away because he knows the level of distress that for me to have yelled. It's not like me. Wow. Ames must be really, really distressed at the moment, and I want to support my wife as best as possible. I'm going to do the thing that she needs. So things that would typically be really pleasant, become awful.

Emma Ketley (06:05):

So you're feeling things much more intently, things that might have been tolerable or even enjoyable. Stop being that.

Amy Green (06:12):

Yeah.

Emma Ketley (06:13):

When you're in burnout.

Amy Green (06:14):

Yeah.

Emma Ketley (06:15):

We talk about Anhedonia in depression where you can't enjoy things, that you don't want to, but you are talking about tolerance, you're talking about that you just can't.

Amy Green (06:23):

Yes.

Emma Ketley (06:24):

It's not the enjoyment is secondary, it's just that you just can't handle that input. Absolutely. So that's a very different point again, isn't it? Yeah. But there's no sign, there would be no obvious side that you are struggling or that you are in burnout, which is obviously one of these factors, right?

Amy Green (06:38):

Yes.

Emma Ketley (06:39):

And it's important for the people around you, to be able to tell them that, that's how you manage through it. Right?

Amy Green (06:44):

A hundred percent. And it's hard. It really is. Particularly in this economy, in this world, I do choose to work, which as I said earlier, it pushes me into burnout. It's one of those factors. And as much as I am very open about sharing my plethora of disabilities and acronyms, a lot of people don't really understand what that means. But for the people that do like yourself, my husband, my people, it is that dichotomy of, wow, she looks like she's doing fine. She keeps going. She keeps waking up every morning and going to work. But the reality is that, that is all I have the capacity to do, anything outside of that one huge task, which is work. Anything outside of that self-care, home care, anything I am completely incapable of doing.

Emma Ketley (07:44):

Yeah, absolutely. You're just kind of in a survival mode, which then makes me think that clinicians, that accessibility isn't at a point here, because these are times when you really need to be able to get in touch with your care team. But if the care team approach is structured in a way that you have to fill out a full form or you have to sit in a office with fluorescent lights or something like that, or you have to do one of those at scale assessments to even access your clinician, then I guess the people that are trying to support you in your path actually are inherently putting barriers in. So I guess my question is, what barriers do you experience before you even walk in the room when you're trying to access support when you need it?

Amy Green (08:28):

You're completely right. A lot of services are designed for the neurotypical human or the neuron normative human, what you said around forms. Oh my gosh, some. You purposely make them long, don't you? And a little bit vague. So you'll sit there and go, what does this mean? Yes, they are long text heavy. It's already a huge barrier to fill out a form to try and access a service at times, particularly when my capacity is low, as well as there are still plenty of services out there where the only way that you can book an appointment would be to pick up the phone and call. And as I said earlier, when I'm in burnout, my access to words, it's not always available for me to grasp and make that phone call. So having online booking systems or portals that people can use is really important for services. And I know that not everybody can do that coming from your clinician perspective, particularly if you own and run your own business, that might be a cost heavy thing that isn't possible. So again, that's just the empathy that I

have for the clinician as well, because not everybody can offer the sorts of accessibility options that may work best for the neurodivergent person, but there's also the executive dysfunction, which can often actually look like.

Emma Ketley (10:03):

Yeah, I've seen that.

Amy Green (10:05):

That's a big one, right. And I can only speak for myself, but having experienced that before has created a lot of shame for me and internalised stigma and ableism. It's hard to want to even access supports and attend therapy when you feel like you are always failing at being consistent.

Emma Ketley (10:30):

Yeah, absolutely. And I think it gets to the point where I perceive that there's been patterns sometimes when clients have almost ghosted services, and then teams will say, oh, they've just disengaged. But what we're seeing is that an active behaviour is that someone in a shame withdrawal. And I mean, you and I have spoken that my pathway into kind of getting really interested in getting skilled up by becoming an ADHD coach was because I was actually working with a population of borderline personality disorder, and I was recognising a co-occurrence of ADHD, but some of those executive functioning challenges, like the person wasn't turning up or they weren't doing their homework or something was actually being seen as a trait, a behavioural trait of that person in active resistance against the system being non-compliant. And so all I started to do back in 2019 was actually scaffolding things. So spending a bit of time at the end of the session to do the homework so that they could body double on some of those things.

Amy Green (11:33):

I love that.

Emma Ketley (11:34):

Well, sending an extra little reminder here and there of an appointment and not shaming when someone turned up a little bit late, but just acknowledging that they'd made it.

Amy Green (11:42):

Oh, see, that's why I love you.

Emma Ketley (11:45):

Ditto, kiddo. I suppose there are some simple changes that I see clinicians could make, and I mean, first all for myself is to probably not assume that everything is that resistive behaviour, but being open and curious.

Amy Green (12:03):

Yeah, curious, not furious.

Emma Ketley (12:05):

Oh, absolutely. Yeah. And you've talked about there, about the different modalities using the different systems. So text message systems, online booking system. I mean, how useful is that now to be able to use technology that someone doesn't have to verbally phone up, talk to a receptionist then to get to talk to a physician or, it's amazing things like using visual aids where possible, things like being curious again about if there's inconsistency in attendance. And I work with a lot of neurodivergent women, and I'm again astounded of how none of our assessment tools ever look at hormonal fluctuations for menstruating individuals, right? Because these are dynamic disabilities. So our clients, a hundred percent is different. And one of the biggest differences is hormonal fluctuations and that running out of spoons quicker, different types of the month.

Amy Green (12:58):

Absolutely. Yeah.

Emma Ketley (13:02):

So if I throw it back to you, again, it feels like a certain amount of repetition, but just to really enforce, what is it about the human aspect of therapy that you found really actually helpful, particularly those things that the clinicians might not have thought about?

Amy Green (13:20):

It really goes back firstly, I think, to that personalised approach, that person centred approach. And like you said earlier, the supports that each neurodivergent human requires, it's not a one size fits all. It would be great if it was, wouldn't it? But there reality is there, and it's one size for this particular person in this particular period of their life. As you said, there's hormonal fluctuations, particularly for AFAB folks. So eventually we're going to experience perimenopause and menopause. So what might have worked five, 10 years ago for that person isn't necessarily going to work now as they're going through that hormonal change. And that's huge. So it's really that individualised care, I cannot stress that enough, and I know we talk about it a lot, but it is something that I wish every health practitioner would meet me with. Also, what I find helpful is yes, there are a lot of challenges that I in particular face, but I also know that I have a lot of strengths as well. And historically that was hard for me to pinpoint what are my strengths. School reports would really highlight all the terrible things that Amy's not great at, but it would never actually really tell me the things that I do well. So really having a strengths based interventions for me, using my hyper focus if I can and do have access to using that intentionally, I can get so much done.

(15:17):

That's not something that the average human might have access to, but it's something that I have access to, which makes it a real strength for me. Also, really leaning into my interests and the novelty things, particularly for my ADHD brain. It's looking for the shiny things, the glimmers,

(15:39):

And then the autistic piece of me has special interests, and I could talk about that for God, time doesn't exist when we start talking about special interests, but also the fact that for the majority of us, we have incredibly creative problem solving and really kind of focusing on the creative problem solving rather than the compliance. For me at work, I really don't like the answer of, well, we do it this way because it's always been done this way. That's never good enough for me, and it shouldn't be good enough for anyone regardless of their neurology. There's so many different creative ways that we can find solutions to problems and creative solutions and strategies that folks can use to kind of manage traits, I guess. But also, I think never before had I had a multidisciplinary care team and supports, it was you just go to the GP or you speak to a therapist. Whereas now I've got an incredible care team. I've got an OT, I've got a psychiatrist, a psychologist. I would consider you to be a coach for me, not in the official sense, but because we are friends and we can bounce those things off of each other.

(17:03):

The power of having people like Emma in my life who understands both the lived experience, but also you have this incredibly rich clinical insight, which you love to share with me. So I'm very blessed to have those supports, which actually help.

Emma Ketley (17:23):

Exactly. I think that's one of the biggest things that I learned is that it's about community. It's about connection. So in the clinical room, it's about that connection, feeling safe if you're a client, feeling safe with the person that is there to support and listen to you. I think that's one of the big things that has changed over time is that it's kind of being called modern therapy in that bringing the human into the room as a clinician as well. It doesn't diminish as clinicians our position of, I suppose, knowledge, clinical knowledge and training, but we can turn up a little bit more human, I think, and really help connect.

Amy Green (18:00):

And I think that's really important. And from a client perspective, I love when any of my support team, these are learned people, they've gone to university, they've got the things that have their names in the letters and stuff. And for that person to sit across from me and say, oh yeah, I've also got an ADHD brain, or yeah, I'm also autistic, or, yep, I've got dyslexic traits, et cetera, that's really powerful and helps me to trust that person a lot more than had they not shared that information about themselves with me.

Emma Ketley (18:35):

But I guess there's a point of clarity. It's not necessary though, is it?

Amy Green (18:40):

No.

Emma Ketley (18:42):

It it's kind of useful in that collegial kind of collaborative approach of partnership, isn't it? If someone is a, clinician's got their own lived experience, but I know of coaches and stuff that don't have that, but they've still managed to hold and work with the client really well.

Amy Green (18:58):

Oh, absolutely. I mean, empathy, right? And compassion. You don't have to be neurodivergent to be supporting neurodivergent people.

Emma Ketley (19:06):

Yeah. And you talked again about the team approach. So you said you've got an OT, you've got a psychologist, you've got a psychiatrist, and I think you build some allies, you might need just more than one professional. And I think clinically sometimes we might be a bit confused if someone has got a psychologist or a therapist and then they've got a coach, but actually the team can actually compliment each other really well.

Amy Green (19:30):

A hundred percent.

Emma Ketley (19:31):

And again, it's really asking the client, what are your needs here? What works for you? Right? The curious not furious type thing. I know we had talked previously about what some clinicians have done have actually unfortunately sometimes increased cognitive load, given you worksheets and things told you to journal. Just as an individual here, just given this an example of what you have heard.

Amy Green (19:54):

The things that don't work can actually be quite harmful. And I have experienced previous to my formal diagnoses and exploration of my neurology, really romanticising wellness trends, especially now that social media is around. So I have experienced in the past mental health practitioners and clinicians kind of saying, just do some journaling or go and do some yoga, just meditate, those sorts of things, which a lot of ADHD folks in particular find stillness based practises really, really dysregulating as well as highly inaccessible.

Emma Ketley (20:39):

That's breathing stuff, is it?

Amy Green (20:41):

Yes. It's telling us, have you tried breathing? It's really not helpful.

Emma Ketley (20:48):

It's kind of like, I liken that too if you've got someone that's very depressed and you just tell them to cheer up, you're kind of missing the point, right?

Amy Green (20:56):

Yeah, yeah, exactly.

Emma Ketley (20:58):

You haven't asked enough questions if you think you can offer a prescription of what that person should do.

(21:04):

The other thing, when you were talking about strengths there, the power of listening means that you would be someone that if you came in and you've said, my special interest is psychology, and I knew that I wanted you to understand a principle. I wouldn't give you a worksheet. I might ask you if you want one, so you can decline it if you want, but I would probably utilise the strength of you liking to research, because I would know that that would be regulating for you if that's one of your special interests. So I would say, do you want to look at this paper? Do you want to look at that? And I would offer to work with your strengths, but we would get to the same goal as if I just had handed you a stock standard worksheet. Right?

Amy Green (21:43):

And like you said, there are people who want that, right? They want the homework. They want you to provide maybe those journaling activities. I personally am not that kind of human, but I love researching on my special interest, which happens to be psychology and neurodivergence and the human experience. And for me, in therapy, quite often my psychologist will send me links to papers and all sorts of things because I do find that therapeutically helpful and regulating for me. And it's also how I learn. So it's really important for me that whoever is supporting me understands that about me.

Emma Ketley (22:28):

Yeah, because some ideas look great on paper, right?

Amy Green (22:31):

Yes.

Emma Ketley (22:32):

The therapist handbook of we do this, this, and this, but it's all about adapting it for the individual needs.

Amy Green (22:37):

Exactly.

Emma Ketley (22:38):

And again, if I've got a client whose strength is say drawing, or if their strength is writing or something like that, I'll just say, could you help me understand what that feels like in whatever modality you want? It doesn't have to be written form because it's not always verbal language. That is the first choice to express. Absolutely. Particularly with things like alexithymia that you mentioned earlier. Sometimes it is really hard for autistic folks, ADHD, is to access what it actually feels and put a label to it, to reassure our clinicians. That's not that person being deliberately obstructive.

Amy Green (23:17):

No. I mean, we can be.

Emma Ketley (23:19):

Oh, of course. It's absolutely in your choice, but it's not always right.

Amy Green (23:25):

Exactly. Right. And part of that for me is I need processing time. If you are putting the question of, well, how does that feel for you? I might not know right now, but in five business days maybe I've processed and I'm like, oh yeah, actually this is how that feels within my body or whatever. It's, I might be able to better articulate it after that processing time.

Emma Ketley (23:53):

So would that be useful then, if you had the agreement with your clinician to be able to say, Amy, what did you think of the last session? Is it sometimes that you need a bit more processing time?

Amy Green (24:04):

Yep, absolutely.

Emma Ketley (24:05):

Just a side question, do you find that clinicians try to talk at you too much? Is there enough empty space and sessions for you to process and talk.

Amy Green (24:13):

Previously? Yes. Historically, particularly before unpacking my neurology and learning all of these new and wonderful things about how my brain works, yes. I felt that therapy was more being talked at, whereas now I am being supported in the way that I need and I am given the grace of processing time.

Emma Ketley (24:38):

Brilliant. Before coming into this podcast, there is a model that's come from the uk, which autistic doctors have come up with, Mary Doherty, and it's called the space model, which is just to consider in the room the sensory needs, the predictability of the session, telling the client what's going to happen, well not telling them, but just saying, this is how this session could run, is that okay with you. You know working on acceptance of what things are rather than deficit focus, asking the client how they prefer communication to happen. Do they want pen, paper, and just that human empathy. So that's the space model that I quite often go to, and it's a good acronym. Yeah, we love a good acronym, don't we.

Amy Green (25:17):

Don't we!

Emma Ketley (25:18):

Okay. So the space model, it's really good. From Mary Doherty, we could talk for hours, Amy, that's obviously a danger. So is there any final words that you want to give our audience?

Amy Green (25:30):

So for me, really, non-pharmacological support isn't about fitting myself into systems. It's about shaping the environments, the relationships and supports that honour how my brain actually works. So the more practitioners approach neurodivergence, as you said, with curiosity and humanity, the more that we create care that people can truly engage with and feel supported.

Emma Ketley (26:03):

Yeah. Okay. That's wonderful. That's a brilliant summary of your experience within these rooms and navigating through. So thank you for joining us for this part two, which was our concluding section on conversations about non-pharmacological supports with ADHD folk with Amy. We have covered a lot of territory today, which I'm hoping is of value to the audience. The things that we've covered in parts one and two is the relational safety, establishing that place where a person can be really truly themselves in excess services when they're in burnout. In particular, a place that's free of judgement and that is inclusive and collaborative. You've given us some amazing strategies of things that work for you in sessions. Your posture breaks, the permission just to do whatever you need to use those accommodations, using technology where possible. So it's not always verbal communication and that sense of just being able to openly guide therapy rather than being passive in it.

(27:06):

So thank you so much for your time, and thank you to the audience for joining us on this episode of MHPN Presents, which has been a conversation about non-pharmacological supports with ADHD folk. Like I said, we've covered a lot of territory, so it might be worth a re-listen at some point. 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 further and 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 podcasts. I also want just to highlight that WA has its own state, MHPN for ADHD professionals that I'm very proud to run. So please join us for that or any other networks around Australia. And thank you for your commitment to ongoing learning and to multidisciplinary mental health care. Thank you.

Host (28:16):

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