

Cambridge & Peterborough Training Hub

*Belonging in Practice - Inclusion, Identity and Thriving in
General Practice in Cambridgeshire & Peterborough*

Session 3: Neurodiversity as Strength in General Practice

Wednesday 1 July 2026, 7:00–8:30pm (virtual)

Dr. Susie Lister



Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: emotional dysregulation, RSD, sensitivity to scrutiny, PDA, overwhelm, hyperempathy, sensory processing differences**
 - **Mental Health Comorbidity**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**



My Story

1999 – Uni of Cambridge, Natural Sciences: Physics & Philosophy of Science

2004 – Cambridge Graduate Course in Medicine

2010 – GP Training, started med student teaching

2013 – 3 years of 8 clinical sessions as a Salaried GP → **burnout** → received **coaching** with Rachel Morris

2016 – Returned from mat leave → 4 sessions as Salaried GP + teaching portfolio (GPEG, CCS, PPG)

2020 – Contracted Covid-19 → **Long Covid**: ++fatigue, brain fog, low grade temp elevation
→ continuous symptom with recurrent flares requiring time off work

2021 – Realised I had **ADHD**. Started giving GP Coaching with CPTH.

2022 – NHS GP work contributing to health decline, handed in notice, **3 months of bed rest**.

2023 – Returned to work; **flexible**, remote private GP role (DCA), 2x 4 hr days/week,
with breaks & bed rest days between. ADHD diagnosis, started formal ADHD training

2024 – Health improved with treatment of ADHD, POTS, MCAS & PMDD/perimenopause.
Started working at **CamADHD**, started teaching GPs

2025 – Started **ADHDdoc.co.uk** information hub website



Personal research,
developing an
understanding of the
links between ADHD,
Long Covid, hEDS,
POTS/OI, MCAS,
viral reactivation, &
hormone sensitivity



THE
CAMBRIDGE
ADHD & AUTISM
CENTRE



Training & Learning Networks

I have attended the gold standard programmes in the UK for the assessment, diagnosis & treatment of ADHD & Autism, including training provided by the:

- **UK Adult ADHD Network (UKAAN)**
- **British Association for Neurodiversity (B4ND)**
(a national network of GPs working in ADHD)
- **Royal College of General Practice**
- **Royal College of Psychiatrists.**
- **Compass Psychology**
- **UK Doctors Long Covid Group**



UK Doctors Long Covid

Private group · 1.7K members



Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: emotional dysregulation, RSD, PDA, overwhelm, hyperempathy, sensory processing differences**
 - **Mental Health Comorbidity**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**



ADHD 🌀 Specific Learning Disorders

Percentage Rate in ADHD

- Overall SpLDs (at least one): **31% – 45%** (Aksoy, 2024)
- Dyslexia (Reading): **25% – 40%** (Aksoy, 2024)
- Dysgraphia (Writing): **59%** (Mayes et al., 2017)
- Dyscalculia (Maths): **26%** (Gross-Tsur et al., 1996)
- DCD / Dyspraxia (Motor Coordination): **~50%** (Delgado-Lobete et al., 2020)
- Auditory Processing Disorder (APD): **~50% – frequently missed** (Riccio et al., 1994)



Multiple neurodivergence / SpLD comorbidity is therefore the norm rather than the exception

- ***These factors represent a hidden additional layer of challenge***
- ***The accumulated effort to compensate increases susceptibility to overwhelm, fatigue & burnout.***
- ***Screening & diagnosis can allow targeted interventions, accommodations & support.***



Case 1: Dyslexia & Hidden Effort

Fatima was struggling with her PhD work, so arranged a SpLD assessment:

“The test came back that I have a very high IQ, but my dyslexia is off the charts!”

What was challenging?

- **Slow scanning** — reading word-by-word rather than skimming for key information.
- **Hidden time cost** — emails, websites, forms & signage took more time & effort than others realised.
- **Extra checking** — spellcheck, rereading & proofreading were needed for accuracy, taking time & energy.
- **Overload worsened errors** — tiredness, rushing or overstimulation made misreading more likely.

What helped her thrive?

Fatima is now a teacher, and her dyslexia has become part of what makes her effective.

- She offers **representation** — pupils see that dyslexia is compatible with intelligence, achievement & professional success.
- She **models helpful strategies** openly: using spellcheck, dictionaries, rereading and asking others to check.
- She can **advocate for pupils** who are struggling, because she understands the hidden effort involved.
- She uses her **verbal skills, creativity and empathy** as strengths.

“What makes my ND ok is that I have found something where I can use all my traits as positives and where I get positive feedback as an employee.”



Case 2: Auditory Processing Disorder & Fatigue

- **Ayana** had always found hearing difficult, but hearing aids had never seemed to help.
- She was able to get by at school by **sitting at the front & lip reading**, & she used **subtitles** on the TV..
- At work or socially, talking 1:1 was ok, but it was **much harder in groups or in noisy environments**
- When Covid happened, meetings were online more & more...
 - ◆ She found it harder to lip-read on a **screen**.
 - ◆ **Voice-to-text functions** were helpful, but it was hard to **keep up, & read facial expressions & nuance**.
 - The effort was exhausting.
- When Ayana reached her 40s, she found it harder to compensate.
 - ◆ She was missing things and becoming more & more exhausted by the end of the week.
 - ◆ She didn't have any energy in the evenings & weekends, and
 - ◆ it was affecting her mental & physical health.

What Helped?

- *Ayana chose to move to a four day week. She found the extra rest boosted her resilience, making her better able to compensate.*
- *Ayana started taking HRT, which helped with her executive function & energy levels.*
- *She moved to a job where she was able to work face to face, with time & space to recover.*
- *In her work, she campaigns & advocates for equality, inclusion & diversity in the workplace.*



SpLD – Potential Strengths

Evidence suggests some diagnosis-specific strengths (data primarily in dyslexia)

- **Big-picture (global) thinking** (*dyslexia*) (*von Károlyi et al., 2003; Maw et al., 2024*)
- **Visual-spatial reasoning** in some individuals (*dyslexia*) (*von Károlyi et al., 2003; von Károlyi, 2001*)
- **Creative and innovative approaches to problem-solving** (*dyslexia; evidence mixed but supportive*) (*Maw et al., 2024; Logan, 2009*)

Across Specific Learning Differences, many people develop strengths through compensation & adaptation

- Resilience and persistence (*de Beer et al., 2014; de Beer et al., 2022*)
- Flexible problem-solving (*Maw et al., 2024*)
- Good metacognitive awareness (understanding how they learn best) (*de Beer et al., 2022*)
- Effective use of assistive technology and adaptive strategies (*de Beer et al., 2014*)
- Adaptability and resourcefulness (*Maw et al., 2024*)



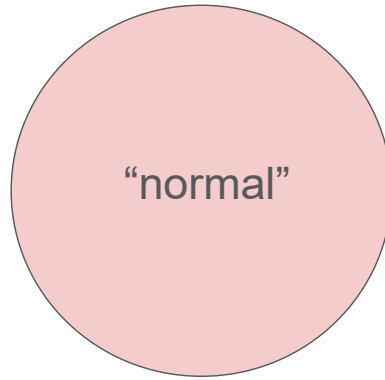


Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: emotional dysregulation, RSD, PDA, overwhelm, hyperempathy, sensory processing differences**
 - **Mental Health Comorbidity**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**



***Strengths, Challenges,
Stories & What Helps?
ADHD, Autism & AuDHD***



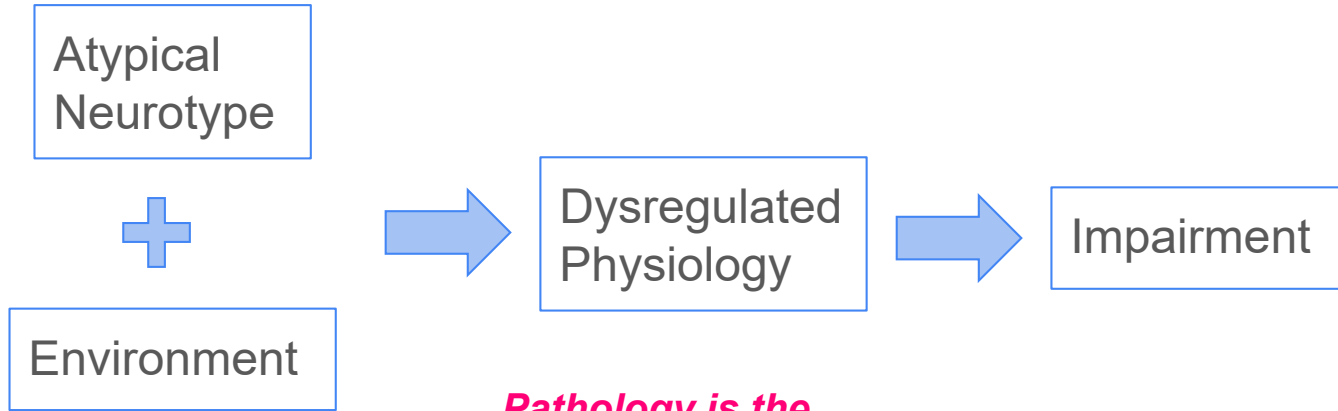
V.



- ***Everyone*** is predisposed to different challenges
- Not everyone with **autistic/ADHD traits** meets the threshold for a diagnosis
- Those at the extremes of each spectrum are likely to experience more difficulties
- The diagnostic threshold is related to the level of **impairment/impact**
- The level of impairment is **variable** depending on **environment & triggers**
- **Knowledge** of traits & triggers can help everyone, whether or not they meet the threshold for diagnosis
- **Neurodivergent-friendly, neuro-inclusive & neuro-affirmative** education & workplaces can help **everyone**
- **Awareness, representation & advocacy** supports **clinicians and patients alike**.



Is it Difference or Deficit?

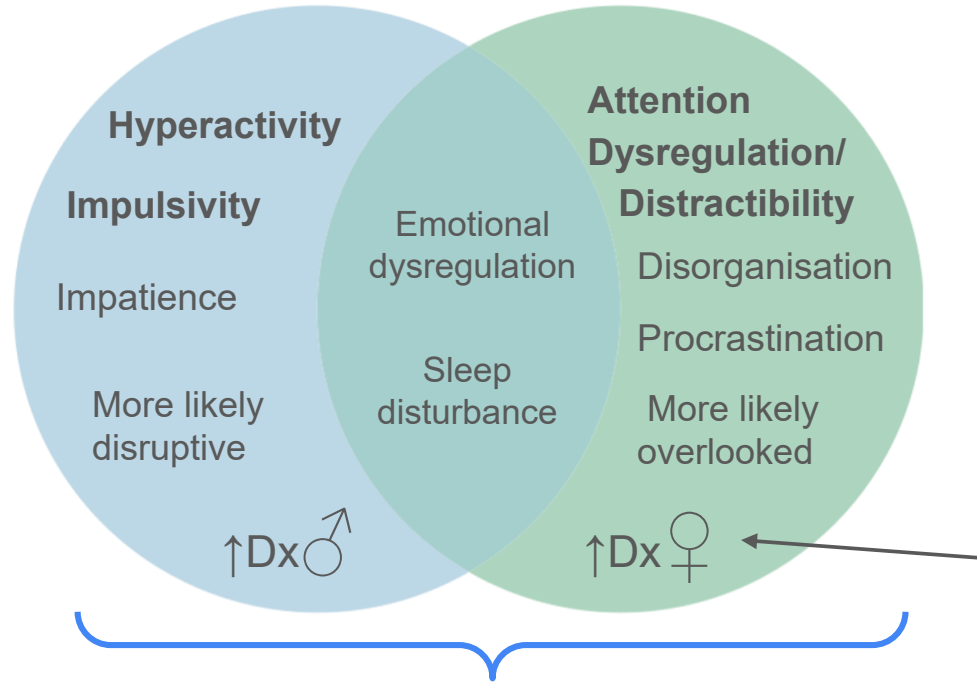


Pathology is the dysfunction of systems causing harmful or impairing processes



**Attention-Deficit/Hyperactivity Disorder,
Predominantly Hyperactive
Presentation
'ADHD-H'**

**Attention-Deficit/Hyperactivity Disorder,
Predominantly Inattentive
Presentation
'ADHD-I'**



Hyperactivity may be present but more masked in girls & women

Attention-Deficit/Hyperactivity Disorder, Combined Presentation, 'ADHD-C'



Strengths in ADHD :)

open-minded
spontaneous
insightful adaptable driving_force
intuitive
quick_witted innovative
motivational responsive courageous
engaging energetic life&soul
athletic inspirational
hyperfocus creative charismatic
non-judgmental high-achieving



ADHD (& ADHD Traits) - *Potential Strengths in Primary Care*

- Recognising patterns; understanding & optimising systems
- Getting to the heart of a matter in meetings & emails
- Representing things clearly for education & communication
- Innovative ideas for research & solutions for complex problems
- Highly motivated & passionate in areas of interest
- Creative approaches bridging gaps across formats, services & specialities
- Embracing change with adaptability & optimism
- Authentic, open communication style builds relationships with staff & patients
- Energy & enthusiasm can boost morale & team cohesion



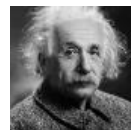
Successful & influential people throughout history with ADHD or likely ADHD traits

Famous Inventors, Geniuses & Entrepreneurs

- **Ada Lovelace:** Widely considered the world's first computer programmer; "lightning-fast", non-linear mind, described her thoughts as a racing "inner universe," and struggled heavily with impulsivity & a severe gambling addiction.
- **Leonardo da Vinci:** Renaissance genius who famously jumped between disciplines, leaving many masterpieces unfinished.
- **Thomas Edison:** Relentless inventor who channeled boundless physical energy into securing 1,093 patents.
- **Albert Einstein:** Struggled with rote learning & rigid classrooms; inattentive & rebellious in school. Forgetful & disorganised but able to focus intently on physics, showing rapid, unconventional connections with exceptional creativity & non-linear problem-solving
- **Wolfgang Amadeus Mozart:** Possessed boundless energy & a racing mind, frequently writing entire symphonies in a single sitting.
- **Richard Branson:** Virgin founder Dx ADHD, delegates details to focus entirely on big-picture strategy.
- **Ingvar Kamprad:** IKEA founder who credited his diagnosis with his risk-taking global retail empire.
- **David Neeleman:** JetBlue founder who calls his racing ADHD mind his business "superpower."

Creative Minds & Elite Achievers

- **Agatha Christie:** Known for intense forgetfulness & tendency to start dozens of plotlines at once. She frequently lost track of details but was able to write entire masterpieces in rapid bursts.
- **Walt Disney:** Animation pioneer who linked his school struggles to his later creative risk-taking.
- **Greta Gerwig:** Oscar-nominated director who credits adult ADHD for her rapid-fire, high-energy filmmaking.
- **Jamie Oliver:** Celebrity chef who manages his childhood diagnosis through an active, fast-paced culinary career.
- **Simone Biles:** The most decorated gymnast in history openly champions her lifelong ADHD diagnosis, showcasing how neurodivergent individuals can achieve absolute elite-level mastery.
- **Dr Camilla Pang:** award-winning scientist & author who uses her childhood ADHD & autism diagnoses to decode complex human behavior.



Why GP can be the perfect place for ADHDers!

- Novelty & variety - new & different challenges all through the day!
- Built in deadlines - fixed time-checks every 10-20 minutes!
- Problems with short term resolution, giving satisfaction & feedback!
- Fewer long, unstructured & self-motivated projects!
- Fast pace & high urgency, keeps engagement!
- STEM problem solving!
- Excellent interpersonal skills required!



ADHD: Potential Challenges – Hyperactivity

hyperactivity
sing
impatience fatigue
rush steamrolling
sleep burnout clumsiness
disturbance fidgeting trichotillomania loud
memory_issues tapping mistakes
fast_talking dermatillomania
talking_too_much chaotic stimulus seeking
busy brain behaviour



ADHD: Potential Challenges – Impulsivity

forensic_history
employment_difficulties
overspending
steam-rolling no-filter impatience
gambling addiction promiscuity
binge-eating conflict risk-taking
poor_decision_making interrupting violence
relationship_difficulties inconsiderate



ADHD: Potential Challenges – Inattention

losing things
‘careless errors’ forgetfulness not planning ahead
distractability procrastination
time-blindness
not listening inefficient zoning out
daydreaming
difficulty following disorganisation
long explanations
unfinished tasks working memory impairment



ADHD – Potential Challenges in Primary Care

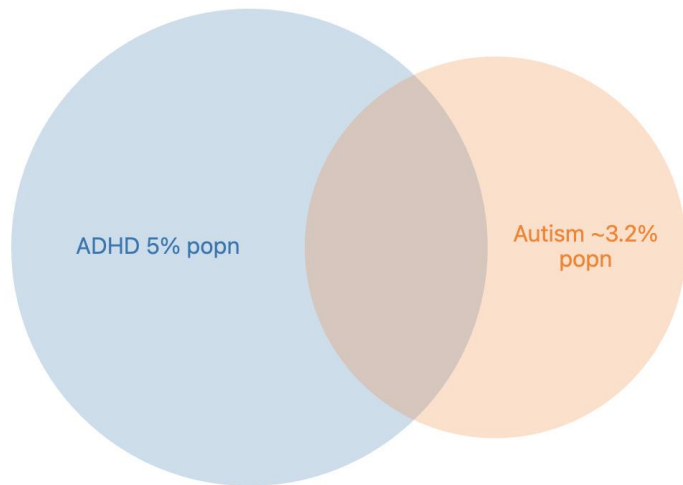
- **Running to time:** Time blindness, over-talking, perfectionism, day-dreaming or difficulty closing consultations can make rigid 10-minute appointments hard to sustain.
- **Admin debt & procrastination:** Letters, forms, coding, audits, referrals and e-portfolio tasks can build up when tasks are low-novelty, low-urgency, repetitive or emotionally aversive.
- **Working memory overload:** Holding multiple details in mind — history, risks, medication doses, safety-netting, results, tasks — becomes harder under pressure or interruption, leading to unfinished tasks and errors.
- **Sensitivity to feedback / scrutiny:** Constructive feedback, tutorials, complaints or perceived criticism may trigger disproportionate shame, anxiety, defensiveness or avoidance.
- **Communication mismatch:** Fast, enthusiastic or non-linear thinking may be misread as chaotic, interrupting or not listening, even when the clinician is engaged and making connections.
- **Masking tax & burnout:** Constantly suppressing restlessness, emotional intensity, distractibility or non-linear thinking to appear “professional” can be exhausting.



ADHD, Autism & AuDHD

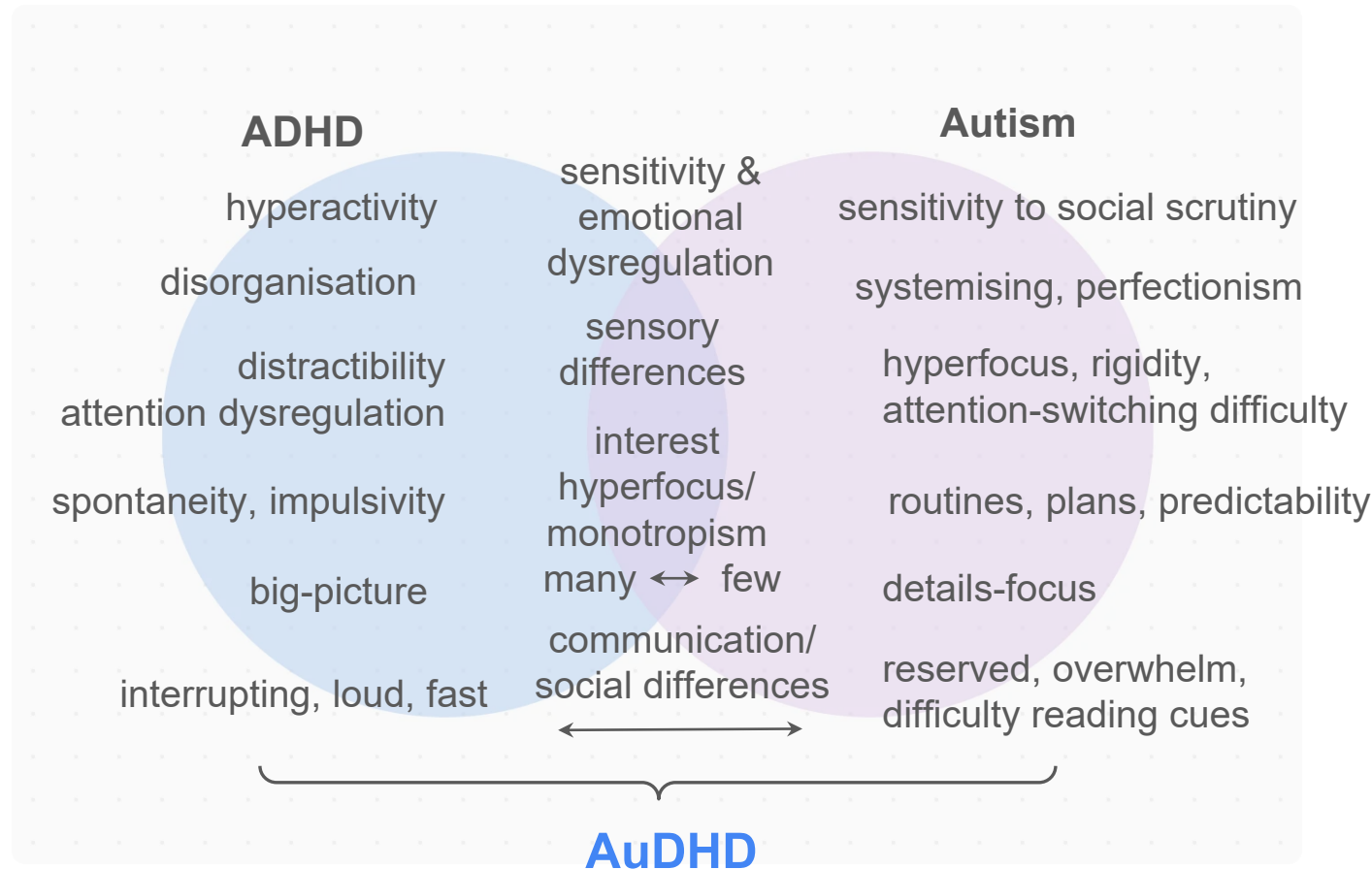
- ADHD & autism were *mutually exclusive diagnoses*, by definition, until 2013
- ADHD & autistic traits may **mask**, **compensate for** and/or **exacerbate** one another
- Girls & women, with high IQ & AuDHD are more likely to mask & compensate
- Many dual diagnoses have therefore been overlooked

**~20–50% of ADHDers
have autism**
(Srinivas *et al.*, 2021).



**~30–50% of autistic
people have ADHD**
(Rong *et al.*, 2021).





Autism - Different genetic cohorts

- Historically, **two** broad patterns have been recognised within the autistic population
- Recent advances in genetic testing have helped to characterise these cohorts more precisely
- **Clinically**, *these groups are **not** always distinguishable due to overlapping presentations*, and because current **genetic testing** identifies a causative variant in only a minority of individuals
- **Genetic testing** may be useful in early presentations of autism & those with associated symptoms to **screen for genetic conditions** rather than to identify the cause for autism.
- Awareness of the two cohorts may help patients with **patient self-understanding**, with reduction of **stigma** and **resource allocation**.

Group A ~ 80-90% - Lower Support Needs

- Polygenic / Later-Diagnosed / No Intellectual Disability Association
- *More likely diagnosed later, e.g. in adolescent/adult clinics*
 - Polygenic neurotype variance
 - *More* likely inherited
 - More commonly concurrent with ADHD & anxiety
 - No consistent evidence of pathological environmental

exposures

Group B ~ 10-20% - Higher Support Needs

- High-Impact / Early-Onset / Intellectual Disability Association
- *May present early in paediatric/CDC diagnostic clinics*
 - Genetic syndromes, monogenic, new mutations, rare variants
 - Associated with regression, speech delay, intense stereotyped movements, dysmorphia & epilepsy
 - Biological pathological processes (e.g., teratogenic, inflammatory, hypoxic, metabolic).



Strengths in Autism :)

careful
determined
reliable
committed
systematic
accurate
punctual
conscientious
highly skilled
sensible
principled
high-achieving
consistent
trustworthy
excellent recall
hyperfocus
thorough
honest
perceptive
unconventional
planner



Autism (& Autistic Traits) - *Potential Strengths in Primary Care*

- **Conscientious, responsible & reliable** task in completion
- **Consistent, thorough & accurate** work in complex, detail-heavy tasks
- **Justice sensitivity** can lead to a principled, ethical approach – may advocate for equality, patient & employee-centred practice and/or environmental issues.
- **Determined & committed**
- **Honest**, straightforward communication
- **Aesthetic** skill may be helpful for design
- Skills in **numeracy, systemising** & profit-focus may support business viability & sustainability



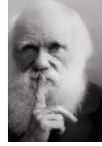
Successful & influential people throughout history with autism or likely autistic traits

Scientists, Geniuses & Innovators

- **Rosalind Franklin:** Literal comm style, extreme precision & dedication in extensive data collection of X-ray crystallography.
- **Charles Darwin:** Extreme social isolation, strict daily routines & years of cataloguing detailed observations.
- **Sir Isaac Newton:** Favoured extreme isolation, intense obsession with single topics, & ++difficulty with casual conversation.
- **Marie Curie:** Intense, systematic monotropism, working for years in isolation, entirely bypassing social norms.
- **Dr Camilla Pang:** Credits her autism with empowering her to analyse complex human behavior through structured science
- **Alan Turing:** Literal communication style, social eccentricities, obsession with structured logic and mathematical patterns.
- **Elon Musk:** The tech billionaire and founder of SpaceX and Tesla with Asperger's syndrome.
- **Nikola Tesla:** severe sensory sensitivities, reliance on rigid geometric routines, intense interest in complex electrical systems.

Creatives, Authors & Artists

- **Greta Thunberg:** Ability to see complex global issues in clear terms without bending to social or political pressure.
- **Sia:** Talented musician, able to predict musical patterns. Struggles with scrutiny, covers eyes on stage so cannot see crowd.
- **Lewis Carroll:** Social anxiety among adults, a fixation on creating complex mathematical puzzles & invented words.
- **Michelangelo:** Intense, singular preoccupation with his art, rigid routines, a lack of interest in relationships or personal hygiene.
- **Satoshi Tajiri:** Diagnosed with autism, Tajiri says Pokemon was born of his intense childhood interest in collecting insects.



Potential Challenges in Autism

stressed
unadaptable
sensitive
contrary overly_cautious rigid negative
aloof inflexible overwhelmed fixed
stick_in_the_mud perseverating perfectionist
controlling repetitive
blunt literal intractable
pedantic stubborn
withdrawn regimented
obsessive
difficulty_with_nuance



Autism (& Autistic Traits) – Potential Challenges in Primary Care

- **Sensory overload:** Noise, lights, smells, and constant interruptions can lead to errors or shutdown.
- **Unexpected changes:** Sudden room or schedule changes can cause stress due to a need for predictability.
- **Deep focus:** It can be hard to stop a task or switch tasks, making interruptions or time pressure more difficult.
- **Under scrutiny:** Being observed can shift focus from the task to worrying how you appear.
- **Vague expectations:** Unwritten rules, social cues, or ambiguous feedback take extra effort.
- **Communication differences:** Direct or low-affect communication may be misread as blunt.
- **Masking:** Constantly performing social expectations leads to fatigue.
- **Shutdown:** After sustained overload, capacity may suddenly drop, causing withdrawal or slower responses.





Interactive Exercise

Do you have any **ADHD (or leaning)** or **autistic (or leaning)** traits?

Or do you work with/know someone who does?

- Think about a **workplace** where you/they **excelled**, leaning into strengths & overcoming challenges.
 - *What was it about the **environment** that helped you/them to thrive?*
- Think about a **workplace** where you/they **struggled** with ND-leaning challenges, and were not able to make best use of your/their strengths.
 - *What was it about the **environment** that contributed?*

If you don't feel comfortable reflecting on your own strengths or challenges, consider a friend, colleague, patient, or hypothetical case.



What Helps in the Workplace? Neuro-inclusive Core Principles

- **Autonomy** — flexibility over timing, format, workload and workflow
- **Clarity** — explicit expectations, written instructions, clear priorities
- **External structure** — checklists, templates, timers, reminders, deadlines
- **Accountability without shame** — regular check-ins, body doubling, shared task lists
- **Reduced switching** — batching tasks, protected focus time, fewer interruptions
- **Sensory control** — quiet space, lighting/noise/temperature control
- **Recovery time** — breaks, buffer slots, decompression time, realistic workload
- **Psychological safety** — factual feedback, different communication styles accepted
- **Strengths-based design** — match work to interests, skills and complementary teams



Practical GP Adjustments

Clinic structure

- buffer slots / catch-up time
- flexible appointment lengths where possible
- breaks for food, movement, socialising or decompression
- visual timers or prompts for running to time

Admin systems

- protected admin blocks
- admin support for routine or repetitive tasks
- body doubling for admin, forms, portfolio, audit or revision
- templates, dictation, AI, checklists
- clear instructions & communications, verbal + in writing
- written explicit & clear triage/escalation routes, protocols, templates, checklists, deadlines & prioritisation
- written role expectations & meeting agendas
- reduce duplication and unnecessary bureaucracy

Task activation

- realistic designated time for tasks
- shorter deadlines & visible accountability
- rewards, accountability and novelty — **RAN**
- shared working sessions rather than isolated “catch up later” work

Environment

- access to quiet/communal admin space
- fewer non-urgent interruptions
- control over light, noise, temperature
- permission to move / stand / fidget
- standing desk, wobble cushion/chair



Support, Supervision & Team Design

Support

- coaching
- mentoring
- named supervisor / buddy
- regular supportive check-ins
- occupational health / reasonable adjustments plan where needed

Feedback

- clear purpose of observation
- specific, kind, factual, feedback
- ask how an individual wants to receive feedback upfront
- avoid vague criticism: “be more organised,” “manage time better”

Team working

- pair big-picture thinkers with detail-focused colleagues
- use complementary strengths intentionally
- explicit ownership of tasks and deadlines
- allow people to contribute where they are strongest

Culture

- normalise reasonable adjustments
- recognise fluctuating capacity & hidden effort
- value outcomes other than speed
- intervene before burnout or crisis



Case 3: GP with Autism (AuDHD), Dr. J:

“The variable wasn’t my capability or commitment. The variable was the environment. In the wrong environment, I burn out. In the right environment, I am exceptionally good at my job.”

What made one environment exhausting?

- **Unnecessary cognitive load** — inefficient systems, duplicated work, bureaucracy and avoidable admin burden.
- **Unpredictability** — changing rooms, changing supervisors, interruptions and fragmented workflows.
- **Transitions** — e.g. home visits disrupted flow, required switching environment, routines and roles, and added sensory/social unpredictability before returning to clinical work.
- **Hidden social demands** — apparently small tasks could involve unclear expectations, awkward negotiations or unspoken rules.
- **Little autonomy** — being unable to adapt workflows or fix obvious inefficiencies.
- **Repeatedly having to prove competence** — over-explaining safe decisions rather than being trusted and understood.

“What I struggle with is unnecessary inefficiency, duplicated effort, poorly designed systems, & repeated avoidable burden.”

What helped her thrive?

• *Predictability* • *autonomy* • *efficient systems* • *continuity of supervision* • *trust* • *being allowed to use her strengths intentionally.*

“I felt like a valued clinician whose strengths were recognised and used well, rather than someone being managed or monitored.”



Everyone has different strengths, challenges & pressures inside & outside the workplace...

"On days I have to do pick-up, I have to get there before the nursery closes. If I have complex patients or an admission it's really hard to leave on time. I get so stressed. Once I got a speeding ticket."

"I heard it called 'the yellow cardigan effect' - clinicians who are 'too sympathetic' can attract more patients with mental health problems who take longer."

"By the time I've got the kids out the door, I'm already exhausted. I feel like I've already done a day's work! "

"My mother has dementia, so she and my family contact me throughout the day. It's harder to get through work with the interruptions and the worry."

"I spend my days off doing household chores and family admin. I find it hard to find time for audits etc. and even harder to find time for myself."

"People don't understand that with a child with additional needs, we often have very disturbed sleep, even though she is older. She has never slept through the night."

"A patient said, 'I only go to your colleague if I have something quick & simple. If I have something more complicated, I come to you as I know you will listen properly & help.'"

"I get lots of gynae cases...the history, examination & swabs takes so long, it can be hard to keep to time."

"I was seen as being the sympathetic one, so the staff used to come to me with all of their issues. It ended up taking up hours of my week."

"I feel criticised for taking longer with patients, but I find that some of the other clinicians have rushed & not sorted them out."

"I try to do my admin at the end of the day, but I'm so tired, I can't think straight and it takes ages."

"I felt guilty that I was working, 'part time' but hospital consultants don't do eight clinics a week with long days...they get scheduled admin time."

When the children were small, I rarely got a full night's sleep. They were up multiples times a night with feeding, then illness, teething or growth spurts. It was so hard at work...I didn't realise until afterwards how exhausted I'd been. I crashed the car on one of those days."



Coaching

Mentoring

- A trained coach supports individuals in developing their own skills, ideas & solutions
- Structure, space & time to take a step back and think about:
 - **Priorities & values**
 - **Strengths & challenges**
 - **Needs & wants**
 - **Aspirations & ambitions**
- Goal setting with deadlines & accountability

&

- A more experienced/senior expert
- Perspective - *is it me?*
- Understanding of the unspoken rules of the workplace & career progression, e.g. changemaker & stakeholder dynamics
- Advocacy & support - *someone who wants what's best for you*
- Information about options & opportunities for work types, formats & environments



Big Picture v Detail Focus – What Helps?

- ADHDers may struggle to complete the details in projects, leading to things being unfinished & making silly mistakes. They may benefit from **deadlines, accountability** and working in **teams**. They have strengths in coming up with ideas, moving quickly and motivating others.
- ASD individuals may be very **details-focussed** and struggle to see the bigger picture, e.g. strategy. They may have perfectionist traits and take a long time on projects. They can be very valuable in projects requiring a systematic, accurate approach, giving consistency and reliability.
- These two groups **working together** with their complementary skills can make very effective teams.



Novelty v Predictability – What helps?

All change!

- Autistic people can struggle with **transitions**. This may impact on their wellbeing much more than others anticipate. A transition may be a new working environment or format, new colleagues, and/or a new project or direction.
- **Signposting** changes & expectations, and providing **information** about new locations and experiences, and giving **time** to adjust can help with adjustment.



All change please!

- ADHDers conversely crave **novelty**, and may become bored & unmotivated working on repetitive tasks. Enabling automation or delegation of repetitive tasks can help, as well as a **varied calendar, social interactions, deadlines, visibility, accountability & rewards**.



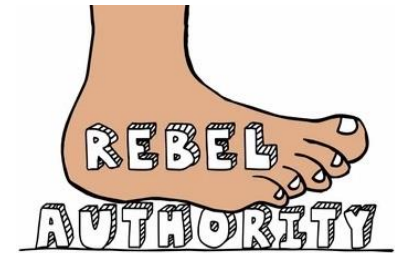
- **A Strong Sense of Justice & Rigidity**

NT types can have a strong sense of justice. This can help them to be committed **campaigners**, e.g. Greta Thunberg & Chris Packham. Particularly those with ASD may be **rigid** about rules being obeyed & appear unwilling to compromise. This can lead to conflict in work when there is a requirement for flexibility. It may help to discuss the reasons for the rules and come up with a different interpretation of the rules that the individual can follow.



- **Hierarchies**

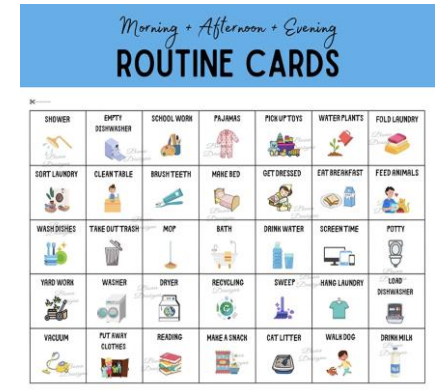
Some ND types, particularly ADHDers may not feel comfortable within hierarchies, and may fail to demonstrate behaviours of deference that may be expected towards senior colleagues. They may feel more comfortable in working environments where colleagues are on a more **equal** footing.



High & Low Registration

- **Clutter** - ADHDers may struggle to keep their workspace tidy. Autistic people may find cluttered surroundings distracting & overwhelming. AuDHDs may struggle with both.
- **Out of sight, out of mind** - particularly ADHDers may forget that objects, people and projects exist when not visually reminded. This can impact on reliability at work, and personal & professional relationships.

Software, apps, planners, notes & timetables may help.





Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: Emotional dysregulation, RSD, PDA, Overwhelm & Burnout, Hyperempathy, Sensory processing differences**
 - **Mental Health Comorbidity**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**



Emotional Dysregulation

Case 4, Mrs A:

“I’m nearly 60, and despite being able and intelligent, I’ve never been able to have a high level job.

I’ve always been too sensitive. I feel judged and criticised.

My emotions flare quickly & intensely, and I spiral.

I end up feeling overwhelmed and I want to leave.

It’s worse when there are changes at work, and when there’s lots going on.

When things feel unfair, I get angry and speak without thinking.

The office politics are too much, the power struggles, the fakeness...

I take on easier jobs where there isn’t conflict - I can just do the job, not get too involved and leave.

This has been the most impactful part of my ADHD & autistic traits.”



Emotional Dysregulation - *the Evidence*

ADHD

- Emotional Dysregulation is not yet in the diagnostic criteria, but is increasingly conceptualised as a **core dimension of adult ADHD** (*Soler-Gutiérrez et al., 2023*)
- **Emotional dysregulation reported in ~30–70% of adults with ADHD** (*review, Shaw et al., 2014*)
- **Emotional dysregulation predicts greater impairment across social, academic & occupational domains beyond core ADHD symptoms** (*Barkley & Fischer 2010; Shaw et al. 2014*)
- **Moderate–severe emotional dysregulation in ~62.7% of individuals with ADHD** (*twin study, Astenvald et al., 2022*)
- **PMDD prevalence elevated in ADHD: ~31–41% in ADHD vs ~10% in non-ADHD population** (*Broughton et al., 2025*)
- **Stimulant medication treatment for ADHD can help with emotional regulation**, leading to less irritability, reactivity & impulsive emotional outbursts for many; ~40–60% benefit vs ~25–35% placebo. (*Gamli, 2018; Spring, 2024*)



Autism

- **Moderate–severe emotional dysregulation in ~56.1% of autistic participants** (*twin study, Astenvald et al., 2022*)
- **Alexithymia predicts anxiety & social-communication difficulties over time** (*Oakley et al., 2020/2022*)
- **Alexithymia prevalence ≈ 50% in autistic individuals vs ~5% in controls** (*meta-analysis, Kinnaird et al., 2019*)
- **SSRIs may help with anxiety, rigidity, demand intolerance, task initiation, overwhelm & hypervigilance** (*Liang et al., 2022*)



Emotional Dysregulation Mechanisms in ADHD & Autism



ADHD – Emotion Regulation Difficulty	Autism – Emotion Processing & Integration Difficulty
Emotional lability / rapid mood shifts	Distress triggered by change, transitions, unpredictability
Rejection sensitivity (RSD) / heightened response to criticism	Sensory overwhelm driving emotional escalation
Emotional inertia, difficulty shifting out of emotional states	Cognitive rigidity / perseveration on emotional themes
Rapid affective reactivity / low emotional inhibition	Alexithymia (~50%), difficulty identifying or describing emotions, often emotional empathy $\geq$ cognitive empathy
Hormonal amplification (e.g. PMS/PMDD vulnerability) (same but less evidence in ASD)	Masking fatigue → exhaustion / autistic burnout
Dysregulation ↑ by executive overload, sleep loss, stress & linked physical health conditions	Dysregulation worsened by social and sensory load & linked physical health conditions



Rejection Sensitivity & RSD (Rejection Sensitivity Dysphoria)

- ☐ Sensitivity to perceived **criticism/disapproval**
- ☐ Sensitivity to perceived **exclusion**

- Present in **ADHD, autism, EUPD, social anxiety, depression & trauma**-related presentations
- **Rejection Sensitivity (RS)** – more established term in the research
- **Rejection Sensitivity Dysphoria (RSD)** – symptom descriptor increasingly used in ND

Mechanism: – Social rejection activates threat/social-pain networks (ACC/insula) – an evolutionary drive from the survival advantage of group acceptance (*Eisenberger & Lieberman, 2004*)

- In ADHD, this system may operate at higher gain due to: emotional dysregulation, reduced regulatory control, attention bias to negative social cues & repeated criticism / negative feedback history

☐ amplified social-threat responses & stronger emotional impact of rejection

Impact: Qualitative ADHD studies describe:

- intense emotional pain after perceived criticism ☐ rapid shame / anger / withdrawal
- masking, avoidance ☐ **relationship strain, reduced occupational/social participation** (*Rowney-Smith et al., 2026*)

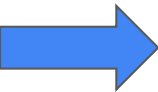


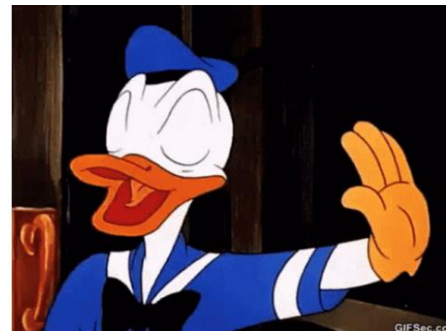
PDA (Pathological Demand Avoidance / Persistent Desire for Autonomy) & Demand Sensitivity

Knee-jerk resistance to demands & perceived demands

- Instructions, requests, advice, obligations, expectations
- Introducing new ideas, e.g. books, films, music
- New treatment & medication
- Initiating conversation/asking a question
- Being perceived

 **overwhelm** →  **demand tolerance**

- 
- Conflict at school, work & home
 - Overwhelm, shut-down → school refusal
 - Control issues, rigidity, defensiveness, contrariness, negativity.
 - Difficulty ceding power → equalising behaviours
 - Idea ownership difficulties, border/territorial/financial disputes & relationship issues.



‘PDA’ is currently considered in the UK to be a ‘behaviour descriptor term’ associated with autism rather than a standalone diagnosis.

*The term **‘PDA’** was first characterised in 1980 by **Professor Elizabeth Ann Newson**, developmental psychologist, who founded the **‘Child Development Research Unit’** at the University of Nottingham in **1958**.*

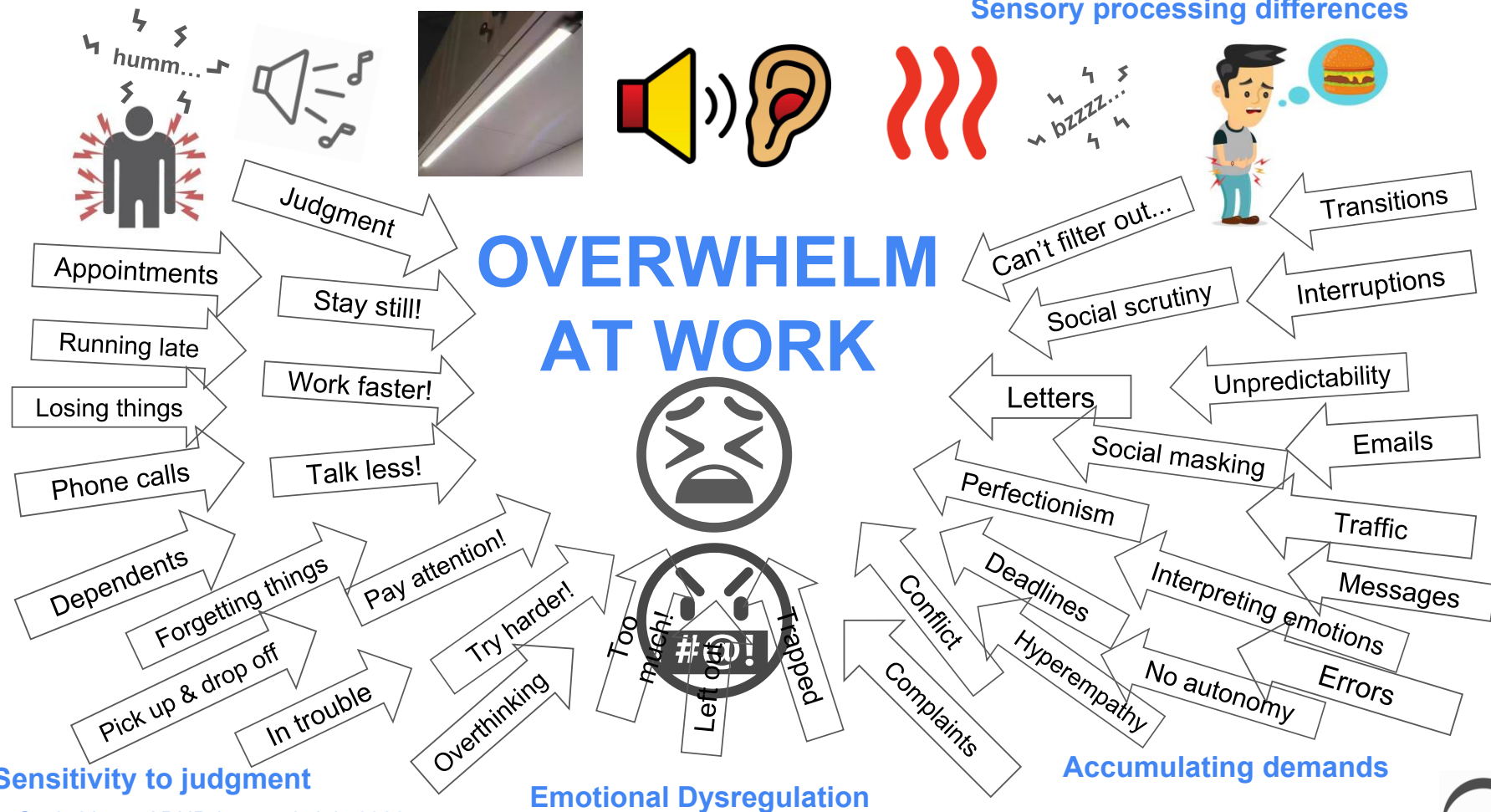


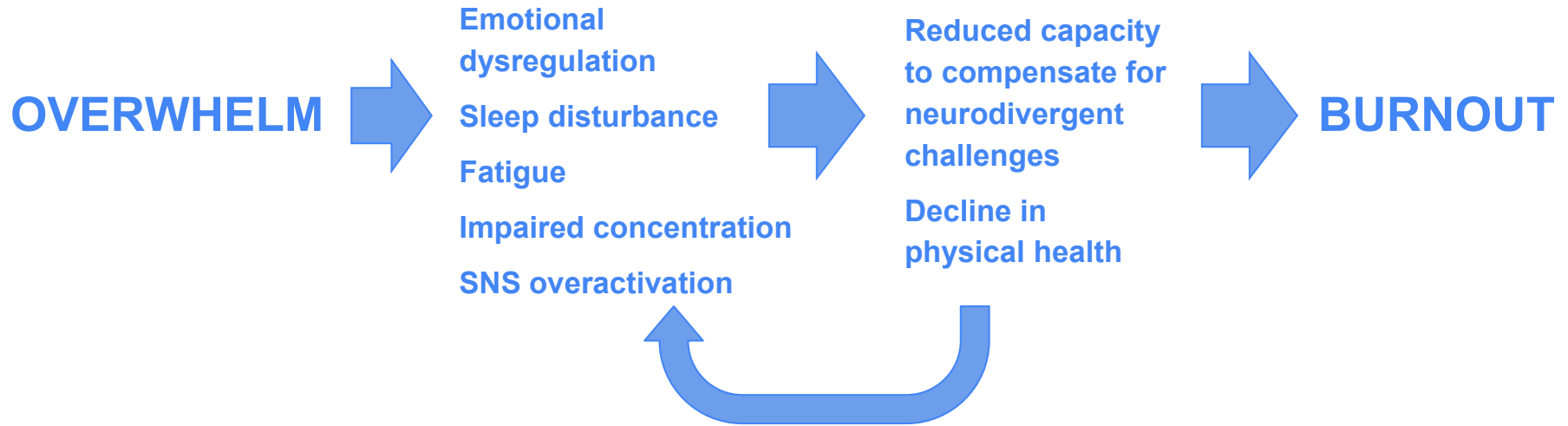
Support Strategies for those with Demand Sensitivity

Reducing pressure & facilitating autonomy

- **Pick your battles:** Accommodate and enable autonomy where possible.
- **Avoid power struggles:** Escalation → Dysregulation.
- **Model respect & compromise:** Choose flexibility over rigidity & autocracy.
- **Disguise demands:** Use visual/non-verbal prompts (gestures, written notes) over verbal requests.
 - Always explain the *reason* for a task.
- **Facilitate choice:** Make time for individual-led activities & shared decision-making.
- **Regulate first, reflect later:** Consider sensory needs (light, sound, hunger, space).
 - Use humour & distraction in the moment.
 - Wait until emotions are fully settled before discussing rules or reflection.







Causes of Fatigue/Burnout more common in ADHD, Autism & AuDHD

- Hyperactivity & hyperfixation, then crash - 'boom & bust'
- Procrastination, then rushing to meet a deadline
- Impact of errors, lost items, forgotten appointments
- Impact of time lost through zoning out & distraction
- Increased effort of staying still, and moderating speech amount & volume
- Burden of tolerating sensory discomfort & overwhelm
- Increased work of sensory processing & filtering
- Perfectionism driving increasing work burden
- Increased work of social masking & navigating social interactions
- Hypervigilance from perceived threat of uncertainty, scrutiny & judgement.
- Impact of conflicts & misunderstanding from differing interpretation
- Emotional burden of hyperempathy & rejection/criticism sensitivity
- Missing hunger/thirst cues
- *Chronic sympathetic nervous system activation*
- Impact of medication
- Increased susceptibility to:
 - mental health problems: bipolar disorder, depression, anxiety, psychosis, disordered eating.
 - social problems: addiction, criminality, relationship problems, accidents, trauma, family challenges, financial issues.



- Increase susceptibility to:
 - physical health problems including:
 - Sleep disturbance
 - Migraines
 - POTS
 - Autoimmunity
 - Severe, prolonged, recurrent infections, e.g. EBV, Covid-19
 - Allergies
 - Fibromyalgia
 - MCAS
 - PMS/PMDD
 - Hypermobility/hEDS
 - Obesity



Overwhelm & Burnout – What helps?

- Consider managing potential stressors - **noise, light, heat, physical discomfort, screens, human interactions, commute, childcare**
- Consider least tiring **format** - video, audio only, face to face or text?
- What activities restore battery daily & longer term?
- Consider buffer slots & protected **breaks** during sessions to allow for rest and processing
- May require **rest days**, consider portfolio career
- **Autonomy** over session structure
- **Realistic** workload / fewer back-to-back clinics
- **Quiet** workspace / decompression space
- Reduced **sensory** load & fewer **interruptions**
- Protected admin time
- Admin support, templates, dictation, AI
- Clear protocols and written expectations
- Explicit prioritisation and deadlines
- Reduced masking demands
- Acceptance of different communication styles
- Supportive, factual feedback
- **Mentoring / coaching**
- **Flexible** or **hybrid** working
- Matching work to strengths
- Complementary team working
- Normalised reasonable adjustments
- Early burnout monitoring
- Permission to reduce load before crisis



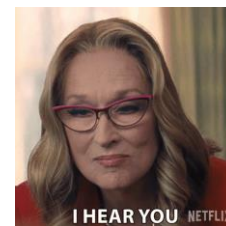
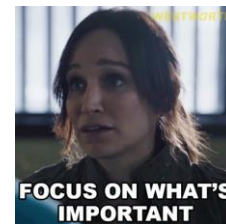
What helps? *Fatigue & Burnout – Actions & Adaptations*

- **Flexible working** - may require half days/short days/rest days
- Consider the impact of childcare/dependent commitments, fixed leaving times
- Optimising working **environment** to minimise impact of sensory issues & overwhelm
- Consider individual **triggers**, e.g. on-calls, and adapt schedule where possible
- Delegation
- Smart working: automation, apps etc.
- Safeguards/checks to reduce errors
- Regular check-ins to monitor wellbeing
- Encouragement & recognition to boost self esteem, mood & motivation
- Restorative activities, social & meal breaks
- “Body Battery” function on smart watch allows monitoring of energy & reserve
- **Responsiveness** to concerns from colleagues, HR & management



Communication differences – what helps?

- **Info-dumping** - some ND types start talking and don't stop! It may help to ascertain sensitively whether they mind being interrupted, e.g. with a signal. This may invoke **RSD**! Again, **signposting required structure, timing & content** may help with this, and/or simply allowing more time.
- **Jumping around** - ADHDers may seem to jump around in their thought processes. This may seem chaotic, but it may be all relevant, important and connected for them. This may mean **allowing more time**. **Signposting** and **framing** may help them to keep to task if you have a particular agenda.
- **Literal interpretation** - ASD types can take things literally - careful with ambiguous language & abstract concepts; **specific instructions** can help.
- **Getting stuck (perseveration)** - some ND types may struggle to move on from a point, fixating on it and going over it. This may be a sign of an unresolved emotional need associated with this topic. De-escalate with **active listening, repeating their words, recognition** and **validation**



Case 5: Stephen. Autism, belonging, sensory load & scrutiny

A workplace I struggled - secondary school teaching

- *“I really struggled with the constant pressure of being perceived and the exhaustion of masking.”*
- *“Any disruption would be audible to neighbouring rooms; losing control of a class felt like a very public failure.”*
- *“I have always found it difficult to execute a task while being observed — a feeling I find incredibly disabling.”*
- *“The staffroom... [felt] far too public to work effectively.”*
- *“I constantly craved a safe, quiet space where I didn’t feel watched or judged.”*
- *“By 3:30 pm, I would be completely exhausted from masking without a break.”*
- *“I had to go home, recover, and then work late into the evening.”*

A workplace I thrived - a university role

- *“Blended working ... gives me a vital break from managing constant social interactions.”*
- *“I appreciate always having the option to transition to quieter spaces on campus if needed.”*
- *“I rarely feel as though I am forcing myself to navigate a strictly neurotypical world.”*
- *“We talk openly about communication preferences, sensory needs, and fidget tools.”*
- *“People are generally very accepting of differences, which fosters a genuine sense of belonging.”*
- *“Analytical problem-solving... pattern-spotting, and sharp attention to detail... are highly valued where I work.”*



Sensitivity to Being Perceived/Scrutiny in Autism

- **Difficulty Fully Switching Off:** Many autistic people find it hard to relax when most other people are present, because of overactive social monitoring & threat attribution.
- **Hypervigilance is Exhausting:** Constantly scanning for tone, facial expression, silence, disapproval, exclusion or 'getting it wrong', can lead to fatigue.
- **Being Seen Can Feel Exposing:** Direct observation, supervision, tutorials, meetings or informal team interactions can feel like being watched or evaluated.
- **Scrutiny Can Disrupt Competence:** Under observation, attention may shift from the task to managing how one is coming across — tone, eye contact, facial expression, posture or wording — reducing bandwidth for thinking clearly.
- **Link with RSD:** For some, perceived judgment, criticism, disapproval or exclusion can trigger intense anxiety or shame, especially after repeated experiences of being misunderstood or corrected.
- **Masking Loop:** Fear of being perceived negatively may increase masking, which can briefly feel protective but adds to fatigue and burnout risk.
- **What Helps:** Private space & time without interruption for recovery, listening, understanding & acceptance, flexibility with working format, timing & location.



Sensory/Interoceptive Processing Disorders/Differences in Autism

Inattention/Undersensitive



Hyperfocus/Oversensitive

Impaired auditory processing	Hearing	Hyperacusis/misophonia
Swimmy vision, unobservant	Vision	Photophobia, noticing everything
Reduced registration	Fine touch	Touch sensitivity, FND
Not noticing if clothing wet	Wetness	Aversion to getting wet
Clumsy	Proprioception	Movement aversion
Stim seeking	Vestibular	Vertigo/PPPD
Reduced smell/taste, strong flavours preference	Smell/taste	Sensitivity to strong smells/tastes
Reduced registration of injury	Pain	Fibromyalgia/pain syndromes
Reduced hunger/thirst signals	Interoception	'Hanger'/reactive hypoglycaemia
Constipation, soiling	GI control	IBS
Wetting	GU control	Irritable bladder



Hyperempathy: when caring becomes overwhelming

Some neurodivergent people experience **hyperempathy**: an intense emotional response to other people's distress, conflict, disappointment or perceived judgement.

This can mean they are deeply affected by:

- patients' distress, anger or trauma
- team tension or criticism
- complaints or negative feedback
- perceived rejection or disapproval
- seeing someone being excluded, misunderstood or treated unfairly

Hyperempathy does not always look like “typical” empathy from the outside. Someone may care intensely but show it differently — for example by becoming quiet, practical, problem-solving, emotionally flooded, or needing to withdraw.



In GP work, hyperempathy can be a strength:

- noticing subtle distress
- taking patients seriously
- strong advocacy
- deep commitment to fairness
- careful, compassionate follow-up

But it can also increase burnout risk:

- absorbing emotional distress from patients
- difficulty “switching off” after work
- over-responsibility and guilt
- finding complaints or conflict disproportionately painful
- needing more recovery time after emotionally intense encounters



Masking: what is it & why does it matter at work?

Masking is when a neurodivergent person consciously or unconsciously hides, suppresses or compensates for their natural ways of thinking, communicating or regulating in order to appear “normal” or “professional.”

Masking can look like:

- Forcing eye contact, facial expressions or small talk.
- Suppressing stims, movement, restlessness or sensory needs.
- Rehearsing conversations or copying others' communication style.
- Hiding confusion, overload, anxiety or fatigue.
- Working extra hours to compensate for difficulties others cannot see.
- Avoiding asking for adjustments in case of stigma or judgement.

Workplace impact

- High cognitive effort just to “appear fine.”
- Exhaustion after meetings, clinics, teaching or social interaction.
- Reduced capacity for admin, reflection and learning.
- Increased anxiety, shutdowns, irritability or burnout.
- Delayed disclosure and delayed access to support.
- Misinterpretation: the person may look “capable” while becoming overwhelmed.

Masking can make neurodivergent staff appear to be coping — but the hidden cost may be fatigue, reduced performance, poorer wellbeing and burnout.



Sensory Differences – What helps? Neuro-inclusive design

Noise

Communal areas with shiny/hard surfaces tend to bounce and amplify Noise, increasing above a safe decibel level, and triggering fight or flight in neurodivergent individuals. Soft furnishings and the inclusion of sound-dampening '**acoustic panels**' can make a big difference.

Quiet spaces

Designated areas where individuals can go to escape, rest and have a break from social interaction can help with workday stamina & resilience.

Crown overwhelm

Workplaces and schools with quieter areas and **alternative & outside routes** can help with those who find crowds and noise overwhelming – *"In the other place, everyone was funnelled into one corridor and it was one big crush."*

Easy navigation

Simple layouts and colour coded areas can help, *"We chose the school that had one large area and **coloured corridors** coming of it, otherwise he would have gotten lost."*





Interactive Exercise

Have you ever struggled with **emotional dysregulation, rejection sensitivity or demand sensitivity? Sensitivity to scrutiny, masking or overwhelm?**

Or do you work with/know someone who has?

- Think about a workplace where you/they excelled.
 - *What was it about the **environment** that helped you/them to thrive?*
- Think about a workplace where you/they struggled.
 - *What was it about the **environment** that made it worse?*

If you don't feel comfortable reflecting on your own strengths or challenges, consider a friend, colleague, patient, or hypothetical case.





Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: emotional dysregulation, RSD, sensitivity to scrutiny, PDA, overwhelm, hyperempathy, sensory processing differences**
 - **Mental Health Comorbidity, Disordered Eating**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**

ADHD @ Mental Health Comorbidities

Percentage Rate in ADHD (v. general population)

- Overall Psychiatric Comorbidity (at least one): **70% – 80%** (v. ~20%) (Katzman et al., 2017)
- Sleep Disorders (e.g., Insomnia, Delayed Phase): **50% – 75%** (v. ~10% – 30%) (Wajszilber et al., 2018)
- Depressive Disorders: **18% – 53%** (v. ~5% – 7%) (Instanes et al., 2018)
- Anxiety Disorders: **25% – 50%** (v. ~3% – 5%) (Katzman et al., 2017)
- Substance Use Disorders (SUD): **15% – 30%** (v. ~5% – 8%) (Zulauf et al., 2014)
- Obsessive-Compulsive Disorder (OCD): **11% – 30%** (v. ~1% – 2%) (Abramovitch et al., 2015)
- Eating Disorders (esp. Binge Eating & Bulimia): **11% – 16%** (v. ~1% – 3%) (Pallanti et al., 2016)
- Schizophrenia / Psychotic Disorders: **0.9% – 2%** (v. ~0.5% – 1%) (Nourredine et al., 2021)
- Bipolar Disorder: **9% – 21%** (Salvi et al., 2021)



A large part of the mechanism of anxiety is (over)activation of the sympathetic nervous system.

Autism (and to a certain extent, ADHD) directly cause overactivation of the sympathetic nervous system.

Therefore the overlap between autism, ADHD & anxiety is significant.

The experience of neurodivergence in many environments can also drive anxiety & low mood.

Anxiety & depression can in turn worsen concentration, motivation & sleep.

Direct treatment supporting mood, e.g. SSRIs & talking therapy, is often valuable.

Diagnoses of
mental health
conditions are
more common in
neurodivergent
individuals

Condition	Prevalence in Autism	Prevalence in ADHD	General Population
Agoraphobia	10% – 15%	4% – 5%	~1.3%
Any Anxiety Disorder (Overall)	40% – 50%	40% – 50%	19% – 31% (Lifetime)
ARFID	15% – 30%	3% – 5%	1% – 3%
Bipolar Disorder	5% – 8%	10% – 20%	2% – 3%
Clinical Depression (MDD)	30% – 40%	30% – 40%	7% – 8%
Eating Disorders (All types)	10% – 15%	10% – 15%	5% – 9%
Generalized Anxiety (GAD)	15% – 20%	25% – 31%	~3.1%
Hoarding Disorder	10% – 15%	15% – 20%	2% – 3%
Obsessive-Compulsive (OCD)	17% – 25%	10% – 15%	1.2% – 2%
Oppositional Defiant (ODD)	5% – 10%	20% – 40%	3% – 5%
Panic Disorder	10% – 15%	10% – 15%	2% – 3%
PTSD & Complex PTSD	32% – 40%+	15% – 20%	6% – 8%
Schizophrenia / Psychotic Disorders	4% – 8%	1% – 3%	~1%
Sleep Disorders	50% – 80%	50% – 70%	10% – 20%
Social Anxiety Disorder	30% – 50%	20% – 30%	7% – 12%
Specific Phobias	30% – 40%	10% – 20%	7% – 9%
Substance Use Disorders	10% – 16%	20% – 30%	8% – 10%



Disordered Eating & Neurodiversity - Summary

Autism - *restricted eating related to sensory processing differences, autonomy & control*

- **Anorexia**
- **Atypical Eating Behaviours / ARFID**
(Avoidant/Restrictive Food Intake Disorder)

Contributing Factors

- Social/mealtime anxiety
- Demand avoidance / power struggles surrounding food intake
- Sensory aversions
- Rigid food routines, rituals & rules
- Interoception differences → hunger signals reduced or missed

+ **PICA** – persistent craving & compulsive eating of substances that are not food, more common in cohorts with intellectual disability

ADHD - *binging & purging related to impulsivity, reward-seeking & emotional dysregulation*

- **BED (Binge Eating Disorder)**
- **Bulimia (Purging)**

Contributing Factors

- Impulsivity → bingeing
- Dopamine-seeking/emotional driven eating → sensory/sugar/fat cravings
- Hyperactivity, disorganisation & distractibility → skipped & incomplete meals
- Emotional dysregulation → guilt, purging, self-harming-type behaviours
- Stimulant appetite effects

AuDHD - *a combination of the above factors*

- **Restrict - Binge Cycle**





Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: emotional dysregulation, RSD, sensitivity to scrutiny, PDA, overwhelm, hyperempathy, sensory processing differences**
 - **Mental Health Comorbidity**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**

‘Physical’ Conditions Linked with Autism & ADHD

- Increasingly recognised, emerging model of interconnected conditions more common in neurodivergence
- Accumulating evidence that these presentations have **overlapping mechanisms & physiology**:
 - **Neurodivergence**
 - **Hypermobility/hEDS**
 - **Orthostatic Intolerance/POTS/dysautonomia**
 - **Immune dysfunction/MCAS**
 - **Hormone sensitivity**
- Combinations of these conditions have already described in various models in different specialities
- **Siloing of care in different specialities** means the medical profession has been slow to establish consensus in definition, diagnosis, management & awareness
- Typical physiological presentation: ***low BP, high HR, SNS dominance, fatigue, brain fog & pain.***



Interlinked Conditions more common in ADHD & Autism

Hypermobility/hEDS/
connective tissue disorder

Hormone
sensitivity/PMDD

Orthostatic
Intolerance/POTS/OH

Immune system
dysfunction/allergies/
autoimmunity/MCAS

The Pentangle Model of ND-Linked Conditions



Physical Health Conditions Linked to ND:

Knowledge of these can help with identification & treatment

- **Hypermobile Ehler Danlos Syndrome (HEDS) / Hypermobility Spectrum Disorder**
 - Joint pain
 - Soft tissue & blood vessel laxity
 - Cardiac issues
- **Dysautonomia**, SNS/PNS dysregulation, sensory processing disorders
 - **Orthostatic intolerance/POTS**
 - **Migraine**
 - **Fibromyalgia**
 - **IBS**
- **Hormone sensitivity**
 - **PMS/PMDD**
 - **Impactful Perimenopause**
- **Immune System Hypersensitivity**
 - **MCAS**
 - Chronic inflammation/
neuroinflammation
 - Autoimmunity & allergies
 - Increased susceptibility to
severe/prolonged/reactivating infections,
e.g. **Covid-19, EBV, HSV etc.**



Recent evidence links ADHD to systemic conditions

• Hormone sensitivity

- **6.2 - 9.0x risk PMDD** (Dorani et al., 2021)
- **97% report ADHD worse in perimenopause** (Gurvich & Osianlis, 2026)

• Hypermobility

- **4.3x risk symptomatic hypermobility** (Eccles, J.A. et al., 2022)
- **Hypermobile individuals 5.6x ADHD**

• Hypermobility 🌀 **Connective tissue disorder**

e.g. *hEDS* (Hypermobile Ehlers Danlos Syndrome) /
Hypermobility spectrum disorder

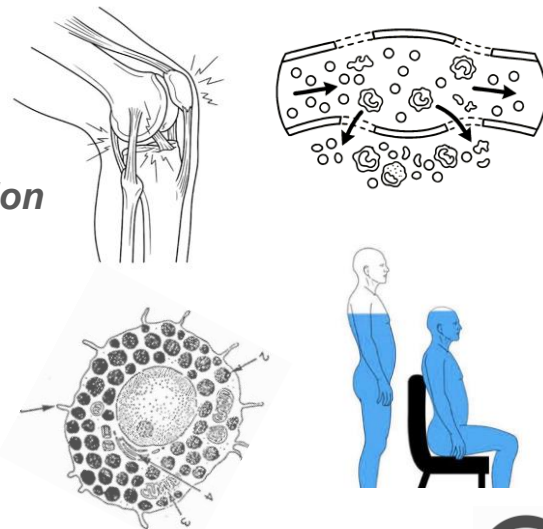
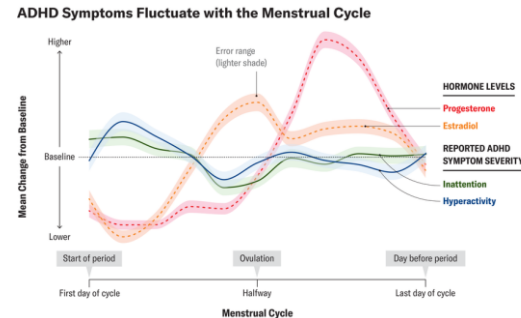
• Hypermobility 🌀 **Orthostatic Intolerance/POTS/Postural hypotension**

• Immune sensitivity, MCAS

- **1.8x risk childhood asthma, 1.6x risk hay fever, 1.4x risk eczema** (Miyazaki, 2017)
- **1.6x (♀) / 1.3 (♂) risk psoriasis, 1.4x (♀) risk Crohn's disease** (Hegvik, 2018).

• Migraine

- **~1.5x risk migraines** (Fasmer et al., 2022).



Hypermobile Ehler Danlos Syndrome (hEDS) Orthostatic Intolerance/ Hypermobility Spectrum Disorder (HSD) POTS

This 2025 study used doppler to measure blood flow to the brain in hypermobile patients, and showed that their POTS-type symptoms correlate with impaired blood flow to the brain



American Journal of Medicine Open

Volume 14, December 2025, 100111



Clinical Research Study

Hypermobile Ehlers-Danlos Syndrome: Cerebrovascular, Autonomic and Neuropathic Features

Peter Novak MD, PhD ^{a g}  , David M. Systrom MD ^{b g}, Sadie P. Marciano PA-C ^a, Alexandra Witte PA-C ^a, Arabella Warren MD, PhD ^{b g}, Donna Felsenstein MD ^{c g}, Matthew P. Giannetti MD ^{b g}, Matthew J. Hamilton MD ^{d g}, Jennifer Nicoloro-SantaBarbara PhD ^{e g}, Mariana Castells MD ^{d g}, Khosro Farhad MD ^{a g}, David M. Pilgrim MD ^{a g}, William J. Mullally MD ^{a g}, Mark C. Fishman MD ^{f g}, Jeff M. Milunsky MD ^h, Aubrey Milunsky MD ^h, Joel Krier MD ⁱ



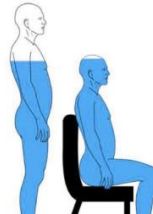
Support for the

Cerebral Hypoperfusion Hypothesis:

- **79% of hEDS** patients (270) had reduced **orthostatic cerebral blood flow velocity**, linked directly to dizziness upon standing **v. 0% in controls** (29)
- **Only 30% of these met the tilt-table diagnostic criteria for POTS**

This strongly supports that:

- hEDS & OI/POTS are closely linked*
- OI/POTS symptoms are correlated with impaired brain perfusion*
- POTs diagnostic criteria & diagnostic tools do not adequately identify the affected population.*



Interlinked Conditions more common in ADHD & Autism

Hypermobility/hEDS/
connective tissue disorder

Hormone
sensitivity/PMDD

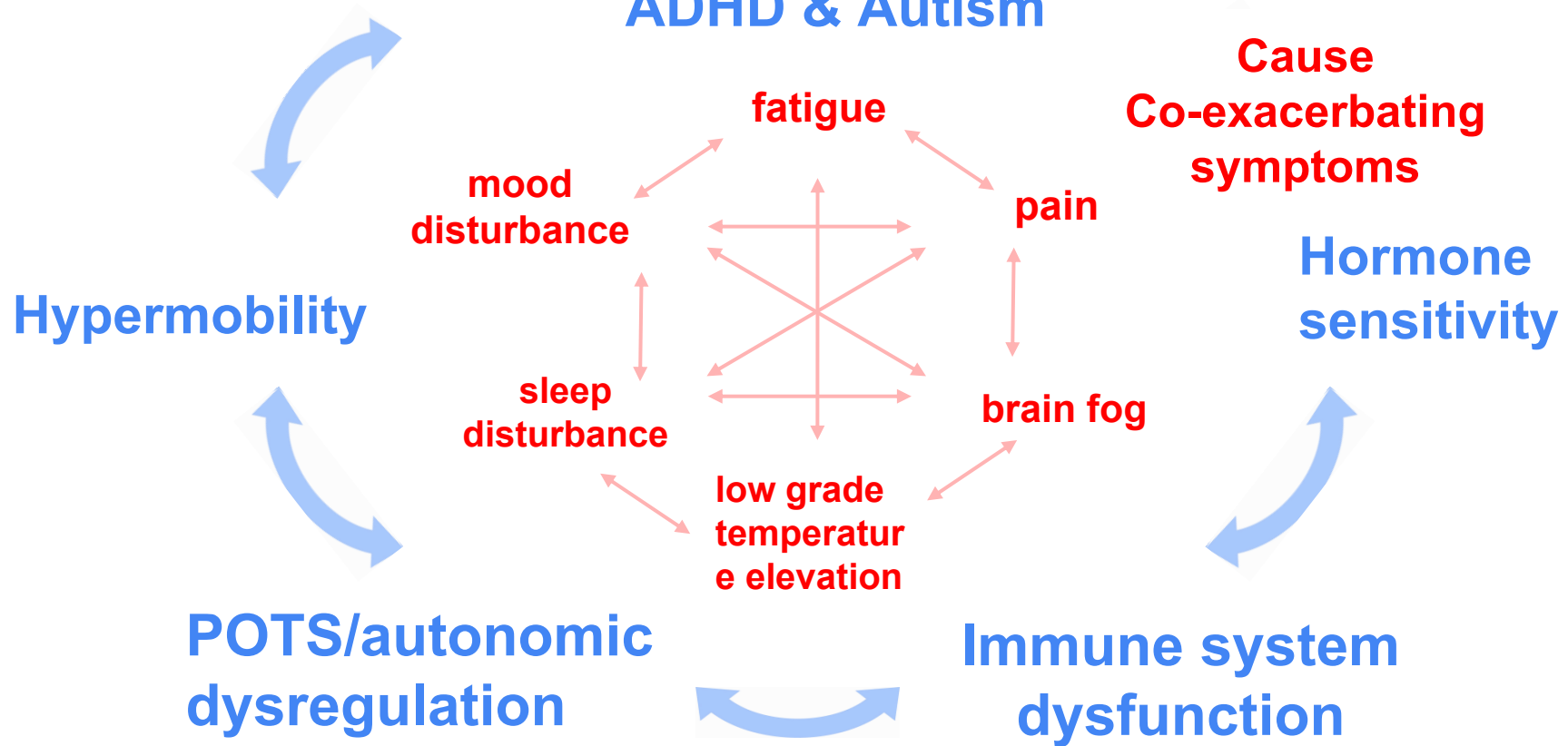
Orthostatic
Intolerance/POTS/OH

Immune system
dysfunction/allergies/MCAS/
autoimmunity/viral reactivation

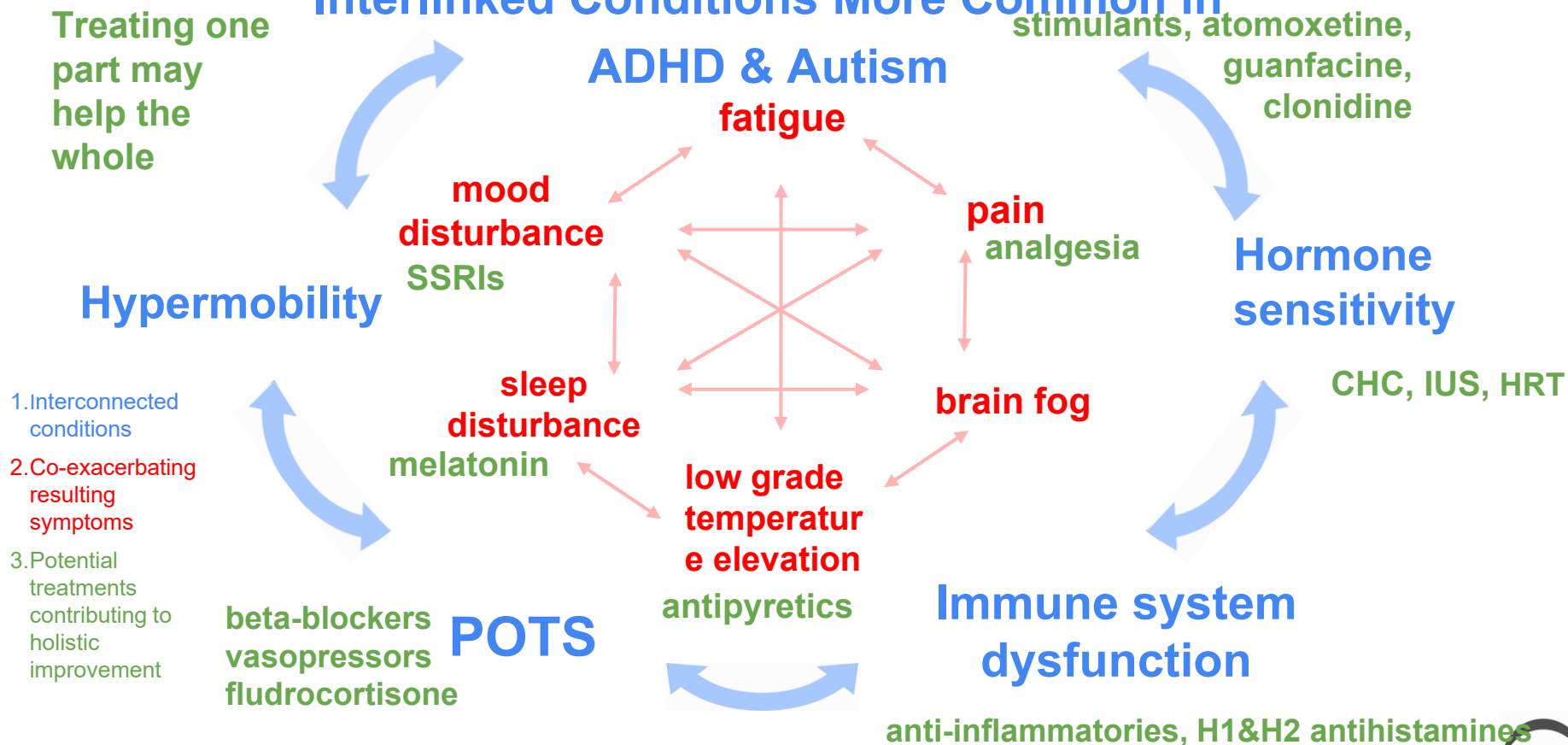
The Pentangle Model of ND-Linked Conditions



Interlinked Conditions more common in ADHD & Autism



Interlinked Conditions More Common in ADHD & Autism



1. Interconnected conditions
2. Co-exacerbating resulting symptoms
3. Potential treatments contributing to holistic improvement





Summary

- **My story**
- **SpLD: dyslexia, DCD (dyspraxia), dyscalculia, dysgraphia, auditory processing disorder**
- **ADHD, Autism & AuDHD**
 - **Strengths & Challenges in GP**
 - **Important presentations: emotional dysregulation, RSD, sensitivity to scrutiny, PDA, overwhelm, hyperempathy, sensory processing differences**
 - **Mental Health Comorbidity**
 - **Linked Physical Health Conditions**
 - **Treatment, Disclosure, Adjustments & Accommodations.**

What Helps?

- **Recognition & Management of Neurodivergence & Linked Conditions**
- **Psychoeducation**
- **Lifestyle Modification**
 - Sleep, Exercise, Diet
- **Adjustments & Accommodations**
- **Psychological Support/Coaching**
- **Medication, *which often facilitates engagement with all of the above***

What helps? – *high impact pillars of lifestyle modification*

Sleep, exercise & diet are proven to have a significant impact on **attention, emotional regulation & energy levels**.

Sleep

- Sleep difficulties @ND, & reduce compensation reserve, making symptoms more prominent & reducing stress tolerance
- To settled cortisol levels, try a sleep **routine, music, white noise, sleep stories, guided meditation, or familiar audio** rather than silence, & **weighted blankets**. Avoid screens, alcohol & caffeine.
- Despite UK restrictions, many find **melatonin** life-changing, and is generally thought to be safe & well-tolerated
- Stimulant treatment may help or hinder sleep



Exercise

- Proven to improve focus & attention, reduce hyperactivity & impulsivity, enhance executive function, help with mood regulation & improve sleep in ADHD.
- **Regular movement** before and during the school & work day can have a significant impact on wellbeing.
- Inability to continue with regular exercise (e.g. from injury) may trigger decompensation
- Exercise tolerance may be limited by some linked conditions, e.g. orthostatic intolerance and/or post-exertional malaise.

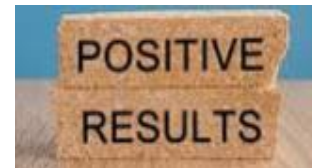


Diet

- **Steady blood sugar** can support attention, emotional regulation & consistent energy levels, therefore low GI & high protein meals, and healthy snacks may help.
- Different **interoceptive signalling** may cause **forgetting to eat & drink**
- Additives, dyes, allergens, sugar & processed foods may exacerbate ADHD in some children
- Slight evidence for supplements/adequate levels of omega-3 fatty acids, iron, zinc & magnesium
- Emerging evidence links the gut biome with chronic & neuro-inflammation, '*the gut-brain axis*', suggesting the importance of gut-supporting diet, probiotics & fibre.



ADHD Medication – Benefits: The Evidence



Stimulants: one of the most effective treatments in psychiatry (beaten only by long term antipsychotics)

- **Core ADHD symptoms** – Within days: large, consistent reductions in ***inattention, hyperactivity & impulsivity***.
60–80% improve vs 20–30% placebo • NNT $\approx$ 2–3 (SSRIs for depression: NNT $\approx$ 6–8) (Cortese, 2018; Storebø, 2015/2025)
- **Executive control** – Better ***sustained attention, inhibition, task completion, working memory***.
Clear improvement in most people; ~1 in 2–3 show cognitive gains beyond placebo (Coghill, 2014; Faraone, 2021)
- **Day-to-day behaviour** – Less ***restlessness/interrupting***; better compliance and ***classroom/work functioning***.
Moderate improvements; typically noticeable to parents/teachers in daily life (Storebø, 2015/2025)
- **Emotional regulation** – Less ***irritability, reactivity, emotional outbursts*** for many.
~40–60% benefit vs ~25–35% placebo • NNT ~4–6 • helps many, not all (Gamli, 2018; Spring, 2024)
- **Aggression / oppositional behaviour** – Reduces ***impulsive/reactive aggression***; limited effect on trauma/relational causes.
Helps when behaviour is ADHD-driven; inconsistent when causes are social/trauma-based (Pringsheim, 2015)
- **Academic/work performance** – Improves ***productivity*** and ***on-task time***.
Small average gains in grades/tests; helps “doing the work” more than “ability” (2017: Arnold, 2020: Lu)

Risks Associated with Neurodivergence

Risk Area	ADHD	Autism
Suicide	3–5× risk, (<i>Impey, 2012; James, 2004</i>)	≤9× risk (<i>Cassidy et al., 2014</i>)
University Dropout	~2× risk, (<i>Barkley, 2010</i>)	36% dropout vs. 29% overall, (<i>NEAutism Society, 2023</i>)
Sexual Assault (Victim)	1.5–2× risk, especially ♀ (<i>Rasmussen, 2001</i>)	2–3× risk, especially ♀, (<i>Weiss & Fardella, 2018</i>)
Addiction	2–3× risk of SUDs, (<i>Wilens, 2003</i>)	Lower use; higher risk of misuse if used, (<i>Weir, 2021</i>)
Criminal Behaviour	≤46% youth offenders have ADHD (<i>Young, 2008</i>)	2–3× victimhood of crime, (<i>Allely, 2015</i>)
Psychosis	~5× risk of schizophrenia , (<i>Shyu et al., 2015</i>)	Not more common unless other factors, (<i>van der Meer, 2014</i>)

Evidence of Risk Mitigation with ADHD Medication

Significant long-term real-world benefits: *Consistent findings across large national studies –*

- ↓ **Suicidal behaviour** by ~17%
- ↓ **Substance misuse** by ~15%
- ↓ **Transport accidents** by ~12%
- ↓ **Criminality** by ~13–25% (*Zhang, 2025; Li, 2025*)
- ↓ **Injuries, self-harm & ED presentations** (*Vasiliadis, 2024, Li, 2025,*)

Healthcare utilisation

- ↓ **Psychiatric & non-psychiatric hospitalisations** • ↓ **Emergency healthcare use** • ↓ **Work-disability risk**, (*Taipale, 2024*)



SSRIs in Autism

- SSRIs should not be framed as **treating autism itself**, but may help **co-occurring anxiety, OCD-type symptoms, rigidity, overwhelm, hypervigilance and emotional dysregulation**.
- Early SSRI studies often asked the wrong question: they measured “core autism” outcomes such as repetitive behaviours, communication or global severity, rather than **anxiety, function, quality of life, meltdowns or burnout**.
- Historic studies may also have overrepresented higher-support-needs / early-diagnosed cohorts, limiting relevance to later-diagnosed, verbally fluent, lower-support-needs autistic adults. (*Williams et al., 2013; Liang et al., 2022*)
- More recent evidence suggests better outcomes in **adults** & those with **lower baseline symptom severity**. (*Liang et al., 2022*)
- Modern trials such as **STRATA** are reframing the question by testing sertraline for **clinically significant anxiety in autistic adults**, rather than as a treatment for autism itself. (*Dheerendra et al., 2024*)
- Tolerability remains important: autistic people may be more sensitive to activation, agitation or insomnia, so prescribing should be **start low, go slow, with clear target symptoms and careful monitoring**. (*King et al., 2009*)

SSRIs may be valuable in autism when used to treat specific co-occurring distress and impairment — especially anxiety, rigidity, overwhelm and OCD-type symptoms.



Toolkit

Consider:

- Is it ADHD/autism?
- Is there anything else going on?
- Are they diagnosed?
- Are they informed?
- Are lifestyle factors optimised?
- Has coaching/therapy been considered?
- Are they treated?
- Is treatment optimised?
- What are their individual strengths?
- What are their individual challenges?
- What accommodations & adjustments could help?
- What are they entitled to?

Support access to:

- screening
- comorbidity screening
- assessment
- self-education/psychoeducation
- review sleep, diet, exercise
- coaching / psychological support
- medication initiation
- medication review
- review of strengths & optimise utilisation
- review of challenges & minimise impact
- individual & practice-specific adjustments
- information about entitlements



Disclosure



Disclosure Ladder

- **Public advocacy disclosure**
"I'm open about this because I want to change the culture."
- **Full diagnostic disclosure**
"I have ADHD / I am autistic / I am dyslexic."
- **Partial disclosure**
"I have a neurodevelopmental condition that affects attention/sensory processing."
- **Needs-based disclosure**
"I need written instructions and fewer interruptions."
- **Private self-understanding**
"I know what helps me work safely."



What Helps at Work? – *Entitlements for Doctors & Patients*

- **Equality Act 2010:** ADHD is a legally recognised disability. Employers have a legal duty to prevent indirect discrimination by implementing reasonable adjustments (*Equality and Human Rights Commission, 2014*).
- **Access to Work Grant:** Employees are legally entitled to this UK government scheme & can apply online. It travels with them & can fund bespoke specialist ADHD coaching & assistive technology (e.g., dictation software, *'Brain in Hand'* support service with coaching & digital tools).
- **Less Than Full Time (LTFT) Training:** Strong advocacy for LTFT (e.g., 60% or 80%). The cognitive load of masking means a 40-hr week may feel like a 60-hr week; LTFT is vital 'cognitive recovery time'.
- **Exam Entitlements:** The right to apply for 25% extra time & low-distraction rooms for assessments
- **Specialist Pastoral Care:** Access to NHS Practitioner Health, providing a confidential, specialised pathway for neurodivergent doctors that bypasses standard NHS waiting lists (*NHS Practitioner Health, 2024*).

Reasonable Adjustments for ADHD / ADHD Traits

Time, task initiation & admin

- Protected admin blocks
- Visual timers / appointment prompts
- Shorter deadlines & visible accountability
- Body doubling or shared working sessions for admin, forms, audits or portfolio tasks
- RAN: rewards, accountability and novelty
- Admin support for routine or repetitive tasks

Memory, organisation & safety

- Templates, checklists and prompts for prescribing, results, referrals and follow-up
- Written task lists & clear prioritisation
- Dictation / speech-to-text / AI support where appropriate
- Named place/system for key documents and tasks

Workload & energy

- Buffer slots / catch-up time
- Breaks for food, drink, movement or social reset
- Flexibility around task order and working style
- Permission to move, stand, fidget or use a wobble cushion/standing desk

Feedback & supervision

- Regular brief check-ins rather than infrequent high-stakes reviews
- Feedback that is specific, factual and task-focused
- Avoid vague criticism such as “be more organised” or “manage your time better”
- Coaching, mentoring or buddying for planning, prioritising and accountability



Reasonable Adjustments for Autism / Autistic Traits

Predictability & clarity

- Agendas, questions or teaching topics in advance
- Written instructions & written follow-up after meetings
- Clear expectations, priorities, deadlines and “what good enough looks like”
- Reduced last-minute rota, room or timetable changes where possible
- Advance warning and explanation of changes

Sensory environment

- Quiet workspace or admin room
- Reduced non-urgent interruptions
- Control over lighting, noise, temperature and seating where possible
- Permission to use headphones/earplugs for admin work
- Recovery/decompression space after high-intensity clinics, meetings or feedback

Communication & social load

- Acceptance of direct, literal or low-affect communication styles
- Reduced unnecessary meetings or social expectations
- Written rather than verbal-only requests
- Clear routes for escalation, questions and decision-making

Scrutiny, observation & feedback

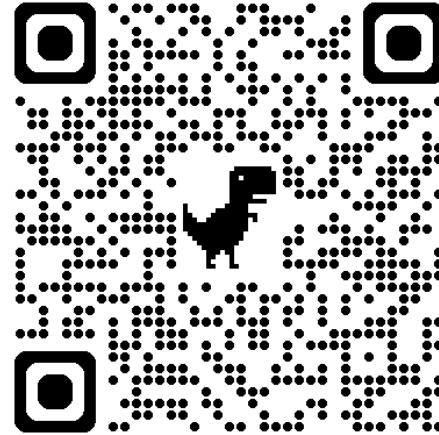
- Clear purpose and structure for observed surgeries/tutorials
- Specific, kind, factual feedback — preferably written
- Private space/time to process feedback
- Avoid ambiguous criticism or expecting people to “read between the lines”



Thank you!

Questions?

Your feedback is valued! :)



<https://www.surveymonkey.com/r/FF9YGDN>

