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Reflections from the Field

Perspectives on ADHD Coaching: A Response to Bergey, M. (2024).

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Abstract

In the June 2024 issue of the *Journal of Health and Social Behavior*, sociologist Dr. Meredith Bergey, explores the profession of ADHD coaching. Bergey raises concerns that coaching often commercializes personal experience, lacks clear standards or oversight, blurs the line between professional and personal expertise, and simultaneously challenges and relies on a medical view of ADHD. In this response article, we address the assumptions and perspectives Bergey makes about the nature of ADHD coaching; share our own observations and concerns; and propose an alternative framework through which to view and understand the emergence of ADHD coaching.

Keywords

coaching, ADHD, attention-deficit/hyperactivity disorder, emerging field, wellness

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Introduction

In the June 2024 issue of the *Journal of Health and Social Behavior*, Dr. Meredith Bergey, Associate Professor, Department of Sociology & Criminology at Villanova University, explored the profession of ADHD coaching.

Bergey is a sociologist focused on how mental-health diagnoses—especially ADHD and autism—become medicalized across different social contexts and what that means for identity, policy, and expert roles. Through her publications, Bergey emphasizes the multi-dimensional spread of medicalization—across culture, institutions, and regulation—while examining how lay and semi-professional actors reshape expert authority, identity, and lived experience. Many of her publications are specific to ADHD (Bergey, 2024a, 2024b; Bergey et

al., 2022; Bergey & Conrad, 2018; Bergey et al., 2018; Conrad & Bergey, 2014; Singh et al, 2013).

In the article under discussion, Bergey offers a sociological critique of the rise of ADHD coaching, depicting it as a lay-driven, semi-professional response to dissatisfaction with traditional medical and psychological approaches to ADHD. Based on interviews with 51 ADHD coaches, a review of some literature, and field observations at conferences, Bergey posits that coaches often draw from personal experience, embrace a neurodiversity-informed, strengths-based perspective, and emphasize skill-building and self-actualization. She raises the following concerns about coaching: the commodification of personal experience; commercialization and lack of regulation in relation to credibility and expertise; blurred lines between professional and “lay” expertise; and a partial resistance to the medicalization of ADHD, simultaneously resisting, adapting, and profiting from it.

We appreciate Dr. Bergey’s efforts towards exploring the emerging profession of ADHD coaching from a sociological perspective. At the same time, we take issue with some of the emphasis in her exploration. We have a different perspective to share on the field that may be of use in gaining a more full and accurate understanding of the emerging profession of ADHD coaching.

Positionality

We are not sociologists. We are ADHD coaches, researchers, and academics. We all hold National Board for Health and Wellness Coaching credentials, one also holds an ICF PCC credential, and one holds a BCC credential from the Center for Credentialing in Education. We all have specialized training to coach individuals with ADHD. We all conduct and disseminate research on ADHD and coaching. Additionally, the first author is a Registered Nurse and a university Professor of Health and Wellness Coaching; the second is a Licensed Clinical Social Worker; and the third is a doctoral candidate with a master’s in applied psychology, who oversees coaching and psychoeducation at a medical school department of psychiatry.

Perspectives on ADHD Coaching: Response to Bergey

We have three purposes in this response article:

1) We offer some clarification about the nature of ADHD coaching, an incomplete understanding of which might have informed assumptions made in Bergey’s (2024) article;

2) We share observations and concerns related to Bergey’s assumptions and perspective or lens for writing her article; and

3) We propose an alternative framework through which to view and understand the emergence of ADHD coaching, one that, in our view, is a more accurate portrayal.

Depictions of Coaching

We begin with our concern that Bergey's article does not provide an actual description or definition of ADHD coaching, although a number exist (e.g., ACO, 2021; PAAC, 2024a; Wright, 2014). The article hints at a definition using terms such as "self-actualization" (e.g., p. 257), "personal transformation" (e.g., p. 267), "commercial" (e.g., p. 261), "unbounded" (e.g., p. 261), and "intervention expansion" (e.g., p. 256), which are neither contextualized nor represent a full or accurate understanding of the profession.

As another depiction of coaching, the author repeatedly references "personal experience" as driving ADHD coaching (e.g., p. 257). While many individuals providing ADHD coaching services are likely drawn to the profession due to a personal connection to ADHD, this should not be considered disqualifying. At least two studies of ADHD coaching suggest that clients appreciate having a coach with lived-experience of ADHD, either their own or with a family member (Sander-Williams, 2024; Schrevel, Dedding & Brourse, 2016). Besides, personal experience draws many individuals to contributing through the work they do, such as oncologists drawn to their field by having experienced cancer in the family, or substance-abuse counselors who have overcome addiction. This lived-experience is not a professional disqualification.

What Bergey does not address, and what is perhaps more important, is that, regardless of personal experience, many ADHD coaches are formally credentialed, involving a process of training and mentoring in specific competencies, followed by both factual and practical examinations. Credentialed coaches do not simply offer personal experience as expertise. Instead, they use specific skill-sets within defined competencies to support client growth (e.g., International Coach Federation [ICF], 2019; National Board for Health & Wellness Coaching [NBHWC], 2024; Professional Association of ADHD Coaches [PAAC], 2024b). Further, coaching approaches are grounded in theoretical frameworks, including Self-Determination Theory (Deci & Ryan, 1985, 2002) and positive psychology (e.g., Biswas-Diener, 2010; Niemiec & Casioppo, 2024), that support working with clients to utilize their strengths and to improve self-awareness, self-efficacy, and the ability to optimize functioning. Theoretical frameworks specifically used in ADHD coaching research have been identified as executive functioning, self-determination, and psychoeducation, among others (Ahmann et al., 2018; Tuttle, 2021; Tuttle, Ahmann, & Wright, 2016).

Assumptions about Coaching

A foundation of the coaching profession in general—not just ADHD coaching—is to hold clients as "creative, resourceful and whole" (Kimsey-House et al., 2018). This is a stance firmly supported by a wellness framework in which even individuals who may have an illness or disability can find high-level wellness (e.g., Travis, 1988). This perspective commits trained coaches to work in partnership with clients (ICF, 2019; 2024), respecting that the client is an expert in themselves, which Bergey mentions, and the coach's role is to guide a process of learning, discovery, and growth.

As another example of assumptions that are not quite accurate, Bergey repeatedly refers to ADHD coaching as a type of "health coaching" (e.g., p. 256) although ADHD coaching grew up firmly out of the life coaching realm. While health and wellness coaching has competencies similar to life coaching (see ICF, 2019) and also to ADHD coaching (see PAAC,

2024b), it has a separate credentialing body, the National Board for Health and Wellness Coaching (NBHWC), and some unique competencies (see NBHWC, 2024). Also, anecdotally, while this may change over time, only a small subset of ADHD coaches to date—the three of us are among the exceptions—have chosen this particular credentialing route.

We appreciate Bergey's reflections on the liminal position of the ADHD construct, vis-a-vis its multiple framings (disorder/disability/difference/neurodivergence), and how ADHD coaching, as a nonmedical approach serving the needs of a medical/medicalized population, may share in and contribute to this liminality. What we take issue with is a seeming subtext that the ADHD coaching profession and ADHD coaches pointedly "push to reframe," (e.g., p. 262), "partially resist," (e.g., p. 268) or even "resist" (e.g., p. 258) the medicalization of ADHD, and in so doing "distance themselves from deficit and pathology framings of ADHD…" (p. 266). Any or all of these aims may indeed serve to disrupt harmful narratives concerning ADHD and ADHD-identified individuals. However, the intent of coaching is actually just, morally sound, and quite simply, different. The purpose of ADHD coaching is not to *treat* ADHD but, instead, to holistically support individuals with ADHD to pursue whatever actions and resources may be beneficial to enhance their lives. This may include both encouraging reframing or a broadening of their lens on ADHD and availing themselves of supports that exist outside of coaching, such as medication, psychotherapy, nutrition, exercise, apps, and so forth. The fundamental questions of coaching are: How do you want to live your life? How can you get there? In this context, we wonder if understanding this assumptive framework as different from "treatment" might have shifted the author's interpretation of the data collected. We do agree with Bergey's mention that ADHD coaching aligns with a "wellness model and the broader field of life coaching" (p. 266) but do not understand her minimal treatment of this key perspective.

As another example of the author's misunderstanding of ADHD coaching, is that the specific focus within the coaching, like all coaching, does not "provide" life skills (p. 261). While it may involve limited education and psychoeducation (Wright, 2014), ADHD coaching primarily assists interested clients in identifying, experimenting with, and developing an individualized toolbox of skills to improve well-being and enhance ease. This is often focused around managing executive functioning deficits, common among individuals with ADHD (Brown, 2009; Brown, 2024; Wright, 2014). An emphasis is on individualization to promote self-awareness, empowerment, self-determination, and self-efficacy, all central to high-level, whole-person wellness (e.g., Klepac, 1996).

Coaching may involve "identity work," as Bergey mentions (e.g., p. 266). In fact, in a qualitative case series, Sander-Williams (2024) reports that participants valued ADHD coaching in part for its support for gaining insight and a more positive re-evaluation of self-identity. The importance and value of this pursuit is suggested by a number of qualitative studies among individuals with ADHD that point to the social constructions of ADHD—rather than its "medical" components—as being of particular concern (e.g., Halleröd et al., 2015; Redshaw & McCormack, 2022; Schrevel et al., 2015). As an example, Schrevel et al. (2015) conclude: "The symptoms of ADHD in themselves were not seen as a problem by most of the [study] participants … ADHD appears to become most problematic in the social environment with symptoms, self-image and social environment all playing central roles" (p. 47). While not focused on coaching, Redshaw and McCormack (2022) suggest that

"identifying positive aspects to ADHD offers … a pathway for mitigating the negative effects on self that flow from the challenges of ADHD" (p. 20). Indeed, it is important to note that among the challenges with which individuals having ADHD must contend is navigating the societal stigmatization of ADHD (Mueller et al., 2012).

However, and despite what Bergey suggests, the fact that coaching may address identity work need not be in tension with therapeutic approaches as Bergey suggests (see, e.g., p. 257). When this tension exists, in our experience, it typically arises from therapists, not coaches, and may occur as a result of limited understanding of coaching (see, e.g., Ahmann et al., 2021). To understand why coaching naturally focuses on identity work, it's helpful to understand that coaching has a wellness orientation, is growth oriented, and, as such, is forward-focused on who the client might want to become, how they might want to see themselves, and how they can identify and use their strengths to promote growth (e.g., ICF, 2019; NBHWC, 2024; PAAC, 2024b). This is in line with needs of individuals with ADHD, as suggested in several qualitative studies (e.g., Hallerod et al., 2015; Sedgwick et al., 2018).

Assumptions and Frameworks

In this regard, we contend that the shift from a "deficit" to a "paradox" perspective, offered by coaching, as Bergey posits (p. 261), is not reflective of a resistance towards medicalized discourse *per se*. Rather, coaches may invite clients to consider a shift from a primarily deficit view towards a strengths perspective in order to support individuals with ADHD in reconceptualizing themselves more broadly in a non-stigmatized fashion. In fact, qualitative studies by Nordby et al. (2023) and Broer and Heerings (2012) suggest that individuals with ADHD do see their condition as both a challenge and a gift. What Bergey views as pushing liminal medicalization, or a resistance to medicalization, may actually be evidence that coaches are willing to work as partners with clients in exploring the lived experience of this dialectic. Perhaps this is a reason why individuals may at times choose coaching instead of, or in addition to, psychotherapy–as found in one study from the Netherlands. Schrevel at al. (2016, p.1) suggest that individuals may choose ADHD coaching over therapy, even when it means paying out of pocket, because of coaching's "optimistic, strengths-based, and solution-focused" partnership approach.

As a separate point, and contrary to assumptions reflected in Bergey's article, ADHD coaches neither deem to provide treatment nor seek to either compete with therapists or supplant psychotherapy as a supportive modality. Rather, coaches may, in many cases, collaborate and confer with clinicians or work as part of an interprofessional team (e.g., Ahmann et al., 2021). Credentialed coaches are trained to stay within their scope of practice and refer clients to therapy when coaching is either not effective or a client warrants mental health treatment (see ICF, 2019; NBHWC, 2024; PAAC, 2024b). Many coaches receive referrals from psychiatrists and other mental health clinicians, and clients may simultaneously work with both a coach and a therapist, or may have worked with a therapist in the past (e.g., Ahmann & Saviet, 2025, unpublished data). Coaching, medication, and therapy can and may be engaged jointly as effective supports by individuals with ADHD, and, increasingly, ideal care is understood to have a multimodal focus (Ahmann & Saviet, 2021; Ahmann et al., 2021; Barkley, 2021; Kooij et al., 2010, 2019; Murphy, 2015; Pfiffner & DuPaul, 2015; Prevatt & Levrini, 2015; Sarkis, 2024).

While Bergey is correct that coaching is not a licensed field–and there are some individuals who advertise themselves as ADHD coaches without training or a credential, coaches who obtain training can pursue credentialing by any of the credentialing bodies referenced above, who require demonstration of knowledge and skills, and adherence to a code of ethics. As a subset of life coaching, with its own additional knowledge base, and in existence since the early 1990s, ADHD coaching may be considered an emerging field with a growing body of research literature (Ahmann & Saviet, 2021; plus, some 58 articles in the Springer Institute digital database, 2024). None of this literature, unfortunately, was cited in Bergey's article. Literature on coaching more broadly, including health and wellness coaching, further bolsters the evidence for effectiveness in the coaching field (e.g., Abu Dabrh et al., 2025, Ahmann et al., 2023; Bozer & Jones, 2018 Sforzo et al., 2018; 2020).

Bergey seems to criticize coaches' developing their businesses and marketing themselves, and for this reason choosing to attend workshops on relevant topics at conferences. However, therapists and psychiatrists also develop businesses and market themselves, as any internet search will demonstrate. In fact, this is most true among specialists who, while licensed and potentially able to receive insurance reimbursement, quite often do not accept insurance payments for their services. The author's construing ADHD coaching as primarily an "unbounded" (p. 261), "commercial" (e.g., p. 261), and "commodified" (e.g., p. 257) field is one perspective, but it seems to us to overlook many important factors and key context, and thus strikes a questionable chord.

Alternative Framework

According to the Minnesota Department of Health (2017), "new and emerging professions … are often uniquely positioned to fill gaps in the health care system" (p. 4). And, indeed, gaps in ADHD care have been identified (e.g., Bissett et al., 2023). In this regard, we suggest an alternative perspective to that offered by Bergey: ADHD coaching may be considered an emerging service field, meeting a need not adequately met by other services (see, e.g., Schrevel et al., 2016). The tasks of an emerging field include developing a scope of practice, distinguishing itself from similar or related fields, determining competencies for training, considering models of regulation, exploring funding options, as well as addressing business and legal concerns, engaging in advocacy, and so forth (MDH, 2017). While Bergey characterizes coaches as "health providers without a medical license" (e.g., p. 256), we wonder whether a framing of ADHD coaching as an emerging field, providing a specific type of supportive service, and employing credentialing rather than licensure, might have led her to a different interpretation of the data collected in this study.

In fact, while Bergey refers to ADHD coaches as healthcare providers without a license, the American Medical Association (AMA) considers health coaches—a closely-related role—to be "non-physician healthcare professionals" (NCHEC, 2020, para. 2). In addition, the AMA:

- advocates for health coaching as a useful service;
- provides a toolkit for physicians to encourage incorporating health coaches into their practices both to help patients "take charge of their health" (AMA, n.d.) and to "improve outcomes" (AMA, n.d., para 16; AMA, 2023); and

- offers Continuing Medical Education credits for learning about health coaching (AMA, n.d.).

As of 2019, there have been three Category III CPT codes for health coaching (0591T, 0592T, and 0593T), renewed through 2029; and as of 2024, health coaching is a recognized Medicare telehealth service (Abu Dabrh et al., 2024). This may suggest an eventual direction for ADHD coaching as well, with the potential of making ADHD coaching more widely available.

In terms of methodology, more clarity on the sources of data would have been useful. For example, while Bergey reports a number of demographics about her interviewees, including the fact that 19 had a clinical background, she does not report on the duration of her participants' experience in the ADHD coaching field. Interviewing coaches-in-training, many of whom attend the types of conferences Bergey describes as a source of her data collection, might yield vastly different data than would interviewing either experienced coaches or those leading coach training schools or coaching organizations. She also mentions reviewing peer-reviewed literature, books, and so forth, without identifying these specifically, leaving the reader in the dark about this key data source.

Also, as we understand it, a single researcher, Bergey herself, coded all the data. We acknowledge that this is often a practical approach in qualitative work. However, we wonder whether involving individuals from varied backgrounds and perspectives in coding the data, and/or providing for robust "member checking," approaches that are widely employed to increase reliability in qualitative research (see, e.g., Barbour, 2001; Tong, Sainsbury & Craig, 2007), might have produced a somewhat different interpretation of the data and characterization of ADHD coaching.

Conclusions

What we also see as important, and is missing in Bergey's study of ADHD coaching, is an exploration of why the field of ADHD coaching has emerged and has been growing. We posit that the field did not emerge because of a desire among coaches to capitalize on, and monetize, personal experience, as Bergey seems to suggest, but because of unmet needs among individuals with ADHD. We further posit that ADHD coaching can best be understood from the perspectives of an emerging subspeciality within the larger coaching field, with a strengths-based, wellness-oriented, whole-person model, a field neither opposing nor advancing medicalization but, rather, one offering a complementary approach that both addresses other aspects of the self and is provided within a multimodal framework of comprehensive supportive services.

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