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Academic Paper

Development of a Manualized Coaching Intervention for Adult ADHD

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Abstract

Attention-Deficit/Hyperactivity Disorder (ADHD) poses challenges for affected individuals in varied functional arenas and life domains. Research on specialized ADHD coaching demonstrates benefit across the age span. However, studies of ADHD coaching for adults have only focused on group coaching. We engaged eight expert coaches in an iterative process over five focus group meetings to develop components of a manualized intervention for a coaching engagement for individual adults with ADHD. The resultant guidelines, "ADHD Coaching Engagement: Manualized Intervention" (ACE-MI) offers both best practice guidance for coaching adults with ADHD and a consistent approach to a coaching engagement useful in supporting quality research in the field.

Keywords

Attention-Deficit/Hyperactivity Disorder, ADHD, coaching, executive functioning, manualized intervention

Article history

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Introduction

Attention-Deficit/Hyperactivity Disorder (ADHD) poses challenges for affected individuals in varied functional arenas and life domains. Previously treated primarily with medications (e.g. stimulants), more recently a multimodal approach to treatment, including medications, therapy, and coaching, is considered optimal in supporting successful management of the condition (e.g., Hinshaw & Arnold, 2015; Martinez-Nunez & Quintero, 2019; MTA Cooperative Group, 1999).

Coaching for ADHD is an emerging field with an increasing body of research, focused mainly on the college-aged population (Ahmann & Saviet, 2021). Two studies of ADHD-focused coaching for adults have focused on group coaching (Bloemen, Verbeek, & Tuinier, 2007; Kubik, 2010). Although anecdotally it is a widely used and valued service, no research to date has explored individual coaching for adults with ADHD. Research is therefore needed to explore the effectiveness of this type of coaching for adults.

There are varied definitions of "ADHD coaching" in the literature (e.g., ACO, 2021a; PAAC, 2023; Wright, 2014) and it is, thus, unclear if there is one specific intervention that could be called "ADHD coaching" to study. To conduct rigorous research on ADHD coaching for adults, identification of a consistent coaching "intervention" is needed. We conceptualized this as a "manualized intervention" of sorts that would describe the essential elements of each session of a coaching engagement. Thus, the objective of the current project was to bring together experienced ADHD coaches of varied training backgrounds, using a focus group methodology to identify common elements of what could be considered the guidelines for a manualized intervention (or standardized approach) comprising a coaching engagement of individual sessions for adults with ADHD.

In a coaching engagement, three months is considered, anecdotally, "long enough to make meaningful progress, establish some new habits, and experience…benefits" (e.g., Moore, Jackson, & Moran, 2016, p. 134). This is also consistent with the practice of some ADHD coaches who offer 12-session or three-month coaching "packages" to potential clients. Ahmann, Tuttle, Saviet, and Wright (2018) summarized research literature on individual coaching for college students with ADHD, demonstrating positive outcomes. These studies included coaching that ranged from 8 to 24 weekly sessions (actual reported weeks of coaching: 8, 8, 9, 10, 8-13, a semester (weekly), an average of 17-18, and 12-24, from, respectively: Swartz, Prevatt, & Proctor, 2005; Prevatt & Yelland, 2015; Reaser, 2008; Parker & Boutelle, 2009; Maitland, Richman, Parker, & Rademacher, 2010; Parker, Hoffman, Sawilowsky, & Rolands, 2011; Field et al., 2013; Richman, Rademacher, & Maitland, 2014). Among all these studies, the approximate mean number of sessions was just over 12. For these several reasons, 12 sessions seemed to be an appropriate length for a coaching engagement for a manualized intervention for coaching adults with ADHD.

Guiding Research Question: What are the key components comprising a 12-session engagement of individual coaching for adults with ADHD?

Literature Review

Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterized by symptoms of inattention, hyperactivity/impulsivity, or a combination (APA, 2013). ADHD is the most common disorder of childhood, and some 5% of children and adolescents are diagnosed with ADHD (Polanczyk et al., 2014). While long thought to be a disorder with origins in childhood, gradually diminishing over the lifespan, more recent research on ADHD paints a different picture (Song et al., 2021). ADHD is now understood to continue into adulthood for many diagnosed as children (Sibley et al., 2016). Additionally, it is understood that adults can be newly diagnosed with ADHD as well (Hartung, Shelton, Abu-Raman, & Canu, 2022; NIMH, n.d.). The prevalence of ADHD in adults is in the range of 2.5% to 6.8% (Kessler et al., 2006; Fayyad et al., 2017; Simon, Czobor, Bálint, Mészáros, & Bitter, 2009; Song et al., 2021). Based on a systematic review and meta-analysis, Song et al. suggest that in 2020, the prevalence of "persistent ADHD from childhood" was 2.58% globally while the prevalence of "symptomatic adult ADHD" was 6.76% (p. 8). Among adults, ADHD is more prevalent in men, although the prevalence in adult women has been increasing (Faheem et al., 2022), likely due to increased awareness and consequent diagnosis. According to London and Landes (2021), "the gender gap in the prevalence of ADHD among adults decreased by 31.1% from 2007 to 2012 due to increased prevalence among adult women of all ages" (p. 771). The DSM-V (APA, 2013) reports a male to female frequency ratio among adults of 1.6:1 (p. 63).

According to the DSM-V (APA, 2013), ADHD has three main diagnostic presentations. One presentation is *ADHD predominantly hyperactive/impulsive* which, in adults, is characterized by extreme restlessness and a desire for immediate rewards, among other symptoms. A second

presentation is *ADHD predominantly inattentive* which, in adults, manifests behaviorally as forgetfulness, difficulty sustaining focus, and disorganization, among other symptoms. A third presentation is considered a *combined* type, when specific characteristics of both hyperactive/impulsive and inattentive are present in one individual. Wilens et al. (2009) explored the relative percentage of presentation type (called "subtype" in the DSM-IV) among adults with ADHD in an outpatient adult population, finding that 7% had the hyperactive/impulsive subtype, 31% the inattentive only subtype, and 62% the combined subtype (p. 1557).

In addition to the core symptoms of ADHD, executive functioning (EF) is often found to be impaired in individuals with the diagnosis (Barkley, 2011; Brown, 2022). EFs are the neuropsychological processes that serve to organize and manage cognitive functions and goal directed behavior. EFs comprise processes including activation, focus, effort, emotion, memory, and action (Brown, 2022). Deficits in these areas are increasingly understood to impact functioning among individuals with ADHD. NIMH (n.d.) details the functional challenges related to ADHD and EF deficits as follows:

> *Some adults who have ADHD … may feel it is impossible to get organized, stick to a job, or remember to keep appointments. Daily tasks such as getting up in the morning, preparing to leave the house for work, arriving at work on time, and being productive on the job can be especially challenging for adults with undiagnosed ADHD. These adults may have a history of problems with school, work, and relationships. Adults with ADHD may seem restless and may try to do several things at the same time—most of them unsuccessfully. They sometimes prefer quick fixes rather than taking the steps needed to gain greater rewards*. (p. 4)

Treatment for ADHD

Experts increasingly point to multimodal care as the optimal approach for treatment of ADHD (e.g., Hinshaw & Arnold, 2015; Martinez-Nunez & Quintero, 2019; MTA Cooperative Group, 1999). Multimodal care is often described as including medication management, therapy, coaching, and at times other individualized approaches such as neurofeedback, nutritional supplements, meditation, and the like.

Stimulant medication is typically the first line of treatment for ADHD and may be effective in addressing core symptoms (e.g., inattention, hyperactivity, impulsivity) (NIMH, n.d., p. 5). However, it does not address EFs or functional impairment very successfully. Other medications, such as non-stimulants and antidepressants, may also be used as appropriate, particularly when common comorbidities such as anxiety and depression are present, but additionally as second-line ADHD treatments.

Therapy may be a useful support for individuals with ADHD, especially those experiencing co-occurring conditions (NIMH, n.d., p. 5). Cognitive Behavioral Therapy (CBT) is perhaps the most commonly used therapeutic approach. A systematic review and meta-analysis of nine randomized controlled trials found that CBT was superior to both waitlist and active controls in reducing ADHD symptomatology (Young, Moghaddam, & Tickle, 2020); it appears to be useful even in the absence of medication use (Ramsay & Rostain, 2011; Weiss et al., 2012). Dialectical Behavioral Therapy (DBT), may also help with specific challenges related to ADHD, such as skill development and self-regulation, and can contribute to symptom reduction (e.g., Hirvikoski et al., 2011). In general, functional challenges such as organizing, planning, procrastination, and other key skills that are components of personal and professional or vocational success, appear to be best targeted using behavioral interventions which can occur in CBT and DBT as well as through ADHD coaching (Chan, Fogler, & Hammerness, 2006; Rajeh, Amanullah, Shivakumar, & Cole, 2017).

Schrevel, Bedding, and Bourse (2016) conducted a qualitative study of 23 adults with ADHD in the Netherlands who chose to pay out-of-pocket to work with a coach specializing in ADHD rather than continue with public mental health care. These adults with ADHD indicated appreciation for, and a

high valuation of, the client-centered, strengths-based, individualized partnership model of coaching which they felt offered more substantial and effective support than their prior therapy experiences. Participants felt that coaching was useful in gaining insight that helped them to proactively search for solutions both to better manage their symptoms and to develop skills to optimize functioning and improve their current and future quality of life. The Schrevel study is not alone in pointing to benefits of coaching. In fact coaching for individuals with ADHD is a non-clinical behavioral modality receiving increasing recognition as a useful and important component of comprehensive care for individuals with ADHD and/or EF challenges (c.f., Barkley, 2015; Kooij et al., 2010, 2019; Murphy, 2015; Pehlivanidis, 2012; Pfiffner & DuPaul, 2015; Prevatt & Levrini, 2015; Sarkis, 2014).

Coaching for Individuals with ADHD

Coaching can be defined as "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential" (ICF, 2021, para. 1). Specialized coaching with individuals having Attention-Deficit/Hyperactivity Disorder (ADHD) was first documented in the literature in 1994 (Hallowell & Ratey, 1994) and has since continued to evolve as a field (Ahmann & Saviet, 2021). ADHD coaches combine foundational coaching skills with: use of an "ADHD lens" (PAAC, 2023, para. 6) or framework; psychoeducation; knowledge of pertinent skills and strategies; and a client-centered approach, to support growth for individuals having ADHD and/or executive functioning challenges (c.f., Wright, 2014). ADHD coaching is a collaborative process that can assist clients in identifying personal "goals and … develop[ing] the self-awareness, systems, skills, and strategies necessary for the client to achieve those goals and full potential" (ACO, 2021a, para. 2) as well as empower clients "to manage their attention, hyperactivity, and impulsivity" (PAAC, 2023, para. 3).

While it is not a new field, ADHD coaching shares many characteristics with "emerging" fields, including a growing evidence base. In fact, ADHD coaching has demonstrated benefit in studies conducted across the lifespan (Ahmann & Saviet, 2021). At least eighteen studies to date of outcomes of coaching for clients with ADHD are varied in size (*n*s range from 1 to 1782 participants) and research design (three are randomized controlled trials/RCTs) (Ahmann & Saviet, 2021). Collectively, these studies have found evidence, of varied robustness, across age groups, of improvement in clients' ADHD symptoms and executive functioning and, in some cases, well-being. For example, a study of coaching for children with ADHD and their parents found improvement in the children's ADHD symptoms as well improvement as in family functioning (Garcia Ron et al., 2016). Numerous studies among high school and college students have explored ADHD coaching for individual clients (as opposed to group coaching), finding benefit for participants' executive functioning and, in some studies, self-esteem or other aspects of well-being (see summaries in Ahmann, Saviet, & Tuttle, 2017, and Ahmann et al., 2018).

Coaching for adults, who are not full-time college students, has received less attention in the literature. Only two studies of ADHD coaching have explored coaching for non-student adults, both focused on group coaching, and both reporting positive outcomes (Bloemen et al., 2007; Kubik, 2010). Bloemen et al. (2007), conducted a quantitative study of eight weeks of ADHD coaching for ten adult patients in the Netherlands. Although patient ratings of ADHD symptoms did not show improvement on the Attention Deficit Self Rating Scale (ASRS; Adler, Kessler, & Spencer, 2003), ratings by significant others (e.g., spouses), using the same measure, indicated symptom improvement for patients. Significant improvement was also demonstrated in patient reports of functional impairment using the Weiss Functional Impairment Rating Scale (WFIRS; Canu, Hartung, Stevens, & Lefler, 2020).

Kubik (2010) conducted an observational study on group coaching, including psychoeducation, for a total of 45 adults with ADHD. Each group comprised six 2-hour sessions and a one-month follow-up session. A 41-item "area of concern" measure with Likert-scale items was developed for the

study, using reworded questions from the Brown Attention Deficit Disorder Scale (Brown, 1995) and the Wender Utah Rating Scale (Wender, 1995). Kubik reported that coaching had a "strong impact" on adults with ADHD across multiple dimensions, including cognition, distractibility, inattention, and social and behavioral outcomes (p. 450). Kubik's study also demonstrated maintenance of gains over a one-to-four-year period.

Although many adults with ADHD are coached individually, rather than in groups, the literature to-date has not explored individual coaching for adults with ADHD. Research is needed to fill this gap.

Need for a Manualized Intervention

To explore outcomes of individual coaching for adults with ADHD, the coaching "intervention" should be specified. Effective and rigorous research on outcomes of any intervention depends on a degree of consistency in the delivery of the intervention. A consistent approach to an intervention assures treatment fidelity, minimizes practitioner effects, allows for clarity in reporting, and supports replication of the intervention (Blanche, Fogelberg, Diaz, Carlson, & Clark, 2011). Treatment fidelity, in particular, has been identified as a key aspect in research evaluating any interventions supporting behavior change (Bellg et al., 2004). Fidelity of an intervention supports internal and external validity and the ability to achieve greater confidence in the study results (e.g., Karas & Plankis, 2016).

Studies of ADHD coaching for youth have addressed the need for consistency of the intervention by engaging coaches trained in one or another specific approach to ADHD coaching. However, in practice, ADHD coaches working with adults have varied training backgrounds. For example, on its website, the ADHD Coaches Organization (2021b) identifies nine training programs for ADHD Coaches, four of which provide complete, or "fully integrated", coach training, focused on working with clients having ADHD, and five of which provide ADHD-coach specific training to augment coach training received elsewhere (such as life coach or health and wellness coach training, for example). Because each training program has a slightly different approach to the process of ADHD coaching, coaches trained in each program may work somewhat differently with their clients. Thus, for research on ADHD coaching for adults, an approach would be needed that assures consistency of a coaching intervention, or treatment fidelity.

Blanche et al. (2011) summarize literature suggesting that "currently, most psychosocial interventions … rely on manualization as the key mechanism for ensuring treatment fidelity and guaranteeing success" (p. 711). A manualized intervention can be used to assure treatment fidelity (Moncher & Printz, 1991). Manualization assists in linking intervention processes to research outcomes (Carroll & Nuro, 2002). Manualization also facilitates rigorous evaluation of any intervention, supports validity, and is considered the first step in designing research that can lead to the highest level of evidence (Blanche et al., 2011). This approach also assists in allowing the clearest interpretation of study findings (Bellg et al., 2004) and, thus, has implications for implementation of evidence gathered in such research (Bellg et al., 2004; Blanche et al., 2011). Further, manualization facilitates replication in future studies (Carroll & Nuro, 2002). Additionally, research based on manualized interventions may achieve greater acceptance by policy makers and funders (e.g., Addis, 2002; Murphy & Gutman, 2012). According to Goldstein et al. (2012), development of manualized interventions has become a research priority. A manualized intervention for coaching adults with ADHD would provide guidelines allowing for consistency that would support valid, replicable research in the field and "facilitate the translation of [coaching] interventions from research into…practice" (Pyatak, Carandang, & Davis, 2015, p. 188).

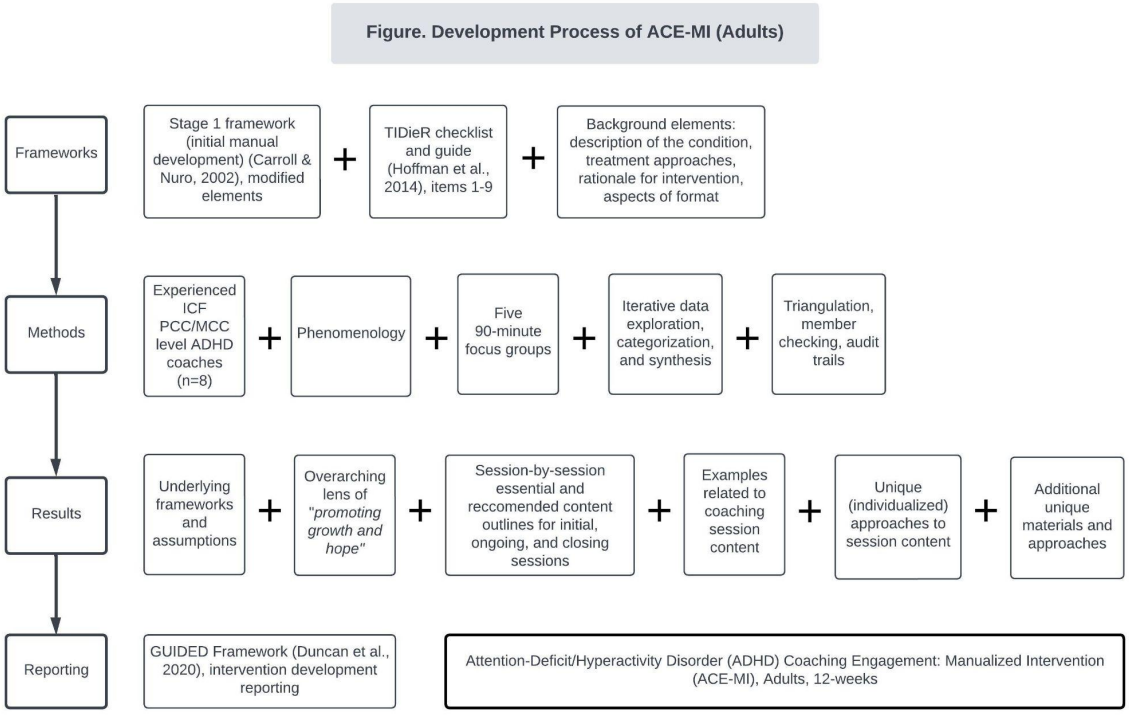
Methods

Frameworks for the Study

Carroll & Nuro (2002) outline a three-stage model for the development of a manualized intervention in psychotherapy. The present study, while not in psychotherapy, corresponds most closely to Carroll & Nuro's (2002) stage 1 in which a manual for an intervention is initially developed. According to Carroll & Nuro, a stage 1 manual includes seven key components. We adapted these seven components to a coaching lens as follows: (1) description of the condition; (2) varied treatment approaches; (3) overview, description, frameworks, and rationale for the intervention; (4) aims of the intervention; (5) general format of the intervention; (6) specification of the intervention (essential, recommended, and unique elements); (7) detailed session-by-session content. These stage 1 guidelines are parallel to items 1-9 outlined in the TIDieR guidelines for intervention development (Template for Intervention Description and Replication; Hoffmann et al., 2014) which recommend addressing: the intervention name, rationale and theory, procedures, intervention providers, mode and location of delivery, frequency and duration as well as approaches to individualization. Additional aspects of TIDieR guidelines address later stages in Carroll and Nuro's model and are not part of the current study.

In this case, we (the authors) compiled several background aspects of a Stage 1 manual (see Figure 1 for overall process for manual development). We documented components 1 and 2 of Carroll and Nuro's model, as outlined above (description of ADHD and common treatment modalities) based on the literature related to ADHD and ADHD treatment. We documented components 3 and 4 (overview and aims of coaching for ADHD) based on the literature to date on coaching for ADHD. We also selected certain aspects of component 5 (format of the intervention)—individual vs. group coaching, a focus on adults, and the choice of a 12-session coaching engagement–based on both the literature to date on ADHD coaching, and the gaps in the same.

Figure 1: Development Process of ACE-MI (Adults)



Next, expert coaches were engaged in the present study to complete the identification of components of a manualized intervention. In particular, they were engaged to address components 6 and 7: identify specific session by session content, including specification of essential, and recommended aspects of a coaching intervention for adults with ADHD, as well as add to component 5, identifying any particular format considerations beyond those specified by the researchers.

To inform the development of the coaching intervention for a best-practice manualized intervention comprising an individual coaching engagement for adults with ADHD, the present study uses a phenomenological approach to examine coaches' lived experiences and perspectives of the ADHD coaching process (see: Finlay, 2013; Wilson, 2015). Engaging experienced ADHD coaches facilitated identifying, synthesizing, and documenting key components of the ADHD coaching process. To capture the most common and consistent elements of the ADHD coaching process for adults, as well as the breadth and depth of content common in an ADHD coaching engagement, we purposely chose to include coaches from varied training backgrounds.

The goal was to identify a session-by-session outline for a manualized coaching intervention, with accompanying documentation, that included key components, both essential and recommended, of the structure of the coaching engagement, as well as potentially unique approaches allowing for flexibility to tailor the coaching individually to coach and client, as is typical in practice**.** Similar to Pyatak and colleagues (2015), we aimed in this process to address the goals of a stage 1 model (Carroll & Nuro, 2002), while balancing the need for a "well characterized intervention with the flexibility that characterizes [coaching] practice" (Pyatak et al., 2015, p. 191).

Research Design

A participatory, collaborative research process was selected for the process of developing the manualized intervention. Experienced, credentialed ADHD coaches were engaged as the key stakeholders, with the purpose of "generating an intervention that reflects the thoughts, feelings, and opinions of groups that will use the manual and resulting intervention…" (Goldstein et al., 2012, p. 2).

A qualitative focus group design, based on a phenomenological framework, seemed an ideal approach for engaging ADHD coaches of differing backgrounds in jointly identifying common elements comprising a manualized coaching engagement for individuals with ADHD. Qualitative exploration is commonly used when studying situations about which little is known, such as in the current study (Creswell & Creswell, 2018). Focus groups are a useful method to capture experiences, and explore the depth and nuances of an issue, with a target audience. A hallmark of focus groups is the use of group interaction and a set of broad, prompting questions, to encourage a brainstorm-like process, obtaining insights on the study questions that would otherwise be less accessible (Berg, 2001; Morgan, 1996). Focus groups have been used in prior research to develop manualized interventions (e.g., Schnyer et al., 2008).

This study was approved by the Institutional Review Board at Maryland University of Integrative Health. The Guidance for Reporting Intervention Development Studies in Health Research (GUIDED), "a checklist and guidance [that] provides a clear and structured basis for the reporting of intervention development studies" was used to assure thoroughness, quality, and transparency in this report of the development of the manualized intervention for ADHD coaching (Duncan et al., 2020, p. 11).

Recruitment

Our aim was to recruit eight to ten coaches for the study. According to Central Connecticut State University's (n.d.) Office of Institutional Research and Assessment this is the ideal size for a focus

group as:

> *a larger group will limit the detail of some responses because participants feel a pressure to share airtime with others. Conversely, participants in a smaller group may feel an uncomfortable pressure to talk more than they would otherwise to fill dead air.* (para. 3)

We also focused on recruiting coaches with International Coaching Federation (ICF) credentials and with varied ADHD coach training backgrounds. In particular, we sought a balance of coaches from each of the "fully integrated" ADHD coach training programs, as indicated in the coach inclusion criteria in Box 1. We wanted to bring together coaches from these key ADHD coach training programs to achieve a consensus of the common elements used in ADHD coaching, as described above.

To recruit coaches, we used a combination of convenience sampling–beginning with experienced coaches known to the researchers, plus some snowball sampling. We also contacted researcher connections at several ADHD coach training programs to identify additional potential participants. This process resulted in successful recruitment of eight experienced ADHD coaches.

Coaches received a small honorarium for participation. Participants provided informed consent and completed an online survey collecting demographic information and characteristics of their coaching practices prior to the focus group meetings.

Box 1. Coach Inclusion Criteria

- Received coach training at one of the four coach training programs designated "Fully Integrated ADHD Coach Training Programs" on the website of the ADHD Coaches Organization (ACO) (2021b) or the Optimal Functioning Institute (an earlier comprehensive ADHD coach training program that is no longer in existence, but at which many current ADHD coach trainers got their initial coach training).
- International Coaching Federation (ICF) Professional or Master Certified Coach (PCC or MCC) credential
- Minimum of 4-5 years of ADHD-specific coaching experience
- At least half of coaching practice comprised of adult clients with ADHD
- Coaches individual adults, not only groups
- Fluent in English
- Coach based in, and coaching clientele (75%) primarily in, the United States (note: this is where future research using the manualized intervention is likely to occur)
- Age 18 or over

Participant Demographics

Eight coaches participated in the study. All coach participants held a bachelor's degree, and half (*n*=4) held a master's degree. Seven participants held an International Coaching Federation (ICF) Professional Certified Coach (PCC) credential, and one held an ICF Master Certified Coach (MCC) credential. Seven coaches also held additional coaching credentials. Participants had between five and 26 years of experience of coaching with each of the following client categories: any population (*M*=15.75 years, *SD*=8.1); individuals with ADHD (*M*=12 years, *SD*=7.7); and adults with ADHD (*M*=11.9 years, *SD*=7.8).

Half of participants (*n*=4) reported coaching full-time, while 37.5% (*n*=3) reported coaching part-time, and one participant reported splitting her time between coaching and directing a coach training program. All coaches worked with individual clients, and some coaches (*n*=3) also reported coaching groups of adults with ADHD. All participants coached adults; some also coached college students *(n*=5), adolescents (*n*=2), and children (*n*=1), as well as parents (*n*=1), and emerging

coaches (*n*=1). The current total number of clients that participants coached with in a typical week ranged from 3-18 in the following two categories: any client (*M*=11.75, *SD*=5.3) and any client with ADHD (*M*=10.6, *SD*=5.2); the number of adult clients with ADHD coached per week ranged from 3-16 (*M*=9, *SD*=3.9).

Participating coaches were also engaged in other coaching-related activities: teaching in an ADHD coach training program (*n*=4); developing coaching materials (*n*=2); mentoring coaches in a non-ADHD coach training program (*n*=2); mentoring coaches, or training to be mentor, in an ADHD coach training program (*n*=4); mentoring coaches "on my own" (not as part of a program) (*n*=6); authoring publications (books, chapters, peer-reviewed publications) (*n*=2); serving on the board or committees of any coaching organization (*n*=2); and public speaking on ADHD (*n*=1).

Focus Group Process

Facilitators

The focus groups were facilitated by the two researchers (EA, MS) both health and wellness coaches; one is also an experienced ADHD coach and the other a social worker in clinical practice. Both researchers are experienced in focus group research and qualitative data analysis. One researcher (MS) moderated the focus group meetings, loosely following predetermined guiding questions, and the other researcher (EA) took notes during each session, using a shared screen that participants could see during the discussion; both researchers asked follow-up and clarifying questions.

Structure

A series of five weekly, 90-minute focus groups were held online (using Zoom) to engage coaches in sharing their experiences of the process of ADHD coaching. An iterative process involving group idea generation—through brainstorming and discussion followed by clarification and review/consensus development—characterized the focus group sessions. The discussions focused on key components of a standardized approach for a 12-session individual (not group) ADHD coaching engagement (the "intervention") for adults (who are not full-time college students), including three specific types of sessions: the initial or early session(s), ongoing sessions, and closure. Participants were also provided with three sets of coaching competency documents to review as background/context prior to the first focus group meeting (see Box 2).

Box 2. Coaching Competencies Provided to Participants as Background/Context

- International Coaching Federation (ICF) Core Competencies
  - https://coachingfederation.org/app/uploads/2021/03/ICF-Core-Competencies-updated.pdf
- Professional Association of ADHD Coaches (PAAC) Professional ADHD Coaching Competencies and 5 PAAC Essentials
  - https://paaccoaches.org/core-competencies/
  - https://paaccoaches.org/the-5-essentials/
- National Board for Health and Wellness Coaching (NBHWC) *HWC Certifying Examination Content Outline* (Participants were encouraged to particularly review Competency 1: Coaching Structure, pp. 2-4.)
  - https://www.nbme.org/sites/default/files/2022-05/NBHWC_Content_Outline.pdf

Data Collection & Analysis

Notes were taken during each focus group session in a document visible on a shared Zoom screen. Focus group participants could comment on the shared document as notes were being taken. The focus group sessions were recorded and session "chat" was retained. Between each weekly focus group session, the researchers reviewed session transcripts, the Zoom "chat", and the session notes. This review process allowed the researchers to:

- consolidate and organize the data
- distinguish categories
- note themes
- document common understandings and consensus decisions
- identify discrepancies, areas in need of further elaboration, and any potential gaps (based on their own knowledge of the field).

The researchers' synthesis of the data was developed into an outline after each focus group and shared with participants, sometimes accompanied by clarifying questions related to the areas noted above, one or two days after each meeting. In a collaborative process, and to provide for member checking, one approach to assuring validity in qualitative research findings, participant feedback was invited at each juncture, and was incorporated into the draft manual. Discussion in the subsequent focus groups assured consensus on the synthesized material and addressed any areas of discrepancy or disagreement in the draft outline from the prior group session, explored any potential gaps identified by the researchers, and engaged with any areas in need of elaboration, as well as sharing of additional experiences. The focus at each juncture was most accurately and fully to capture elements of coaching common among the experienced coaches of varied training backgrounds.

This iterative process from one focus group to the next added clarification and nuance to the intervention description. For example, during the discussions, participants shared rich and varied examples of applying the guidelines being developed, as well as unique approaches to their coaching. The researchers captured this extensive additional descriptive material so that it could both enrich user understanding of the key steps of the intervention identified in the manual and provide examples of additional unique or innovative, non-essential aspects to the intervention. Participants were offered the opportunity to comment on the final rough draft of the intervention in the last focus group meeting and by email for a week following the final meeting.

Triangulation between session notes and chat, recordings, and researcher recollection, as well as obtaining participant feedback (member checking)–both between each focus group session and after the final session–supported the reliability and validity (trustworthiness) of the data used in the final draft of the manualized intervention (Birt, Scott, Cavers, Campbell, & Walter, 2016; Carter et al., 2014).

Results

The focus group discussions led to identification of the following, described in detail in the sections below (see also Figure): (1) assumptions underlying the provision of the coaching intervention for adults with ADHD; (2) an overarching theme of *promoting growth and hope,* with relevant session content to be threaded through all ADHD coaching sessions; (3) outlines of session by session thematic categories of content for the intervention itself, addressing essential and recommended aspects of an initial, ongoing, and closing session of a coaching engagement for adults with ADHD; (4) examples related to content of each coaching session; and (5) unique aspects or approaches that could be part of each coaching session to individualize the essential elements to coach and client. The unique, individualized content related to each session was recorded in the form of coach notes, specific questions that could be asked, and examples of tools or approaches related to each

thematic category in the various coaching sessions. The focus group discussions also led to a sixth outcome, the identification of additional unique materials or approaches used by individual coaches.

Underlying Assumptions

While the focus group questions were designed to explore specific content of the coaching engagement, other important issues came to light during the discussions. Of note, participating coaches emphasized a number of key frameworks and assumptions they felt were important foundations for an effective ADHD coaching process. For example, participants emphasized that the development of the manualized intervention was based on a foundational framework of the International Coaching Federation (ICF) Core Coaching Competencies (ICF, 2023) and Code of Ethics (ICF, 2020). This was a framework shared by all participating experts, and participants felt that any coaches using the intervention that was developed should have training in the ICF Core Competencies and Code of Ethics as a foundation. In addition, participants recommended that coaches providing this intervention should also have specific training in ADHD coaching and experience in coaching adults with ADHD.

Additional assumptions for the intervention were identified by participants related to the ADHD coaching process. In particular, participants felt it was important that ADHD coaching be understood as follows:

- ADHD coaching is a client-centered process, and the client is always “at choice”.
- ADHD coaches see and hear all interactions with clients through an understanding of ADHD and Executive Functioning challenges, appreciating the impact of ADHD at all steps of the coaching process and in all facets of the client’s life.

Focus group participants also specified two other foundational aspects of the framework of the coaching engagement for the manualized intervention:

- ADHD coaching is often delivered as a weekly engagement, but the frequency may vary.
- ADHD coaching may be delivered face-to-face, via telephone, or by video-conferencing.

Overarching Theme: Promote Growth and Hope

Considerations

The expert coaches participating in this study repeatedly revisited discussions that were best characterized as exploring a theme of promoting client growth and hope. While acknowledging that all coaching promotes growth, these experts felt that approaches promoting growth, in combination with hope, were a key focus of ADHD coaching and provided a critical foundation for addressing the unique needs, challenges, and thinking patterns common to many adult clients with ADHD.

Essential Session Content

Participants felt that some approach to promoting growth and hope should be threaded through all interactions with ADHD coaching clients, as a vital part of every coaching session, from the initial through the closing sessions.

Recommended Session Content: Subthemes

To operationalize the theme of *promoting growth and hope*, participants identified a range of specific coaching approaches they felt promoted growth and hope, suggesting that one or more of the following should be part of each coaching session:

- Offering psycho-education on ADHD/EF/related factors
- Providing ongoing EF support
- Sharing relevant resources
- Addressing strengths
- Normalizing ADHD and EF challenges
- Encouraging client self-advocacy
- Exploring thought processes, perspectives, and/or limiting beliefs
- Providing acknowledgment and/or supporting celebration

Unique Content

Participants noted that specific training in areas such as mindfulness, somatics, positive intelligence and positive psychology might lead to additional unique approaches that individual coaches might use to promote growth and hope.

As an example of unique content, for the thematic category of *promoting growth and hope*, one coach note - or point to keep in mind - was that “Individuals with ADHD can feel like a ‘deer in the headlights’ when facing a challenge.”; another note was “Discourage use of the term ‘lazy’.” An example of a specific question that could be asked was: “How can you use your strengths to promote growth?” As an example of tools that could be used, one participant discussed working with Frederickson’s “Broaden and Build” theory, and another identified the Elicit-Provide-Elicit approach as the most effective and client-centered method for psycho-education.

Initial Coaching Session

Considerations

Participants discussed the fact that coaching often begins before the actual intervention, with a consultation to assess fit, explain what coaching comprises, and answer basic questions. However, participants identified heterogenous approaches to this consultation process and felt that key components of this aspect of the coaching engagement could be addressed by inclusion in an outline for the initial coaching session rather than as a separate consultation session outline. Combining the content of an introductory consultation and the initial coaching into a single outline would thus allow for flexibility and individualization regarding when to address certain topics with a client.

Participants also identified varied terminology for an initial coaching session, for example: “discovery session”, “intake”, or “strategy and planning session”. The discussion of these considerations preceded identification of the content of the initial coaching session. Finally, participants identified essential session content as well as unique session content for the initial coaching session.

Essential Session Content: Thematic Categories

Participant ideas for the essential content of the initial coaching session fell into the following thematic categories (sub-themes/categories are identified in parentheses):

- Explore and establish partnership (assess fit and design the coaching agreement)
- Explore history and current functioning (discuss history, examine lifestyle/self-care, identify ADHD/EF knowledge base, explore current functioning)
- Explore strengths and values (identify personal supports, explore and recognize strengths/successes, investigate values)
- Explore possibilities (envision new story/life goals/ideal self, identify desired outcomes from coaching)
- Promote growth and hope (note: see section on this theme above)

- Close session (summarize/takeaways)

Detailed Example of Subthemes

As an example of the degree of detail in which participants discussed the various components of the initial coaching session, the section of the session focused on the thematic category of *exploring history and current functioning* included the following specifics for the subthemes:

- Discuss history (Diagnosis; Co-existing/co-occurring conditions; Medications)
- Examine lifestyle/self-care (Sleep; Nutrition; Exercise; Pleasure/joy)
- Identify ADHD/EF knowledge base
- Explore current functioning (ADHD/EF current impact; Life skills/tasks; Current strategies/systems; Personal/family; Vocation/work)

Unique Session Content

Participants agreed on the essential content for the initial session while, at the same time, suggesting that they each had some individual, unique, and, at times, nuanced approaches to implementing the content.

As an example of unique session content, for the thematic category of *exploring history and current functioning*, one coach note was “Explore the common trifecta of ADHD, anxiety and depression.”; another was “Inquire about the presence of learning disabilities.” An example of a specific question that could be asked was: “What is the impact of ADHD/EF on your daily and overall functioning?” As an example of a tool that could be used, some participants suggested using scales to have clients rate their level of satisfaction with various organizational strategies and systems (e.g., “keeping track of and sticking to a schedule”).

Ongoing Coaching Sessions

Considerations

Participants noted that prior to, or during, the first ongoing coaching session, the coach should discuss with a client the flow of a coaching session. Participants also discussed that when clients have ADHD, challenges with focus are common, so in any session the coach may explore a change in direction to clarify the client’s choice and may also note whether the conversation is off track and invite the client back to the topic at hand. Further, participants stressed that throughout ongoing sessions, the coach should keep in mind the importance of promoting client autonomy, self-responsibility, and ownership of both the direction of the coaching and any outcomes.

Participants were largely in agreement about essential and recommended content of a typical ongoing coaching session in which coaches support their adult clients with ADHD in working toward their goals or intentions. Participants further identified unique session content, or ways they individualized the essential and recommended session content.

Essential Session Content: Thematic Categories

Participant ideas for the essential content of the ongoing, or regular, coaching sessions fell into the following thematic categories (sub-themes/categories are identified in parentheses):

- Open the session (check in about the week and prior goal(s), identify current session focus and desired outcomes)
- Explore the topic (connect with client’s bigger context, identify tools and strategies)
- Promote growth & hope (note: see section on this theme above)
- Plan next steps (identify take-aways, next action steps/fieldwork)

- Support success (explore supports and structures related to action steps/fieldwork)

Detailed Example of Subthemes

As an example of the degree of detail in which participants discussed the various components of an ongoing coaching session, the section of the session focused on the thematic category of *planning next steps* included the following specifics:

• Identify take-aways from session
• Explore how to move forward (action steps/fieldwork): Balance intentions with reality; Break intentions (goals) into incremental small steps
• Note: Identify barriers to action steps/fieldwork (optional)

Recommended Session Content

When participants identified aspects of the theme *opening the session,* they felt that exploring the relationship of the client's topic to the client's broader goals and agenda was recommended or important but optional, but not essential, aspect of session content. Similarly, in relation to the theme of *planning next steps*, they felt that identifying barriers to actions steps of field work was recommended but not essential.

Unique Session Content

As an example of unique or individualized session content, for the thematic category of *planning next steps*, one coach note was "Goals can include things to do, to reflect or focus on, or to pay attention to." As an example of an ADHD-specific question, one coach emphasized the frequent need to be very specific (e.g., "Where will you put a post-it note reminder?"). A similar question that could be asked was: "How will you remember to do these action steps/fieldwork?" As an example of a tool that could be used, several participants discussed the use of "future self" exercises or visualizations to tap into dopamine pathways.

Closing Coaching Session

Considerations

Participants all felt that in a closing session, it was important for the coach to recognize and voice the fact that some client goals attained may clearly be measurable, while other important growth may have been more intangible (e.g., increased confidence, awareness, self-esteem). They felt that both types of progress should be celebrated.

In terms of logistics, participants suggested that a coach may ask the client to reflect on progress and feedback in advance of a closing session. Additionally, a coach may choose to use an evaluation form to elicit feedback. Finally, there was some discussion about a three-month review that would include elements of a closing session, even if a client were not to end coaching at the 12-session mark.

Participants largely agreed on essential content of a closing session for a coaching engagement, and there were no aspects of this session that were simply recommended. Participants also identified unique session content, or ways they individualized the essential and recommended session content.

Essential Session Content: Thematic Categories

Participant ideas for the essential content of a closing session for a coaching engagement fell into the following thematic categories (sub-themes/categories are identified in parentheses):

- Recap progress (reflect by exploring learning and growth)
- Acknowledge and celebrate progress (cover coach/client observations and sources of celebration)
- Explore path forward (take-aways, path forward)
- Elicit feedback for coach

Unique Session Content

As an example of unique, or individualized, session content for the thematic category of *recapping progress*, two coach notes were "Revisit question from intake session about desired change(s)."; and "Revisit question from intake about desired feeling at the end of coaching."

Some powerful questions individual coaches like to ask in the closing session are:

- How will you take what you've learned and apply into your life moving forward?
- What tools and strategies resonate with being your best self?
- How will you continue to implement the knowledge of strengths, values, and strategies you've learned?
- How will you continue to implement and honor your values in life?
- How will you continue to work towards being your ideal self?

Individual coaches also suggested the following approaches to acknowledging client growth:

- Here's what I have had the pleasure of watching through our coaching.…
- You've opened my eyes to ___, and I appreciate that.

Additional Unique Materials and Approaches

Considerations

Participants discussed making use of a wide variety of additional materials and approaches that individualized the coaching based on coach expertise or client need. They suggested that these were used as opportunities to stimulate coaching conversation and help build and further client awareness, growth, and learning. Among these additional materials and approaches, participants identified use of some empirically based, validated measures. Other assessments or tools they identified were designed by coach training organizations or the coaches themselves to address areas in which validated tools may be lacking.

Thematic Categories and Examples

Beyond the typical session content, participants shared a wealth of additional unique materials and approaches they used in coaching their clients. Three thematic categories of individualized materials and approaches were identified: *assessments, tools and exercises*:

Assessments—used to gather and evaluate information, and provide deeper awareness and understanding. Examples were: executive functioning assessments, strengths inventories (e.g. Values in Action [VIA] or StrengthsFinder), a life skills assessment, the wheel of life, and learning styles inventories.

Tools—leveraged for growth, learning, and/or exploration; may be similar to assessments but more narrowly tailored. Examples include a medication checklist, needs and value identification, Maslow's hierarchy, a "task and dump" list, the Positive Intelligence® mental fitness program, and a positive/negative mindset ratio assessment.

Exercises—introduced and practiced as skills or techniques to help expand awareness and/or improve coping. Examples are: mindfulness, breathing exercises, visualizations, and somatic approaches.

Discussion

While a number of prior studies on ADHD coaching have been published (see summaries in Ahmann et al., 2018; Ahmann & Saviet, 2021), this is the first we are aware of that manualizes a coaching engagement for adults with ADHD. The data collected through five focus group meetings with eight experienced, ICF-credentialed, ADHD coaches, of different training backgrounds, led to guidelines for essential, recommended, and unique content for initial, ongoing, and closing coaching sessions. This process and it's outcomes suggest that manualizing a complex, multi-faceted, coaching intervention is feasible and can successfully balance the need for a clearly characterized intervention (Carroll & Nuro, 2002), assuring "replicability and standardization" (Schnyer et al., 2008), while also providing flexibility for individualization (Pyatak et al., 2015; Schnyer et al., 2008).

While ADHD coaching is not a new intervention, prior to this project, no structured manual had been in existence to guide its use in research or practice. As described herein, we incorporated modified elements of Carroll and Nuro's (2002) stage 1 (initial manual development) framework, and the parallel elements of the TIDieR guidelines (Hoffman et al., 2014), in developing an intervention manual for a 12-week individual coaching engagement for adults with ADHD. The researchers developed several sections of the intervention manual, based on extant research. A focus group process, engaging expert coaches with varied training backgrounds, was used to identify, document, and synthesize common session-by-session content elements of ADHD coaching. As detailed in the results section, the data obtained was far richer than anticipated. The data additionally revealed the following: (1) frameworks and assumptions underlying the provision of coaching (including some aspects of format); (2) an overarching theme of *promoting growth and hope*, that participants felt was essential to employ when working with adults having ADHD; (3) both examples and potential unique aspects of each coaching session, illustrating useful approaches for individualizing the essential elements of each coaching session based on coach expertise or style and specific client needs; as well as (4) a broad array of additional unique and individualized materials and approaches that can be incorporated into the coaching process. Overall, we developed a comprehensive, robust manualized intervention manual that can be used to provide consistency in a coaching engagement for adults with ADHD and could be employed in future research.

Because it was based on a participatory, collaborative research process, and a qualitative phenomenological framework, with focus group members who had extensive experience in ADHD coaching—a range of 5-26 years of coaching, and an average of nearly 12 years of coaching adults with ADHD—the resultant manualized intervention is well-grounded in ADHD coaching best practice. For this reason, while it is yet to be pilot-tested, it is expected to be feasible to use in a research study or otherwise.

The manual as a whole, titled "Attention-Deficit/Hyperactivity Disorder (ADHD) Coaching Engagement: Manualized Intervention, Adult" (ACE-MI; Ahmann et al., 2022), can be accessed at: https://springerinstitute.org/adhd-coaching-engagement-manualized-intervention-adults-12-weeks/. As published, ACE-MI (Adult) comprises six sections. The "Background and Context", was compiled by the researchers. Focus group discussions assisted in identification of some of the components of the: "Framework and Assumptions". For example, it emerged that coaching clients with ADHD was best guided by: a client-centric perspective, the use of ADHD as a key perspective for understanding clients and client interactions, and ICF coaching competencies and ethics.

As described above, the focus group discussions also led directly to detailed outlines for coaching sessions. These comprise the intervention itself and are documented in three sections of the ACE-MI manual. These sections include essential and recommended aspects of the coaching engagement for the following:

- "Introductory Consultation and Discovery Session"
- "Ongoing Sessions"
- "Closing Session"

Finally, the collection of rich and varied examples of ways to implement the essential elements of the intervention, as well as illustrations of unique and innovative non-essential approaches that serve as examples of what can be incorporated as coaches individualize the intervention, are documented in two ways in the manual. These materials are referred to in each of the above-mentioned session outlines and are also collected in the nine parts of the ACE-MI's "Appendices" section. Anecdotally, ADHD coaches who have had the opportunity to look over the ACE-MI (Adult) manual have found the format clear, easy to follow, representative of common ADHD coaching practices, and relevant to their own coaching approach.

In a systematic review of manualized psychotherapy interventions, Forbat and colleagues (2016) found that, in psychotherapy, "clinicians who have used manuals appraise them positively, and view them as facilitating flexibility, allowing for therapeutic relationship[s] and keeping therapy on track" (p. 409). Our hope is that coaches who might use the ACE-MI (Adult) manualized intervention for ADHD coaching, whether in practice or in a research study, might experience similar benefits. In this regard, one ADHD coaching trainer, reviewing ACE-MI (Adult), commented that he felt it would be a very useful addition to his training classes (A. Graham, personal communication, January 22, 2023), an encouraging sign.

Strengths and Limitations

Measures taken to increase reliability and validity of data collected included maintaining audit trails; data triangulation among notes, recording transcripts and chat, researcher recollections; and the researchers challenging each other to think about underlying assumptions and biases (Carter et al., 2014; Nowell et al., 2017). As a further check on the accuracy of the data synthesis, focus group members were invited to provide feedback on synthesized data between each focus group and on a final draft at the conclusion of the process, a validation procedure called member checking (Birt et al., 2016). Other strengths of this manual's development process include application of two sets of guidelines for development of a manualized intervention–Carroll & Nuro (2002) and TIDieR (Hoffmann et al., 2014)–and the use of the GUIDED framework for reporting its development (Duncan et al., 2020).

In developing ACE-MI (Adult), we chose to use focus groups with expert stakeholders, an approach that allowed for interactive discussions which would not have been possible with a more formal method of obtaining expert agreement (e.g., Delphi method; see, e.g., McPherson, Reese, & Wendler, 2018). However, including larger numbers of coaches in the manual development, and potentially using several separate focus groups, might have yielded some differences not identified in the current process. Additionally, the fact that all participating coaches were white women both living, and predominantly coaching clients, in the United States, may limit generalizability to, and utility among, other groups.

Conclusions

Individual ADHD coaching for children, teens and college students has shown benefit, as has group coaching for adults with ADHD (for a summary of the literature see Ahmann et al., 2018; Ahmann &

Saviet, 2021). However, studies to date on coaching for adults with ADHD have been limited to group coaching (Bloemen et al., 2007; Kubik, 2010). Research is needed to explore coaching for individual adults with ADHD, and defining the intervention is a key first step.

To this end, we described the development of a manualized intervention–ACE-MI (Adult)–for a 12-session coaching engagement for individual adults with ADHD. We hope that this manualized intervention, developed as an outcome of focus group research, offers both best practice guidance for coaching adults with ADHD and a consistent approach to a coaching engagement useful in supporting quality research in the field. As Carroll and Nuro (2002) suggest, future research using ACE-MI (Adult) will likely allow for both refinement and elaboration of the manual itself, and perhaps for exploration of modifications needed for application among varied, diverse groups.

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References

Addis, M. E. (2002). Methods for disseminating research products and increasing evidence-based practice: Promises, obstacles, and future directions. *Clinical Psychology: Science and Practice*, 9(4), 367. DOI: 10.1093/clipsy.9.4.367.

ADHD Coaches Organization (ACO). (2021a). *We are the ADHD Coaches Organization, and we are here to help*. Available at: https://www.adhdcoaches.org/.

ADHD Coaches Organization (ACO). (2021b). *ADHD coach training programs.* Available at: https://www.adhdcoaches.org/adhd-coach-training-programs .

Adler, L. A., Kessler, R. C., & Spencer, T. (2003). *Adult ADHD Self-Report Scale-v1.1 (ASRS-v1.1) symptom checklist*. World Health Organization.

Ahmann, E. & Saviet, M. (2021). ADHD coaching: Evolution of the field. *The ADHD Report*, 29(6), 1-9. DOI: 10.1521/adhd.2021.29.6.1.

Ahmann, E., Saviet, M., & Tuttle, L. (2017). Interventions for ADHD in children and teens: A focus on ADHD coaching. *Pediatric Nursing*, 43(3), 121-131.

Ahmann, E., Saviet, M., Springer Institute, & Maryland University of Integrative Health. (2022). *Attention-Deficit/Hyperactivity Disorder (ADHD) coaching engagement: Manualized intervention (adults, 12-weeks)*. Available at: https://springerinstitute.org/adhd-coaching-engagement-manualized-intervention-adults-12-weeks/.

Ahmann, E., Tuttle, L., Saviet, M., & Wright, S. D. (2018). A descriptive review of ADHD coaching research: Implications for college students. *Journal of Postsecondary Disability and Education*, 31(1), 17-39. Available at: https://files.eric.ed.gov/fulltext/EJ1182373.pdf.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Barkley, R. (2011). *The important role of executive functioning and self-regulation in ADHD*. Available at: http://www.russellbarkley.org/factsheets/ADHD_EF_and_SR.pdf .

Barkley, R. A. (Ed.). (2015). *Attention-Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment* (4th ed.). Guilford.

Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., Ory, M. … & Czajkowski, S. (2004). Enhancing treatment fidelity in health behavior change studies: Best practices and recommendations from the NIH Behavior Change Consortium. *Health Psychology*, 23(5), 443. DOI: 10.1037/0278-6133.23.5.443.

Berg, B. L. (2001). *Qualitative research methods for the social sciences*. Allyn & Bacon.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, 26(13), 1802-1811. DOI: 10.1177/1049732316654870.

Blanche, E. I., Fogelberg, D., Diaz, J., Carlson, M., & Clark, F. (2011). Manualization of occupational therapy interventions: Illustrations from the pressure ulcer prevention research program. *The American Journal of Occupational Therapy*, 65(6), 711-719. DOI: 10.5014/ajot.2011.001172.

Bloemen, I., Verbeeck, W., & Tuinier, S. (2007). The effect of group coaching in adult ADHD. *European Psychiatry*, 22(suppl. 1), S205.

Brown, T. E. (1995). *Brown Attention Deficit Disorder Scales*. Psychological Corporation.

Brown, T. E. (2022). *The Brown model of executive function impairments in ADHD*. Available at: https://www.brownadhdclinic.com/the-brown-model-of-add-adhd.

Canu, W. H., Hartung, C. H., Stevens, A. E., & Lefler, E. K. (2020). Psychometric properties of the Weiss Functional Impairment Rating Scale: Evidence for utility in research, assessment, and treatment of ADHD in emerging adults. *Journal of Attention Disorders*, 24(12), 1648–1660. DOI: 10.1177/1087054716661421.

Carroll, K. M., & Nuro, K. F. (2002). One size cannot fit all: A stage model for psychotherapy manual development. *Clinical Psychology: Science and Practice*, 9(4), 396-406. DOI: 10.1093/clipsy.9.4.396.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, 41(5), 545-547. DOI: 10.1188/14.onf.545-547.

Central Connecticut State University. (n.d.). *Helpful hints for conducting a focus group*. Available at: https://www.ccsu.edu/oira/assessment/files/FocusGroupsHints.pdf.

Chan, E., Fogler, J. M., & Hammerness, P. G. (2006). Treatment of attention-deficit/hyperactivity disorder in adolescents: A systematic review. *JAMA*, 315(18), 1997-2008. DOI: 10.1001/jama.2016.5453.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.

Duncan, E., O'Cathain, A., Rousseau, N., Croot, L., Sworn, K., Turner, K. M., Yardley, L., & Hoddinott, P. (2020). Guidance for reporting intervention development studies in health research (GUIDED): An evidence-based consensus study. *BMJ Open*, 10(4), e033516. DOI: 10.1136/bmjopen-2019-033516.

Faheem, M., Akram, W., Akram, H., Khan, M. A., Siddiqui, F. A., & Majeed, I. (2022). Gender-based differences in prevalence and effects of ADHD in adults: A systematic review. *Asian Journal of Psychiatry*, 75, 103205. DOI: 10.1016/j.ajp.2022.103205.

Fayyad, J., Sampson, N. A., Hwang, I., Adamowski, T., Aguilar-Gaxiola, S., Al-Hamzawi, A., … & Kessler, R. C. (2017). The descriptive epidemiology of DSM-IV adult ADHD in the World Health Organization world mental health surveys. *ADHD Attention Deficit and Hyperactivity Disorders*, 9(1), 47-65. DOI: 10.1007/s12402-016-0208-3.

Field, S., Parker, D. R., Sawilowsky, S., & Rolands, L. (2013). Assessing the impact of ADHD coaching services on university students' learning skills, self-regulation, and well-being. *Journal of Postsecondary Education and Disability*, 26, 67-81. Available at: https://files.eric.ed.gov/fulltext/EJ1026813.pdf.

Finlay, L. (2013). Exploring lived experience: Principles and practice of phenomenological research. *International Journal of Therapy and Rehabilitation*, 16(9), 474-481. DOI: 10.12968/ijtr.2009.16.9.43765.

Forbat, L., Black, L., & Dulgar, K. (2016). What clinicians think of manualized psychotherapy interventions: Findings from a systematic review. *Journal of Family Therapy* 37, 409-428. DOI: 10.1111/1467-6427.12036.

Garcia Ron, A., Serrano Grasa, R., Blanco Lago, R., Huete Hernani, B., & Pérez Martinez, D. A. (2016). Pilot study of the efficacy of empowering patients through coaching as a complementary therapy in Attention Deficit Hyperactivity Disorder. *Neurologia* (English Ed.), 31, 83-88. DOI: 10.1016/j.nrl.2015.06.017.

Goldstein, N. E., Kemp, K. A., Leff, S. S., & Lochman, J. E. (2012). Guidelines for adapting manualized interventions for new target populations: A step-wise approach using anger management as a model. *Clinical Psychology: Science and Practice*, 19(4), 385. DOI: 10.1111/cpsp.12011.

Hallowell, E. M. & Ratey, J. J. (1994). *Driven to Distraction*. Pantheon Books.

Hartung, C. M., Shelton, C. R., Abu-Raman, T. M., & Canu, W. H. (2022). Proposed terminology to distinguish adult-onset from late-identified ADHD: A preliminary effort in a large survey of adults aged 18 to 80. *The ADHD Report*, 30(6), 1-10. DOI: 10.1521/adhd.2022.30.6.1.

Hinshaw, S. P., & Arnold, L. E. (2015). Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome: Evidence, paradox, and challenge. *Wires Cognitive Science*, 6(1):39-52. DOI: 10.1002/wcs.1324.

Hirvikoski, T., Waaler, E., Alfredsson, J., Pihlgren, C., Holmström, A., Johnson, A., ... & Nordström, A. L. (2011). Reduced ADHD symptoms in adults with ADHD after structured skills training group: results from a randomized controlled trial. *Behaviour Research and Therapy*, 49(3), 175-185. DOI: 10.1016/j.brat.2011.01.001.

Hoffmann, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D. … & Michie, S. (2014). Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, 348. DOI: 10.1136/bmj.g1687.

International Coaching Federation (ICF). (2020). *ICF code of ethics.* Available at: https://coachingfederation.org/ethics/code-of-ethics.

International Coaching Federation (ICF). (2021). *What is coaching?* Available at: https://coachingfederation.org/about.

International Coaching Federation (ICF). (2023). *ICF core competencies.* Available at: https://coachingfederation.org/credentials-and-standards/core-competencies.

Karas, S., & Plankis, L. (2016). Consideration of treatment fidelity to improve manual therapy research. *Journal of Manual & Manipulative Therapy*, 24(4), 233-237. DOI: 10.1080/10669817.2015.1135555.

Kessler, R. C., Adler, L., Barkley, R., Biederman, J., Conners, C. K., Demler, O. … & Zaslavsky, A. M. (2006). The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry*, 163(4), 716-723. DOI: 10.1176/ajp.2006.163.4.716.

Kooij, J. J. S., Bijlenga, D., Salerno, L., Jaeschke, R., Bitter, I., Balazs, J., ... & Asherson, P. (2019). Updated European Consensus Statement on diagnosis and treatment of adult ADHD. *European Psychiatry*, 56(1), 14-34. DOI: 10.1016/j.eurpsy.2018.11.001.

Kooij, S. J., Bejerot, S., Blackwell, A., Caci, H., Casas-Brugué, M., Carpentier, P. J., ... & Asherson, P. (2010). European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD. *BMC Psychiatry*, 10, 1-24. DOI: 10.1186/1471-244X-10-67.

Kubik, J. A. (2010). Efficacy of ADHD coaching for adults with ADHD. *Journal of Attention Disorders*, 13, 442-453. DOI: 10.1177/1087054708329960.

London, A. S. & Landes, S. D. (2021). Cohort change in the prevalence of ADHD among US adults: Evidence of a gender-specific historical period effect. *Journal of Attention Disorders*, 25(6), 771-782. DOI: 10.1177/1087054719855689.

Maitland, T., Richman, E., Parker, D., & Rademacher, K. (2010, July). *The impact of coaching on academic success: A focus on university students with learning disabilities and Attention Deficit/Hyperactivity Disorder*. Paper presented at the conference of AHEAD: Association on Higher Education and Disability, Denver, CO.

Martínez-Núñez, B., & Quintero, J. (2019). Update the Multimodal Treatment of ADHD (MTA): Twenty years of lessons. *Actas Espanolas de Psiquiatria*, 47(1), 16-22. Available at: https://www.actaspsiquiatria.es/repositorio//21/117/ENG/21-117-ENG-16-22-406885.pdf.

McPherson, S., Reese, C., & Wendler, M. C. (2018). Methodology update: Delphi studies. *Nursing Research*, 67(5), 404-410. DOI: 10.1136/ebnurs-2020-103303.

Moncher, F. J. & Prinz, R. J. (1991). Treatment fidelity in outcome studies. *Clinical Psychology Review*, 11(3), 247-266. DOI: 10.1016/0272-7358(91)90103-2 .

Moore, M., Jackson, E. J., & Moran, B. T. (2016). *Coaching psychology manual*. Wolters Kluwer.

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, 22(1), 129-152. DOI: 10.1146/annurev.soc.22.1.129.

MTA Cooperative Group. (1999). Moderators and mediators of treatment response for children with attention-deficit/hyperactivity disorder: The Multimodal Treatment Study of children with attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry*, 56, 1088-96. DOI: 10.1001/archpsyc.56.12.1088.

Murphy, K. R. (2015). Psychological counseling of adults with ADHD. In R. A. Barkley (Ed.), *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (4th ed.) (pp. 741- 756). Guilford Press.

Murphy, S. L. & Gutman, S. A. (2012). Intervention fidelity: A necessary aspect of intervention effectiveness studies. *The American Journal of Occupational Therapy*, 66(4), 387-388. DOI: 10.5014/ajot.2010.005405.

National Institute of Mental Health (NIMH). (n.d.). *Attention-Deficit/Hyperactivity Disorder in adults: What you need to know.* Available at: https://www.nimh.nih.gov/sites/default/files/documents/health/publications/adhd-in-adults.pdf.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1). DOI: 10.1177/1609406917733847.

Parker, D. R. & Boutelle, K. (2009). Executive function coaching for college students with learning disabilities and ADHD: A new approach for fostering self-determination. *Learning Disabilities Research & Practice*, 24, 204-215. DOI: 10.1111/j.1540-5826.2009.00294.x.

Parker, D. R., Hoffman, S. F., Sawilowsky, S., & Rolands, L. (2011). An examination of the effects of ADHD coaching on university students' executive functioning. *Journal of Postsecondary Education and Disability*, 24(2), 115–132. Available at: https://files.eric.ed.gov/fulltext/EJ943698.pdf.

Pehlivanidis, A. (2012). Awareness of adult attention-deficit/hyperactivity disorder (ADHD) in Greece. *Psychiatriki*, 23(suppl. 1), 60-65.

Pfiffner, L. J., & DuPaul, G. J. (2015). Treatment of ADHD in school settings. In R. A. Barkley (Ed.), *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (4th ed.) (pp. 596-629). Guilford Press.

Polanczyk, G. V., Willcutt, E. G., Salum, G. A., Kieling, C., & Rohde, L. A. (2014). ADHD prevalence estimates across three decades: An updated systematic review and meta-regression analysis. *International Journal of Epidemiology*, 43(2), 434-442. DOI: 10.1093/ije/dyt261.

Prevatt, F. & Levrini, A. (2015). *ADHD coaching: A guide for mental health professionals*. American Psychological Association.

Prevatt, F. & Yelland, S. (2015). An empirical evaluation of ADHD coaching in college students. *Journal of Attention Disorders*, 19, 666-677. DOI: 10.1177/1087054713480036.

Professional Association of ADHD Coaches (PAAC). (2023). *PAAC Definition of ADHD Coaching*. Available at: https://paaccoaches.org/.

Pyatak, E. A., Carandang, K., & Davis, S. (2015). Developing a manualized occupational therapy diabetes management intervention: Resilient, Empowered, Active Living with Diabetes. *OTJR: Occupation, Participation and Health*, 35(3), 187-194. DOI: 10.1177/1539449215584310.

Rajeh, A., Amanullah, S., Shivakumar, K., & Cole, J. (2017). Interventions in ADHD: A comparative review of stimulant medications and behavioral therapies. *Asian Journal of Psychiatry*, 25, 131-135. DOI: 10.1016/j.ajp.2016.09.005.

Ramsay, J. R. & Rostain, A. L. (2011). CBT without medications for adult ADHD: An open pilot study of five patients. *Journal of Cognitive Psychotherapy*, 25(4), 277-286. DOI: 10.1891/0889-8391.25.4.277.

Reaser, A. L. (2008). *ADHD coaching and college students*. (Unpublished doctoral dissertation). Florida State University, Tallahassee, FL.

Richman, E. L., Rademacher, K. N., & Maitland, T. L. (2014). Coaching and college success. *Journal of Postsecondary Education and Disability*, 27, 33-52. Available at: https://files.eric.ed.gov/fulltext/EJ1029647.pdf.

Sarkis, E. (2014). Addressing attention-deficit/hyperactivity disorder in the workplace. *Postgraduate Medicine*, 126(5), 25-30. DOI: 10.3810/pgm.2014.09.2797.

Schnyer, R. N., Iuliano, D., Kay, J., Shields, M., & Wayne, P. (2008). Development of protocols for randomized sham-controlled trials of complex treatment interventions: Japanese acupuncture for endometriosis-related pelvic pain. *Journal of Alternative and Complementary Medicine*, 14(5), 515–522. DOI: 10.1089/acm.2007.0826.

Schrevel, S. J. C., Dedding, C., & Bourse, J. E. (2016). Why do adults with ADHD choose strength-based coaching over public mental health care? A qualitative case study from the Netherlands. *SAGE Open*, July-September, 1-18. DOI: 10.1177/2158244016662498.

Sibley, M. H., Mitchell, J. T., & Becker, S. P. (2016). Method of adult diagnosis influences estimated persistence of childhood ADHD: A systematic review of longitudinal studies. *The Lancet Psychiatry*, 3(12), 1157-1165. DOI: 10.1016/S2215-0366(16)30190-0.

Simon, V., Czobor, P., Bálint, S., Mészáros, A., & Bitter, I. (2009). Prevalence and correlates of adult attention-deficit hyperactivity disorder: Meta-analysis. *The British Journal of Psychiatry*, 194(3), 204-211. DOI: 10.1192/bjp.bp.107.048827.

Song, P., Zha, M., Yang, Q., Zhang, Y., Li, X., & Rudan, I. (2021). The prevalence of adult attention-deficit hyperactivity disorder: A global systematic review and meta-analysis. *Journal of Global Health*, 11. DOI: 10.7189/jogh.11.04009.

Swartz, S. L., Prevatt, F., & Proctor, B. E. (2005). A coaching intervention for college students with attention deficit/hyperactivity disorder. *Psychology in the Schools*, 42, 647-656. DOI: 10.1002/pits.20101.

Weiss, M., Murray, C., Wasdell, M., Greenfield, B., Giles, L., & Hechtman, L. (2012). A randomized controlled trial of CBT therapy for adults with ADHD with and without medication. *BMC Psychiatry*, 12, 1-8. DOI: 10.1186/1471-244X-12-30.

Wender, P. H. (1995). *Attention deficit hyperactivity disorder in adults*. Oxford University Press.

Wilens, T. E., Biederman, J., Faraone, S. V., Martelon, M., Westerberg, D., & Spencer, T. J. (2009). Presenting ADHD symptoms, subtypes, and comorbid disorders in clinically referred adults with ADHD. *The Journal of Clinical Psychiatry*, 70(11): 1557–1562. DOI: 10.4088%2FJCP.08m04785pur.

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard*, 29(34), 38-43. DOI: 10.7748/ns.29.34.38.e8821.

Wright, S. D. (2014). *ADHD coaching matters*. ACO Books.

Young, Z., Moghaddam, N., & Tickle, A. (2020). The efficacy of cognitive behavioral therapy for adults with ADHD: A systematic review and meta-analysis of randomized controlled trials. *Journal of Attention Disorders*, 24(6), 875-888. DOI: 10.1177/1087054716664413.

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