Psychiatry and ADD/Life Coaching:
A Collaborative Model of Wellness
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Many adults with ADHD or related executive functioning issues use medications to treat their symptoms. Similarly, a large percentage of these individuals experience co-existing issues with anxiety, depression, or related mood disorders at some point in their lives. Consequently, it is common for these adults to seek assistance from a variety of professionals, including psychiatrists, therapists, and/or ADD coaches. Effective referrals and services are enhanced when the providers coordinate care in a manner that does not violate the patient's privacy. This article describes some "lessons being learned" from a CRG psychiatrist who diagnoses, manages medication, and offers therapy and a CRG ADD/Life coach who coaches adults with and without ADHD.

We are learning more about key issues to consider as we collaborate to provide the best care possible to adults who might benefit from our respective services. A Question/Answer format will be used to present the issues we have explored to date, from each of our perspectives. We hope this approach provides helpful insight into our efforts to coordinate the services for the betterment of the patients/clients at CRG.

From the psychiatrist's point of view (Dr. Lowinsky):

Q: *What patients in my practice would benefit from coaching?*
A: There are a number of ways to answer this question, including what are the diagnoses that patients have who benefit from coaching; how far along in treatment do patients need to be to benefit from coaching; and finally, how motivated do patients need to be to benefit from coaching. Most of the patients I have sent for coaching have a diagnosis of ADHD and other learning disabilities. I have several patients without ADHD whose mood or anxiety impact their school functioning and coaching (and accommodations) can be very useful. Often teenagers have to be farther along in treatment as they often are in power struggles with parents and need to gain clarity on their level of motivation for this work. Coaching may be contraindicated when the parents are more interested than the child. In that situation the parents may choose to be coached so they learn how to interact more effectively with their teen around homework and avoid power struggles.

A high level of motivation is key to successful coaching. It is often helpful for the psychiatrist to utilize motivational interviewing techniques to get a sense of just how interested a patient is in coaching. "You say that you are interested in ADD coaching… Why exactly is that? It will be a fair amount of work on your part on top of the homework you already have. I thought your parents wanted you to have an ADD coach…?" The psychiatrist begins to prepare the groundwork but may find that, indeed, the teen is not motivated. She may be motivated later or never motivated at all but the psychiatrist can easily keep his finger on the pulse through motivational interviewing.

Q: *What are specific contraindications to coaching?*
A: Specific contraindications include imminent dangerousness, florid psychosis,

significant dementing disorders and inability to care for self. Once patients stabilize, however, it is quite possible for someone for whom coaching would have previously been contraindicated to now be a good coaching candidate. I have referred a number of individuals with ADHD whose comorbid severe anxiety and mood disorder have stabilized and who are now ready and motivated to begin the work of coaching. There is fluidity to the psychiatrist-patient-coach relationship such that acute psychiatric decompensation may take coaching temporarily out of the picture OR make the goals of the coach-patient temporarily more modest.

What if an unstable patient wants to see a coach? The answers to that dilemma vary related to the practice situation of the coach (i.e., Is psychiatric and psychotherapeutic care immediately accessible or is the coach in solo practice?) and the experience, background and comfort level of the coach. The coach-client relationship is strength-based and growth promoting for the patient. There are patients who avoid psychiatrists and psychotherapists who are much more comfortable seeing a coach as there is less associated stigma and assumption of illness. At times, it is the coach who prepares the groundwork for psychotherapy and psychiatric evaluation, opening up the patient to new possibilities.

Q: *Who is the right coach for my patient?*
A: Coaches come from a variety of backgrounds and a variety of training experiences. There is no board certification that all licensed coaches must have. Then again there are plenty of board certified physicians and clinicians who may not be a great fit for a particular patient. But physicians, patients and families should be encouraged to ask questions about the training of their coach, his supervisory relationships with other professionals, what he does to improve his professional skills and how the coach will know if a problem is bigger than what he can handle. Does the coach belong to a supervision group in which he can improve and hone his skills, or is he/she a lone ranger? Also important is how and when the coach shares information with other professionals and with the family. A coach who is not comfortable answering these questions might not be the right coach for your patient. Gender is sometimes important to a particular patient, just as age, religion, and race may be important to others. How able is a coach to customize his approach to your patient? Are you a coach who does especially well with a particular patient type and not with others?

Q: *What's my understanding of coaching? What information did I obtain from David or other sources that helped me better understand coaching?*
A: Coaching focuses on the present (not the past). It is a strength-based approach to working with individuals to accomplish their goals in a step-wise, organized fashion, always respecting the fact that answers lie within the patient and within the coach-patient relationship, NOT within the coach. Coaching is not therapy (often deficit-based and past-oriented) and it is not strategy instruction (where advice is given). When coaching is easy, the experience for the patient is one of empowerment, hope, and increasing confidence and productivity. When coaching is more challenging, the experience is one of initial frustration, increasing awareness of habits and patterns that get in the way of moving forward that help maintain an unhappy equilibrium. It is often at this point that courageous conversations take place that straddle the therapy/coaching fence. "Would you prefer to stay put and in old habits that are familiar if not productive? Would you prefer to move on, which is new, terrifying, VERY SLOW GOING and will take a lot of work AND A LOT OF PATIENCE?" Part of

coaching is empowering patients with choices; the patient can choose NOT to move forward, which is a successful coaching outcome and must be framed as such for the patient.

David provided both written and experiential information regarding coaching. Our discussions regarding mutual patients have been the most valuable way for me to learn more about coaching.

Q: *Who's coachable and when are they ready for coaching? How is this readiness related to the patient's mental health/life situations?*
A: If a patient's psychiatric symptoms are impairing to the point of imminent danger or significant disability, he (she) is not ready for coaching. Sometimes patients are ready for coaching before they are ready for therapy or psychiatric intervention. It's often a positive and empowering experience for a patient to come into my office and in one way or another let me know that he/she would prefer to see a coach than to engage in psychiatric treatment. Why empowering? Patients often come into my office believing they have committed to the dreaded prescription! Finding out they options including not returning, returning for non-pharmacologic treatment, or being referred to a coach is often a big relief. This leaves the door open to return in the future. It is so important for me to remember that, when I meet a patient, I have the opportunity to fertilize or contaminate the field, to open up or shut down this patient's willingness to engage with mental health practitioners and coaches in the future.

So, who is coachable? Someone who can develop a trusting relationship with another; someone who is motivated to change; someone who is willing to be held accountable for his/her action and inaction. Severe mental illness-psychosis, severe depression or mania gets in the way of the above. Life situations such as living in an abusive relationship can be a very dicey situation for coach and patient as change can cause danger with the abuser, so both internal (biochemical) and external (environmental) milieu need to be carefully accounted for.

Q: *How do I describe coaching to my patients? How do they think about any differences between coaching and therapy?*
A: I would contrast coaching with psychotherapy and strategy instruction. For some who are threatened by disclosure, I would emphasize here-and-now, strength-based, collaborative both with patient and psychiatrist, empowerment with the patient deciding on what to focus. The focus is on moving forward in life and, with the patient's willingness, removing obstacles such as unhelpful patterns that the patient decides get in the way of progress.

Therapy often focuses on family of origin relationships and how these play out in the present with the therapist. These dynamics may occur with the coach and may be commented on in a here-and-now direct fashion, but will not be the focus of treatment.

Q: *What is it about coaching that seems to interest some patients? What if any fears or concerns do some patients have when they hear about coaching?*
A: I have had a number of highly successful professionals (physicians, attorneys) that are very interested in coaching as a clean (non-stigmatizing) way of moving forward in their lives. They have spent much of their professional lives being perfectionists,

taking more than their share of ownership, putting everyone else first, and feeling completely overwhelmed in their speed-of-light paced life with too little time to sleep. Their willingness to work, their smarts, those same characteristics that have made them highly successful professionally make them highly successful in a coaching relationship, too. Some teens believe that needing a coach is somehow demeaning, suggesting that they are unable to learn for themselves, that they are stupid, retarded, and they will absolutely have nothing to do with coaching. In these cases, the last thing I would recommend is coaching. If they were interested I might tell them about all the physicians, attorneys, businessman, athletes, that I send to Dr. Parker and who do so very well in their coaching work with him.

From the ADD/Life coach's perspective (Dr. Parker):

Q*: What client information is helpful to receive from the psychiatrist when a referral is made?*
A: I am primarily interested in learning more about why the client is interested in coaching at this time. What goals does he/she want to work on? Often the desire to work on goals with a coach seems to be an outgrowth of effective therapy and/or benefits of medication with the psychiatrist. In other words, the client is now *ready* to take action on goals.

Q: *When if at all would I caution the psychiatrist from making a referral or at least want to 'staff' the client before a referral is made?*
A: Again, "readiness" seems to be key here. Sometimes clients are still struggling to take action, follow through, and be accountable to others even when they *want* to be able to do so. I'm also learning from Dr. Lowinsky that coaching can sound like a less stigmatizing service than therapy for some clients. They are ready to work on some life issue but are not sure if that entails talking about it, taking action on it, or both. If the client is primarily needing to talk through difficult issues in their lives but not necessarily ready to take action on their goals, I tend to think that therapy (especially a cognitive-behavioral approach) may be a better way to meet their needs for now.

Q: *With the client's permission, what kind of information is helpful to share with the psychiatrist as the coaching work unfolds?*
A: One of the great things about working in a setting such as CRG is the ability to provide coordinated care. So, when I am coaching clients who are also followed by psychiatrists such as Dr. Lowinsky, I listen carefully to any questions they have about their medications. If these come up, I coach them on how they want to pursue those questions and ask if I can help share such information with their psychiatrist. If their ADHD symptoms seem to remain fairly intense and create roadblocks to reaching their goals, I share these observations with the patient as well as with Dr. Lowinsky. Sometimes this leads to discussions about further testing/formal assessment. The most frequent issue that gets discussed, though, is the client's growing ability to notice and manage their "gremlins." Gremlins is a term developed by Rick Carson to describe self-defeating or self-critical thoughts that impede a person's ability to problem solve effectively. Clients often bring this up with Dr. Lowinsky as we work on it in coaching. In a non-therapeutic manner, coaching often helps clients strengthen their use of more positive self-talk to manage stress, affirm themselves, and problem solve when gremlins try to shut them down. Clients develop a working vocabulary

about the nature of these negative thought patterns and the language they can use to work past them. Sessions with their psychiatrist seem like a natural setting to share what they are learning about gremlins and self-talk skills.

Q: *How is the coaching different from therapy? How if at all does it overlap?*
A: This can vary with each client, since the coaching alliance is unique to each person who is coached. That said, coaching and therapy can have some overlapping qualities. Both approaches can address a person's barriers to progress. Both can help a client reframe how they think about things. Both offer support and are highly individualized to *that* person. Therapy offers insight; coaching helps people increase their self-awareness.

Coaching and therapy differ in a number of ways, too. Dr. Peter Jaksa (a clinical psychologist) and Nancy Ratey (an ADHD coach) discuss this in their wonderful article, "Therapy and ADD Coaching: Similarities, Differences, and Collaboration". Therapy tends to look to the past to better understand how a patient's life circumstance affect their emotional functioning in the present. Coaching tends to focus on future goals and how the client can take action, starting today, to reach those goals. In general, therapy explores a person's feelings/emotional state; coaching addresses a person's ability to act on goals and/or to live a more balanced life. Therapy is insight-oriented; coaching is action-oriented. Therapy helps a person attain a deep understanding of the emotional barriers that impair their happiness or healthy functioning. Coaching, on the other hand, works with people who are able to take action toward their goals but want to better understand what they can do to be more successful.

Many clients benefit from BOTH coaching and therapy. For example, Dr. Lowinsky referred a middle-aged woman to me for coaching. He continued to see her for therapy and medications management. This brilliant, highly energetic client wanted to develop a better way to get to places on time, meet her responsibilities as a wife and mother who ran the family household, and yet still be able to savor the zest of being spontaneous in any given moment of her day. My understanding is that her difficulties with these aspects of daily living also triggered older insecurities that were rooted in harsh criticism she received as a girl for being disorganized. She addressed those negative emotions and family-of-origin issues with Dr. Lowinsky. In coaching, she developed an approach to self-talk with her inner "scheduling secretary," whom she named "Suzie Q." This entailed learning how to pause in the midst of impromptu adventures to think about her mental list of other demands on her time that day. In a lighthearted way, she learned how to check in with Suzie Q to ask if there was anything else that required her time/attention just then? This approach helped the client develop a greater ability to use her executive functioning skills to enjoy the moment without losing track of the rest of her day. She even looked up "Suzie Q" on the Internet and learned it was the name of popular dance in the 1930's, which she taught herself. The dance made her laugh and relax during particularly busy moments in her day while also reminding her in a very tangible way of the need to recall other obligations requiring her attention. "Suzie Q" also helped the client better understand, in therapy, how early difficulties with self-regulation created organizational challenges that led to frequent criticism and internalized emotional wounds.

Q: *How do I explain coaching services to new clients? How have I tried to describe them to other providers at CRG?*
A: Using The Coaches Training Institute framework, I believe that coaching fundamentally helps clients with two related goals: forward their action (i.e., help them clarify and achieve their goals) and deepen their learning (i.e., promote more accurate self-awareness about how they can live a successful, balanced life). Sometimes Dr. Lowinsky will walk a patient over to my office to introduce us. This gives me a brief chance to explain this two-pronged nature of coaching. Whenever I talk with potential clients, I also note that coaching isn't therapy. I try to briefly highlight the differences while pointing out that many coaching clients also benefit from therapy. Finally, I emphasize the importance of the coaching alliance. Coaching is designed to meet that client's goals. We customize how and when the coaching relationship can focus exclusively on the client's agenda (i.e., their preferences and goals). This overview often elicits a smile from the listener and a sense that I'm describing a collaborative approach they have not yet experienced. Coaches refer to this approach as "co-active," meaning the client is empowered to be a highly engaged co-partner in specifying many aspects of the coaching services. *How often do you want to meet? Shall it be in person, by phone, via text, or some other combination? What is the best way to give you feedback if I sense you are stuck or struggling to follow through on your plans?* I also try to be clear that coaching isn't for everyone. I talk about readiness to take action and the need to be accountable as key examples. But I always encourage clients to consider at least one coaching session so they can experience it before deciding if it is for them at that time.

I also share handouts with potential clients and my colleagues to help clarify "goodness of fit" decisions. This includes a flyer that briefly describes coaching and whom it might benefit. The handout is very similar to information CRG has posted on its website. I have created an intake form that clients are asked to fill out and bring to their first session. This includes a Wheel of Life, which is used by many coaches to capture the client's current sense of how fulfilled they are in various aspects of their lives (i.e., finances, relationships, health). Finally, as I meet with new clients, I offer to share a reading list about coaching and related topics if this would be of interest to them.

Q: *What fears/worries/concerns do clients express about coaching and how do I try to help them address these concerns?*
A: I'm often amazed and energized by how quickly and well the coaching model seems to "fit" new clients. If they are motivated to make progress on goals, even the first coaching session can be extremely productive and practical. The client leaves with a clearer understanding of the next steps he or she can take and a plan to keep me updated about their progress before we meet again in person. For other clients, it may take a few sessions for coaching to take hold and help them achieve tangible outcomes. Along the way, I continue to design the alliance with them to customize the services to their needs and preferences. We also talk openly during this stage about whether coaching is an effective service for them at this point in their lives. I have observed that some clients encounter barriers to benefitting from coaching due to the following issues.

First, some clients are primarily interested in me telling them what to do. This makes sense, as many helping professions such as psychiatry and psychology utilize an "expert" model where the professional has and shares most of the answers. In coaching, the best solutions or plans typically come from the client as I help them clarify their goals and consider realistic plans they are motivated to try. This co-active approach isn't for everyone, particularly individuals who fundamentally want someone to tell him or her how to solve problems or achieve goals. Other clients may be uncomfortable with accountability, at least initially. "Accountability" refers to the client's willingness to be open and honest with me about their progress or lack thereof. This can entail sending an email or text to me with a quick update or reporting on their efforts when we next meet in person. I often find that, if a person is uncomfortable with accountability, it is linked in part to fears of being judged. I try to clarify and demonstrate that I don't judge clients. My training in ADHD helps me appreciate just how hard it can be to take action at times. I know that people with executive functioning issues can also simply forget a plan they were motivated to follow through on when they created it. So we use lack of follow through as opportunities to better understand what can get in the way of a client's progress without criticizing those barriers. Finally, some clients continue to struggle with anxiety, depression, or other behavioral health issues that limit their ability to take action on goals. Even if they want to make changes in their lives through coaching, it may be incredibly difficult for them to do so until Dr. Lowinsky or other providers can help them manage these issues with medication, therapy or both. When this happens, I try to help the client understand why coaching may not be practical right now but could be at a later point. This triggers the need to help the client find a qualified mental health professional and/or to communicate this information to their existing mental health provider.