Understanding AD/HD: Symptoms, Diagnosis, Management, & Myths

by Sam Goldstein, Ph.D.

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Articles

Resources & References

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Expert Answers

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What Is the Relationship Between AD/HD & Self-Control?

Parents and teachers report that although children with AD/HD are not supposed to be able to pay attention, there are many activities or situations during which their attention span appears focused, if not even more focused than unaffected children. If AD/HD is a problem of paying attention, how is this possible? In this article, Sam Goldstein, Ph.D., explains this paradox.

Problems sustaining attention are not the cause, but one consequence of AD/HD. If you provide a child with AD/HD with a roll of coins and bring her to an interesting arcade, that child "pays attention" quite well. In fact, in some cases, kids with AD/HD may sustain activities of interest, such as computer games, longer than unaffected children do.

> "Children with a diagnosis of AD/HD possess the self-regulation or self-control of children approximately two-thirds of their chronological age."

What is it about the condition of AD/HD that leads to this phenomenon? **The fact is kids with AD/HD have trouble paying attention in only some situations.** These are situations in which they must bring online increased self-control and effort in order to remain attentive. Such situations are repetitive, effortful, uninteresting, and usually not of the child's choosing. When these situations do not provide immediate, frequent, predictable, and meaningful payoffs or rewards for completion, children with AD/HD struggle even more. Keep in mind that all of us struggle to sustain attention and effort in these types of situations.

What is it unaffected kids do to function in these situations that those with AD/HD appear unable or incapable of doing? The answer: self-regulate. Self-regulation or self-control must be brought online in these types of circumstances.

Research studies find that when tasks are interesting and pay-offs valuable, children with AD/HD attend reasonably well. **As tasks become more repetitive, less interesting, and offer only delayed reinforcement, children with AD/HD lose focus and sustained attention faster than others.** Thus, it's not that children with AD/HD have something unaffected children don't have. It's that unaffected children mature quicker in a skill that kids with AD/HD struggle to develop — self-control. In fact, in research studies, children with a diagnosis of AD/HD possess the self-regulation or self-control of children approximately two-thirds of their chronological age. It's not that their self-control isn't developing, it's developing at a much slower pace.

Self-control allows human beings to think, plan, and organize; to open a window between experience and response; to not be locked into a first response when faced with problems; to separate thought from feeling; to carefully consider alternatives; and to sustain effort and focus, even in the face of frustration or boredom. Although the clinical term for the condition still contains the words "attention" and "hyperactivity," **it is increasingly recognized by researchers and professionals that these are consequences of delayed or faulty self-control**. Even parents of children with AD/HD are quick to comment that there are many situations or activities during which their children appear to pay attention quite well, even if they respond thoughtlessly or impulsively while engaged in those activities.

What Is the Relationship Between AD/HD & Self-Control?

As scientific research emerges, defining problems with the development of self-control as the core deficit in children with AD/HD, a better understanding of treatment is also developing. Medications used to treat AD/HD do not necessarily improve attention. They increase self-control leading to sustained effort, focus, attention, impulse control, and enhanced capacity to manage physical activity. Stimulants, in fact, do not reduce hyperactivity but stimulate a center in the brain that human beings use to govern and regulate themselves. It is for this reason that stimulants, such as caffeine, are popular in our culture because even unaffected individuals many derive some small benefits in regards to enhanced self-control.

We now recognize, however, that **while stimulant medication may reduce immediate symptoms of AD/HD, the medication alone does not appear to contribute to positive, long-term, adult outcomes for these children**. Programs are being developed to help kids during their formative years experience increased opportunities to learn and develop the self-control so essential and necessary to become a productive member of society. Presently, the programs I like best have been developed by Dr. Myrna Shure. They're referenced in the Resources section of this guide.

AD/HD by Other Names and Acronyms

While Attention-Deficit/Hyperactivity Disorder (AD/HD) is the official term and acronym used by today's mental health care professionals, it is sometimes referred to by other names and abbreviations. For example, it is sometimes called:

ADHD (without the "slash" in the middle)

Attention Deficit Disorder (ADD)

Attention Disorder

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What's the Best Way to Diagnose AD/HD?

We have heard that the evaluation for AD/HD during childhood can be completed in as short a time as one hour. Yet some professionals take hours administering a variety of tests before a diagnosis is made. How can a parent be a wise consumer when seeking evaluation if they suspect their child may struggle with AD/HD? In this article, Sam Goldstein, Ph.D., answers this critical question.

First, it is important for parents to understand that when kids struggle emotionally, behaviorally, or developmentally it is likely they may experience difficulty in a number of important life activities. The process of assessment is not just to count symptoms and proclaim diagnoses but to understand a child's strengths, as well as weaknesses, in ways that assist in providing support and help.

To be wise consumers, parents must first understand the important role normally maturing self-control plays in child development. Self-control is critically important to learn, behave, manage emotions, develop friendships, and function effectively in community activities. Thus, it's not surprising that the co-occurrence of learning, behavioral, and emotional problems is the rule rather than the exception for children receiving diagnoses of AD/HD.

> "Keep in mind that inattention, off task behavior, and non-compliance are the most common complaints parents make about children."

The diagnostic process must carefully explore many of these co-occurring problems, not only to provide appropriate diagnoses and assistance but also to identify early signs or risk factors that may speak to an emerging problem. This process allows parents, educators, and professionals to provide help and assistance before children fail.

For example, preschoolers with delayed development of self-control are often disinterested in sedentary, pre-academic activities. Their lack of practice leads to limited proficiency. This often makes them appear as if they may have a learning disability. Yet some children with AD/HD also demonstrate weaknesses in key skills necessary for early academic achievement. **A thorough assessment allows a professional to not only examine the issue of AD/HD but also the possibility of weaknesses in skills necessary for early academic learning.** Further, it is well recognized that among children with early language and learning problems, parent and teacher reports of hyperactive, impulsive, and inattentive behavior are often elevated, not necessarily the result of a biological risk but of the child's day in and day out frustration. Only a thorough assessment can tease out and provide an understanding of these risks and their relationships.

In the clinical diagnostic process there are eighteen symptoms of AD/HD. **These symptoms can be assessed through direct observation and history taking but can also very efficiently be assessed by asking parents and teachers to complete well-researched, normative questionnaires.** In fact, this quickly allows a professional to obtain parent and teacher input specifically concerning the presentation and severity of AD/HD symptoms. However, parents should be cautioned that when this type of questionnaire is the only means of assessment, the result might be an over-identification of kids with AD/HD.

What's the Best Way to Diagnose AD/HD?

Timesaving questionnaires and brief histories provide a very efficient means of identifying the 20% of children in the general population who may struggle. To truly understand the reasons for these struggles, a good evaluator must take a much more detailed and careful history, as well as explore the possibility that symptoms could be the result of other conditions. Keep in mind that inattention, off task behavior, and non-compliance are the most common complaints parents make about children. In particular, inattentiveness is a characteristic description of children with depression, anxiety, oppositional behavior and even learning disability. For many of these children, their inattentiveness is not the result of a biologically based problem with developing self-control.

At the other extreme, it is not necessary to administer a ten hour neuropsychological battery to a child referred for symptoms of AD/HD when a brief history and general questionnaires reveal no indications of delayed academic achievement, severe emotional problems, or family adversity. **When parents suspect their child may experience problems as a result of AD/HD, a good place to begin is by obtaining a book or video about the subject and becoming educated about common signs, symptoms, and behaviors, as well as co-occurring problems.** If parents are then concerned their child may experience symptoms of AD/HD to an impairing degree, I suggest they speak with their pediatrician or family practitioner. Most physicians working with children today also work closely with child psychologists and can refer the child for an initial consultation. I also suggest parents request a consultation with their child's school psychologist. **Although school personnel usually are not in the position to make a diagnosis of AD/HD, the input they can provide to the physician and community psychologist is invaluable in the diagnostic process**.

Finally, keep in mind that when children leave school they are not asked their weakest subject and most annoying behavior and then assigned that job for life. In fact, it is just the opposite. We accomplish our goals in life through our strengths and assets. **For me, an evaluation considering AD/HD in a child must also place equal focus on defining and understanding that child's strengths and abilities.**

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What Can Lead a Child with AD/HD to a Positve Future?

Despite optimism by professionals and researchers years ago that treating AD/HD in childhood would lead to improved outcome in adulthood, current research has not supported this perception. In fact, relieving the symptoms of AD/HD may not necessarily contribute to increasing the likelihood of positive outcome in the adult years. Why not? What should parents and professionals be doing to ensure positive future outcomes? In this article, Sam Goldstein, Ph.D., answers these questions.

We all accomplish our goals and successes in life through our strengths and abilities. Happy, successful adults frequently comment that their success lay, in part, to finding something in life they were good at, having the opportunity to develop the skill or ability, and being appreciated for it. This speaks to an important issue relative to your question. Is symptom relief for AD/HD equivalent to positively changing long-term outcome? Unfortunately, as far as we are currently aware, the answer is no.

"Is symptom relief for AD/HD equivalent to positively changing long-term outcome? Unfortunately, as far as we are currently aware, the answer is no."

Symptom Relief Offers Some Benefit

First, let's focus on symptom relief. Longitudinal studies, including the recent multi-site study of over 300 kids with AD/HD funded by the National Institute of Mental Health, have unequivocally demonstrated the impairment caused by symptoms of AD/HD is dramatically reduced through a combination of education about the condition, medication, parent training in behavior management, and support from the classroom teacher. Although initial data analysis of this research demonstrated medication alone to be the most powerful intervention, **recent re-analysis of data leaves no doubt that the combination of interventions is superior to medication only.**

This finding has been further reinforced in a study of adolescents with AD/HD published in the May 2001 issue of *Experimental and Clinical Psychopharmacology* (Volume 9, Number 2). **Medication in combination with behavior modification intervention improved students' performance on a range of academic measures**, including note taking, daily assignments, and quiz scores. Consistently and conscientiously applied parenting strategies involving behavior management, as well as educational support in the classroom, are very effective in reducing the impairing problems caused by the symptoms of AD/HD.

Specific medications, particularly those that affect certain neurotransmitters in the brain, are also very effective in increasing self-control and thereby reducing symptoms and impairment. In particular, stimulant and antidepressant medications that affect the neurotransmitters, dopamine and norepinephrine, appear quite beneficial for AD/HD. In contrast, the currently popular antidepressant medications that impact serotonin, such as Prozac® and Zoloft®, have not been found to be beneficial for AD/HD.

Unfortunately, as we follow children with AD/HD growing up, those who responded best to our symptom-focused interventions were not necessarily those who turned out to be most functional as adults. Thus, although we once believed that relieving the immediate symptoms of AD/HD led to

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better life outcome, treatment alone doesn't predict outcome. From a common sense perspective, if every day of a child's life is better, certainly the sum total of his life should be better. Yet, we have had difficulty demonstrating this fact. What we have demonstrated, however, **is the factors that contribute to good life outcome for all kids are particularly important for children with disabling conditions, such as AD/HD.**

Resilient Mindset a Crucial Factor

Current treatment for AD/HD is now dual focused. First, we focus on research proven interventions involving medication, education, parent training, and classroom intervention to reduce the symptoms of and impairment caused by AD/HD. We have discovered that by making tasks interesting and payoffs valuable, children with AD/HD function dramatically better.

Our treatment for AD/HD, however, has now taken on a second, equally important component, providing children with AD/HD opportunities to develop a resilient mindset. Kids with such a mindset are empathic. They communicate effectively. They learn to problem solve, develop a social conscience, and, most importantly, are self-disciplined.

Parents engaged in the process of raising resilient youngsters possess an understanding that is sometimes explicit, at other times implicit or intuitive, of what they can to do nurture this mindset in their children. To do this requires parents to appreciate the components of resilience so that their interactions with their children are guided by an important set of principles, ideas, and actions. Although each child's road to adulthood is shaped by a variety of factors, these principles are applicable for all roads and can direct all parents in raising resilient children.

Just as some kids require more support, effort, and instruction to learn to ride a bicycle or swim, similarly it is critical for us to provide support for children with AD/HD to assist them in developing self-control. Day in and day out modeling of the behaviors necessary to become self-disciplined can assist kids with AD/HD to develop the internal skills necessary to function more effectively in future life.

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What Are the Criteria for Diagnosing AD/HD?

One of the most common complaints teachers have about children and teenagers in classroom settings has to do with restless, impulsive, and inattentive behavior. Do all of these kids have AD/HD? In this article, Sam Goldstein, Ph.D., addresses this question.

No, they do not. In fact, the most common complaints of parents and teachers, particularly about young children, relate to restless, impulsive, and inattentive behavior. **Just as not every sneeze is indicative of a cold, so too not every restless, impulsive, and inattentive behavior is indicative of AD/HD.** When these problems are chronic, pervasive, occur across multiple situations, are not easily modified by behavior management or environmental manipulation, and, most importantly, cause significant day-in-and-day-out impairment, they may be indicative of AD/HD.

> "The more specific we can be in identifying the symptoms, behaviors, and achievement problems kids with AD/HD experience in the classroom, the better prepared teachers will be ..."

Ten years ago, the diagnostic process used for AD/HD did not require significant impairment for a diagnosis to be made. The current diagnostic protocol developed by the American Psychiatric Association requires symptoms be present in two or more major life domains and cause clinically impairing problems as compared to the general population. It is exactly for this reason that a thorough assessment beyond just a symptom count is essential when AD/HD is suspected.

In fact, when simple symptom counts are used as an initial screening for AD/HD, researchers have found that nearly one out of five children may meet symptom count in large, general populations. However, when more careful assessment is completed with these children focusing on the chronic nature of the problems, symptom severity, and impairment in general life, the numbers of those that meet the diagnostic criteria for AD/HD reduces significantly. In carefully controlled studies, the incidence of AD/HD is well under 10 percent, with a 3 to 5 percent figure reasonably representing children experiencing impairing symptoms sufficient to warrant a full syndrome diagnosis.

In reality, AD/HD is a very common condition, affecting at least one out of twenty kids to a significantly impairing degree. However, **recognizing the commonality of the condition must be accompanied by a responsibility to avoid over-identification or diagnosis**. It is rare that a child demonstrating hyperactive, impulsive, and inattentive problems is not thought to experience AD/HD. The problem then is false positives (over-identifying kids as having AD/HD) rather than false negatives (under-identifying kids with AD/HD).

The more specific we can be in identifying the symptoms, behaviors, and achievement problems kids with AD/HD experience in the classroom, the better prepared teachers will be to identify children at-risk and make appropriate referrals for assessment. Before a child at-risk for a diagnosis of AD/HD enters an organized school setting, his temperament exerts a significant influence on life experience and interactions with kids and adults. **These children enter school with a number of misperceptions concerning themselves and their environment.** In school settings, they are often victims of their

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temperament, making it difficult for them to persist with repetitive, uninteresting activities, and victims of their learning history that often reinforces them for beginning but not completing tasks. Teachers tend to focus on misbehavior rather than on its termination. This often further disrupts the classroom by having a disinhibitory effect on other children.

In school settings, children with AD/HD demonstrate a normal range of intellectual ability. Thus 2 percent of the population of children receiving a diagnosis of AD/HD suffer from sub-borderline intellectual ability with 2 percent demonstrating gifted intellect. The more intelligent child with AD/HD often manages to survive during the elementary school years and may not be referred for problems until academic and organizational demands increase dramatically in junior high school. At that point, even bright children with AD/HD begin to experience problems that interfere with school performance.

Children with AD/HD often under perform in academic subjects requiring practice for proficiency. Thus, absent any specific type of learning disability, they often struggle with the non-phonetic aspects of spelling, attention to detail in mathematics, and the execution (punctuation, spelling, etc.) of written language. The majority of children with AD/HD do not suffer from a learning disability. Only approximately 20 to 30 percent may experience a specific skill weakness, in addition to AD/HD, that causes them to fall behind academically.

Regardless of family, socioeconomic status, age, and gender, the limited self-control of children with AD/HD exerts a strong negative effect on their achievement, attitude toward school, and general behavior in school and social relations. **Children with AD/HD are rarely chosen by peers as best friends, partners in activities, or seat mates.** In the early elementary school years, they may be oblivious to their struggles, but by middle school years they tend to develop a rather helpless approach to school. In classroom settings, they may exhibit more negative verbalization and physical activity than their classmates.

It is essential that parents of kids with attention problems or AD/HD and school professionals work in a collaborative manner to develop a comprehensive management plan for both home and school. Resources identified below are excellent tools to assist parents, teachers, and kids in developing such an action plan.

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AD/HD and Common Coexisting Conditions

If AD/HD represents a delay in the development of self-control, how does this fact explain the dramatic prevalence of other learning, emotional, and behavioral problems children with AD/HD appear to experience? Will the treatment of AD/HD reduce the occurrence of these problems? In this article, Sam Goldstein, Ph.D., answers those complex questions.

Let's consider four common problems that often present in children with AD/HD: anxiety, depression, oppositional behavior, and learning disability. Consider the role self-control may play in each of these conditions. I cannot think of a manner in which delayed development of self-control would be a buffer or protective factor in reducing the risk of any of these conditions.

> "Kids with AD/HD tend to miss important cues in their environment. This leads them to be 'repeat offenders.'"

In fact, just the opposite appears to be the case. When a child has to deal with stress causing worry, fear, or helplessness, a key component in the child's outcome is her ability to process and think about emotions, consider alternatives, and take some action, whether it be thinking or acting differently, to cope with oncoming stress.

Kids with AD/HD tend to miss important cues in their environment. This leads them to be "repeat offenders." They know what to do but often don't do it because they miss the cues to act. They have trouble developing habits. **Possessing a habit is insufficient if you don't cue yourself when it's time to put the habit into play.** A street corner, for example, is a cue. It reminds you to look both ways. If you forget to remember the cue, even though you understand traffic is dangerous, you may find yourself in the middle of the street as you thoughtlessly chased after your ball.

Thus, **many children with AD/HD over-estimate how they are doing in life.** They seem carefree and apparently unbothered by their struggles. For the most part, this is because they are unaware of exactly how poorly they may be doing. This awareness often hits them like a freight train when they finally realize they're about to fail a grade or lose out on participating in an enjoyable activity.

The primary means by which human beings cope with problems of depression and anxiety relates powerfully to self-control, self-reflection, and thinking differently. When most children engage in problematic behavior, we usually ask them what they were thinking. However, for children with AD/HD the better question is, "What weren't you thinking?" **It is the absence of thinking that often leads to problems.**

Consider **oppositional behavior**, for children with AD/HD, as Rick Lavoie has pointed out, it's "On the Mind — Out the Mouth." **Many children with AD/HD are oppositional simply because it's difficult for them to stop, think through what's being requested, and consider alternative responses.** Their oppositionality occurs either when they're doing something they like and perceive that they'll like what you want them to do less (e.g., playing when called to dinner) or are attempting to access something they view as desirous (e.g., wanting to play Nintendo instead of doing homework). It's rare a child with AD/HD is oppositional in other types of situations. There is no reported case of a child with AD/HD

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who's in the midst of cleaning her room and refuses to stop when parents say it's time to leave for the amusement park.

Finally, consider that if learning to read, write, spell, or complete mathematics is harder to accomplish for a particular child, that child is likely to become frustrated. If, in fact, your self-control is limited, you will frustrate even quicker. Thus, if you struggle with delayed development of self-control and also struggle to develop phonemic awareness, the activities required to master reading — more time on task and more repetitions of reading activities — are exactly the activities you're least likely to choose to engage in.

Thus, it's not surprising that, among a group of kids with AD/HD, the rate of learning disability is 20 to 30 percent, with as high as 80 percent falling behind by high school. **The rate of kids with anxiety may be 20 to 30 percent; depression, as high as 25 percent; and oppositional behavior, 50 to 70 percent.**

The second part of this question addressed whether treatment of AD/HD can reduce the occurrence of these problems. Given the view that AD/HD is a catalyst, the absence of the catalyst decreases the chances of a reaction. Thus, although there are no guarantees a child at risk to develop depression, anxiety, learning disability, or oppositional behavior will not develop these problems if their symptoms of AD/HD are treated, there is a reduced probability these problems will develop. Further, should they develop, the ongoing treatment of AD/HD will likely reduce the severity of these problems.

Expert Answers

Understanding AD/HD: Symptoms, Diagnosis, Management, & Myths

What Are Some Myths about People with AD/HD?

It's romantic and intriguing to believe that great hunters, explorers, inventors, and politicians may have experienced AD/HD, and the qualities of AD/HD were in part responsible for fueling their success. Is this an accurate perception? Should we view AD/HD as an asset rather than a liability during the childhood years? In this article, Sam Goldstein, Ph.D., addresses these questions.

The fanciful tales of Rudyard Kipling, including how the zebra got his stripes or the elephant her trunk, are entertaining. Yet few would interpret these "Just So Stories" as truth or, for that matter, even testable theory. There is, however, a popular view that all human qualities, including anatomical features, behaviors, quirks, and idiosyncrasies, arose and developed through a process of natural selection. Supposedly these factors provided the organisms that possessed or exhibited them with an evolutionary advantage.

"… the diagnosis of AD/HD is provided not just because an individual meets symptom count but because those symptoms cause chronic and significant impairment …"

Thus, it is not surprising that there is an increasingly popular and seductive trend among the public and some professionals to view the symptoms of AD/HD as adaptive behaviors. It has been suggested that these behaviors evolved to serve a functional purpose in the distant past but may not fit well within current culture and expectation. Through some unexplained process, these qualities were selected for their adaptive advantages, providing carriers of the genes for these qualities with either greater reproductive or inclusive fitness over others.

However, those pursuing a brief introduction to evolutionary theory or evolutionary psychology will quickly realize it is implausible to perceive symptoms or behaviors related to AD/HD as being advantageous, regardless of the time or cultural context in which one examined the data. **The model of AD/HD as adaptive does not appear to fit what we know about ourselves, our ancestors, or about AD/HD.** In fact, a better fit is to suggest that those who do not suffer from AD/HD clearly have an adaptive and likely selective advantage across multiple generations given that they represent the current norm.

A much more plausible argument is that AD/HD, rather than representing an adapted or evolved set of valuable qualities, reflects weaknesses in the development of efficient self-regulation and self-control. These functions likely fall on a normal curve similar to height or weight. Those taking the time to understand evolutionary concepts will quickly conclude that falling to the bottom of a normal curve in the development of self-control represents a disadvantage rather than an advantage.

It is important to keep in mind that by definition the diagnosis of AD/HD is provided not just because an individual meets symptom count but because those symptoms cause chronic and significant impairment across multiple life domains. The diagnosis is pervasive. **When children are provided with the diagnosis in research studies, most still meet the diagnostic criteria many years later.** Even in adult outcome studies, though at least half of adults may not meet the full diagnostic criteria for AD/HD, they still report daily impairments.

What Are Some Myths about People with AD/HD?

In the nearly 4,000 peer reviewed, scientific studies dealing with AD/HD over the past thirty years, there hasn't been a single study in which the group with AD/HD performed better on a valuable trait, asset, or behavior than those without AD/HD. This is not to demoralize, demonize, nor pathologize children with AD/HD. It is to suggest that being delayed in the development of self-control in our complex society is no picnic. It is no blessing for the kids who struggle with this problem nor for their dedicated teachers or parents who live with and love them.

Although it has been suggested that some individuals historically and currently who have achieved success have done so because they are inattentive or novelty seeking, it is yet to be scientifically demonstrated that the symptom qualities of AD/HD by themselves lead to positive life outcome. **It is my belief that if, in fact, many great men and women struggled with AD/HD, their greatness was obtained because they possessed other skills and abilities and were afforded opportunities to overcome this condition.**

Fortunately, the symptoms of AD/HD can be treated and managed effectively leading to more successful and happier lives for those who may struggle against its diminished capacity for self-control. We must turn our attention to the multiple forces and critical problems that appear to be increasingly creating a vulnerable youth as we enter this new millennium. I do not believe we need to create myths or "Just So Stories" to help kids with AD/HD and their families feel better about this impairing condition. Rather, I believe it is time that we begin focusing on the strengths and assets of all children while managing those liabilities that impair their ability to meet the world we have created for them.

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Resources

AD/HD & Self-Control

Books

Taking Charge of ADHD: The Complete Authoritative Guide for Parents
http://www.amazon.com/exec/obidos/ASIN/1572305606/
by Russell A. Barkley, Ph.D.

From Chaos to Calm: Effective Parenting of Challenging Children with ADHD and Other Behavioral Problems
http://www.amazon.com/exec/obidos/ASIN/0399526617/
by Janet E. Heininger Ph.D., et al

Raising a Thinking Pre-Teen
http://www.amazon.com/exec/obidos/ASIN/080506642X/
by Myrna B. Shure, Ph.D., et al

I Can Problem Solve
http://www.amazon.com/exec/obidos/ASIN/0878224718/
by Myrna B. Shure, Ph.D.

Raising a Thinking Child
http://www.amazon.com/exec/obidos/ASIN/0671534637/
by Myrna B. Shure, Ph.D., et al

Getting Through to Difficult Kids and Parents: Uncommon Sense for Child Professionals
http://www.amazon.com/exec/obidos/ASIN/1572304758/
by Ron Taffel

Daredevils and Daydreamers: New Perspectives on Attention-Deficit/Hyperactivity Disorder
http://www.amazon.com/exec/obidos/ASIN/0385487576/
by Barbara D. Ingersoll, Ph.D.

Diagnoising AD/HD

Books

Attention Deficit Disorder and Learning Disabilities: Realities, Myths, and Controversial Treatments
http://www.amazon.com/exec/obidos/ASIN/0385469314/
by Barbara D. Ingersoll, Ph.D. and Sam Goldstein, Ph.D.

Hyperactivity: Why Won't My Child Pay Attention
http://www.amazon.com/exec/obidos/ASIN/0471533076/
by Sam Goldstein, Ph.D. and Michael Goldstein M.D.

Resources

Diagnoising AD/HD (*continued*)

Learning Disabilities and Challenging Behaviors: A Guide to Intervention and Classroom Management
http://www.amazon.com/exec/obidos/ASIN/1557665001/
by Nancy Mather, Ph.D. & Sam Goldstein, Ph.D

Overcoming Underachieving: An Action Guide to Helping Your Child Succeed in School
http://www.amazon.com/exec/obidos/ASIN/0471170321/
by Sam Goldstein, Ph.D. and Nancy Mather, Ph.D.

Teenagers with ADHD: A Parent's Guide
http://www.amazon.com/exec/obidos/ASIN/0933149697/
by Chris A. Zeigler Dendy, M.S.

When You Worry About the Child You Love: Emotional and Learning Problems in Children
http://www.amazon.com/exec/obidos/ASIN/0684832682/
by Edward Hallowell, M.D.

AD/HD & Future Outcomes

Books

Raising Resilient Children
http://www.amazon.com/exec/obidos/ASIN/0809297647/
by Robert Brooks, Ph.D. & Sam Goldstein, Ph.D.

Nurturing Resilience in Our Children
http://www.amazon.com/exec/obidos/ASIN/0658021109/
by Sam Goldstein, Ph.D. and Robert Brooks, Ph.D.

The Self-Esteem Teacher
http://www.amazon.com/exec/obidos/ASIN/0886714184/
by Robert Brooks, Ph.D.

Touch Points: Your Child's Emotional and Behavioral Development
http://www.amazon.com/exec/obidos/ASIN/020162690X/
by T. Berry Brazelton, M.D.

Building Healthy Minds: The Six Experiences that Create Intelligence and Emotional Growth in Babies and Young Children
http://www.amazon.com/exec/obidos/ASIN/0738203564/
by Nancy Breslau Lewis & Stanley Greenspan, M.D.

On the Web

Raising Resilient Children Foundation
http://raisingresilientkids.com/

Resources

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Books

Learning Disabilities and Challenging Behaviors: A Guide to Intervention and Classroom Management
http://www.amazon.com/exec/obidos/ASIN/1557665001/
by Nancy Mather, Ph.D. & Sam Goldstein, Ph.D.

The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children
http://www.amazon.com/exec/obidos/ASIN/0060931027/
by Ross W. Greene, Ph.D.

Daredevils and Daydreamers: New Perspectives on Attention-Deficit/Hyperactivity Disorder
http://www.amazon.com/exec/obidos/ASIN/0385487576/
by Barbara D. Ingersoll, Ph.D.

Study Strategies Made Easy: A practical plan for school success
http://www.amazon.com/exec/obidos/ASIN/1886941033/
by Leslie Davis, M.Ed. & Sandi Sirotowitz, M.Ed. with Harvey C. Parker, Ph.D.

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Books

ADHD and the Nature of Self-Control
http://www.amazon.com/exec/obidos/ASIN/157230250X/
by Russell Barkley, Ph.D.

Attention Deficit Disorder: A different perception
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