

Comprehensive care of CWS with attention deficit disorders

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Attention : a definition

- It may be described as an inner tension directed toward an outer object
 - It allows the mind to select one event in the outer world
 - And keep it “in mind” while working on another task
- It has an adaptive function
- It allows the mind to order events in a series- and therefore to deal with time flowing, so the self is not invaded by everything « at once »

The structure of attention

- Qualitative component
 - Sorting process = selective attention
- Quantitative component
 - Resistance to distraction
- Dynamic component
 - Sustained attention in a selective manner

Clinical distinctions

- Alertness
 - Something new and unexpected happens
- Sustained attention
 - Constant level of vigilance
- Selective attention
 - Making priorities
- Divided attention
 - Multitasking

Attention Deficit Disorders

- One of the most common childhood-onset conditions is Attention Deficit Hyperactivity Disorder (ADHD). Up to 7.5% of children and adolescents have been diagnosed with ADHD.
- This, of course, includes children and adolescents who stutter

Attention Deficit Disorders

- Understanding of ADHD has changed considerably.
- Clinicians now talk about three different subtypes of ADHD:
 - children who are primarily *inattentive*,
 - children whose main problem is *hyperactivity*,
 - children who have both *inattention* and *impulsivity* problems to a significant degree (the *combined* subtype).

Attention Deficit Disorders

- Children with the *inattentive* subtype of ADHD are less likely to be a "behavior problem" in therapy than children with the hyperactivity subtype, but learning abilities may thus be impaired
- If the ADD is *combined* with another impairment, such as stuttering, the rehabilitative treatment of that second disorder is going to be affected anyway
- The *impulsive* subtype may be misdiagnosed ; children are thought to have poor behavior and/or a total lack of self-control
- The *impulsive* subtype is the most frequent among CWS who suffer from ADD too (Monfrais-Pfauwadel 2002 and to be published).

Inattention

- Difficulties listening
- Lack of perseverance
- Difficulties staying concentrate on one topic
- Frequent changes of topic while speaking

Hyperactivity

- Inappropriate motor activity
- Unable to stay still ,especially with kindred or same age children
- Fidgety
- Talkative +++++
- Noisy
- Not aware of dangers
- Late sleeper
- Prone to nightmares

Impulsivity

- Impatience, can't wait for his turn
- Act first
- Interrupt inappropriately
- Difficulties task organizing

Agressiveness and impulsivity

- Raging kid, kicks especially when rebuked
- Quick loss of self control
- Sincerely regrets, but forgets quickly
- Lack of malice
- Allergic to being said « NO »

Opposition, provocation

- 40% prevalence
- Won't listen to counseling
- Always « right »
- « bragging »
- Bullies, quarrels

Fabricates and lies

- Make up stories in order to seem coherent
- A dreadful imagination
- Stick to his story even in front of evidence
- But can change the story, if necessary
- Use magical thinking
- Can tell the truth, if calmer

With poor self esteem

- Self deprecation
- Compares himself to the worse
- Sad thoughts
- Menaces of killing himself or threats of death, especially if very depressed

Misbehaviours

- Defiant
- Skips school
- Violent, for no reason
- Steals, breaks, uses illicit substances
- Cruel with peers and animals
- Lies more than fabricates
- Prevalence of 14% (MTA study)

With obsessive compulsive traits

- Very tidy and neat, very rigid
- Refuse changes
- Acts in a ritual manner
- Hates disorder
- Over valorizes cleanliness----or just the opposite

Learning disabilities

- Prevalence of 50-70%
- Language – dysphasia
- Reading – dyslexia
- Motor difficulties : dyspraxia
 - fine : dysgraphia
 - gross: running, ball games, ride a bicycle

What we call it may matter

- Ask the parents, ask the teachers, ask yourself :
- When someone asks
 - "Is this intentional behavior or involuntary?"
- If you were to think of a particular behavior as a "symptom," do you think it might change your reaction to the behavior or your strategy for handling it?
- Or what if you still called it "behavior," but called it an "involuntary" or "involuntary" behavior?
 - Do you think it would change your approach?

Whatever is the subtype, what we call it may matter

- One of the most frequent questions is
 - "How do I know if this is a symptom or a behavior?"
 - The reply is "Why do you want to know? Is it because if you think it's a behavior, you might use negative consequences, whereas if it's a symptom, you might handle it differently?"

If he would only apply himself!

- This type of thinking often interferes with developing effective strategies.
- Asking whether a particular behavior is "voluntary" or a "symptom" may be as unhelpful as posing the old "Is it Nature or is it Nurture?" question because most behaviors involve higher-order cortical inputs from the brain and are modifiable on some level.
- Does he "(mis)behaves" or is it an expression of his disorders ?
- During speech therapy, you may encounter parents who just think that their child could stop stuttering, if only "he could apply himself"

If he just tried harder....

- Have you ever seen a Tourette ?
- The same type of thinking applies when we talk about neurological "symptoms."
- Some symptoms may be involuntary, while other symptoms may be primarily involuntary but be modifiable or have a voluntary component to them.
- Does that mean that they are all "voluntary" behaviors? Of course not.
- Impulsivity is not a voluntary behavior, neither is stuttering

If she would just pay attention...

- Parents who try to explain to the child's school that these "behaviors" are really neurological symptoms are generally doing so because of a fear that the child will be blamed for something that the parent has reason to believe that the child can't help or can't manage easily.
- They are instinctively trying to protect their child from a system that tends to punish departures from a fairly rigid set of expectations for how children should behave.

A name for it....

- For many parents, learning that the child has a condition or "medical problem" was both a relief and a source of fear or grief, or guilt.
- Relief to have a name and an explanation
 - for why the child is acting the way he does
 - and relief that their misbehavior isn't a reflection on their parenting skills,
 - fear for their child's future, and grief over the loss of the perfect child.
- For many parents, there is also a strong component of guilt as parents berate themselves for all the times they may have scolded the child or punished them for behaviors that they now understand are part of the "diagnosis" or "disorder."

Implications

- That it is possible for us to know whether the behavior is voluntary or whether it is involuntary
- That if it's voluntary behavior, then it is "intentional" and the person has somehow chosen to engage in the behavior (on the assumption that we have "free will"), and
- That if it's a "symptom," it's involuntary
- But is that "malice" ?
- The ethical question is : how much responsible are we?

Relationships between ADD and stuttering

Relationships between ADD and language disorders

- Up to 60 à 75 % of children with a language disorder may suffer of some degree of ADD (Hôpital Robert Debré)
- 18 à 30% of children suffering from ADD are likely to experience some difficulty with spoken language (I.Rapin)

Relationships between ADD and stuttering

- Among the 30% of ADD children with inattention predominant who are late talkers (I. Rapin), the main language problem is word finding and denomination
- Troubles with word finding and evocation processes (D. Germane, Nadia Teitler)

Relationships between ADD and stuttering

- Speech (Zellner) implies the integration and synchronization of a whole set of traits
- If the underlying processes are poorly synchronized , there will be some perturbations in the processing of temporal parameters

Relationships between ADD and stuttering

- 10 à 22 % of CWS are likely to suffer of some kind of ADD
- E. Conture (ASHA 2001)
- In my own series, over 30%

Relationships between ADD and stuttering

- H. Peters et coll..have demonstrate that PWS may exhibit disorders of motor conduction and reaction time in speaking tasks as well as in many other motor tasks

Relationships between ADD and stuttering

- Stuttering and Tourette (C. Ludlow, Van Borsel)
 - Tics and stuttering
 - TOC and stuttering
 - Extrapiramidal dysfunctioning
- Stuttering and epilepsy (Y. Lebrun)

Possible consequences of ADD on stuttering

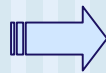
- Talk fast : rate of speech too fast
- Social relationships perturbed
- Learning impairments
- Low self-esteem
- Make stuttering remediation more difficult

Comorbidity of ADD disorders

- Misbehaving
 - 30 to 50 % of all cases
 - + at adolescence
 - Breaking rules
- Learning disabilities
 - Half of those cases drop out of school
 - The most frequent comorbidity

Comorbidity of ADD disorders

- Anxiety
- Mood disorders, depression
- Other symptoms
 - S. de Gilles de la Tourette (most display ADD, majority of stutterers)
 - Epilepsy : 20% of all ADD cases
 - **stuttering**



Diagnosing ADD

Université Paris-Descartes
Colloque Lessius 2010

Diagnosing ADD

- Qualitative assessment
- Quantitative assessment
- More : according to DSMIV, diagnosis is valid only if the trouble is present in two different surroundings i.e. in school *and* at home

Assessment

- The necessity of assessment
- The necessity of tests
- The necessity of questionnaires
 - In at least two different settings

Diagnosing ADD

- Interview the parents : primordial but not reliable enough
- Interview the teachers or forward them a questionnaire
- Specific testing :
 - Specific attention and resistance to distracters : Stroop Test
 - Impulsivity : speed and high rate of errors among the answers

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- Assess also how much the child is
 - Either obnoxious
 - Or bothering
 - Or just at a lost

Neuropsychological Measures

- Stroop Word-Color
 - Timed test measuring the ability to inhibit or suppress automatic responses
 - High % of false negatives (53%)
- Trail Making Test
 - Trails B – Attentional Shift
 - Very high false negatives (80-82%)
 - Overall classification <54% correct.
- Mixed results
- Not consistent in identifying group differences

Rating Scales

- Should address aspects of the following:
 - Core features of ADHD
 - Symptom severity and development
 - Level of impairment
 - Comorbid conditions
- Advantages:
 - Standardized
 - Decreases subjectivity
 - Cost-effective method for multiple informants
 - Can be completed prior to evaluation
 - Access to infrequently displayed behaviors that may be missed in observation periods

Rating Scales

■ **Conners' Rating Scales**

- Parent & Teacher revised versions
 - Children 3-17
 - Parent 80 items (27 on the Short-form)
 - Teacher 59 items (28 on the Short form)
 - Short form has limited scales – focus on ADHD/ADD symptoms
- Self-report for adolescents 12-17
 - Conners-Wells Adolescent Self Rating Scale
 - 87-item (27 on the short form)
- Male & female norms in 3 year intervals
- Rating on a 4-point scale

Rating Scales

- **Conners' Rating Scales**
- Ratings based on the previous month
- Excellent psychometric properties
- Simple comparisons between teacher & parent versions
- ADHD Index (parent form): 12 items
- Hyperactivity Scale moderately related to total hyperactivity score during analogue observation

Behavioral Observation

- Why observe?
 - Increased objectivity
 - Parent evaluations may be biased due to distress or other psychological factors
 - Intense behaviors may be perceived as more frequent

Comprehensive care of the CWS with ADD disorder (mainly impulsivity)

Help..... !

- Help the child, cure the symptoms (or try to !)
- But also
 - Help for the parents
 - Help for the teacher
 - Help for the speech therapist, if there is the need for one

What everybody needs in this case is

- Information
- Comprehension
- Help
- Patience
- Time
 - It takes time to help
 - And time out !
- Organization
- Post-it !!!!
- A Pomodoro

Multidisciplinarity is a necessity

- ADD requires a team work, especially there is some other impairment such as stuttering
- A general practitioner or a pediatrician, with a special interest for the problem
- A specialist : phoniatician, neurologist, pedopsychiatrist
- A psychologist, with a good background in behavior therapies
- A therapist and counselor
- A speech therapist

Medications

- Hyperactivity et impulsivity : psychostimulants
- Without hyperactivity : Modafinil or Strattera
- With tics or anxiety : Strattera
- With tics : Clonidine
- With agressivity and/or impulsivity : Clonidine

Usual strategies – rewards

- Daily agenda of routines
 - Post the agenda or a calendar if necessary
- Reward every effort (points, coins, etc)
- Use a Pomodoro
 - externalizing time

Usual strategies – punishments

- No “breaking” of temperament
- Avoid making the child be a loser too often
- Help quick repair of bad situations
- Keep in mind it becomes better with aging (0-25 ans)

Techniques to use with CWS with ADD- advice for everybody

- Maintain eye contact during verbal instruction
- Deliver clear and concise directions
- Simplify complex directions
- Avoid multiple commands
- One command at a time, simplify tasks
- Make sure child comprehends before beginning the task
- Repeat in calm, positive manner, if needed
- Limitate wild games - be aware of too much excitement
 - TV, DVD
- Suggest outdoor games
- Good hints : time out, stop/think/and go

Techniques to use with CWS with ADD- advice for everybody

- Help child feel comfortable in seeking assistance - most won't ask
- Require daily assignment notebook if necessary- make sure assignments are written correctly
- Give out only one task at a time
- Frequently check progress and give defined timelines if long term projects must be assigned

Techniques to use with children with ADD-mainly at school

- Monitor child frequently - use a supportive attitude
- Make sure you are testing knowledge and not attention span
- Give extra time on assignments - don't penalize for needed extra time
- Private tutoring and/or peer tutoring at school
- Don't penalize for late assignments
- Provide option for oral testing or follow up to insure grades are based on knowledge, NOT the disability

Comprehensive care of the CWS with ADD- counseling the Speech Therapist

- Adapt yourself to the child's attention span and not the other way round
- Structure ahead the timing of the session, design short sequences, plan breaks
- Indicate right away how long you wish the current task to last
- sustain the child's attention with new games, attractive techniques
- Avoid distractions and distractors
- Turn off the phone

Comprehensive care of the CWS with ADD- counseling the Speech Therapist

- Establish rules ; post it
- Establish contracts for each session (F. Estienne)
- Write it down
- Give the patient a note book
- Write down rules, paste exercises, drawings
- Notebooks are very prone to be lost !!!
- Reinforce desired behaviors, praise efforts and achievements

For the speech therapist

- The stuttering therapy is not that much different but....beware !
- Organize yourself in advance
- Avoid distractions
- Good time line
- Timing for each activity
 - Pomodoro technique
 - Plan the breaks; they are no necessary
- Write down everything



For the parents

- Avoid asking the child to pay more attention : he just can't
- No judgment ; no punishment : comprehension
- Time slices : 20 to 25 minutes, then a break, a reward if necessary- or if justified
- Praise, praise, praise, reinforce
- Keep track of time
- Commit yourself 100 % when helping your child
- Speak slower, act slower, you'll gain a lot of time

Verbal praise

- Great job, well done
- Good answer
- Waoouuhhh
- I am impressed
- Nice try
- I knew you could do it
- Good thinking
- *When criticizing, remain positive*
- You really catch that quick
- Much better
- Perfect
- Way to go
- You keep improving
- *4 praises for one remark*

Behaviors appropriate for Time Out

- Temper tantrums
- Hostile teasing
- Kicking others
- Hair pulling
- Throwing toys
- Screaming
- Mocking parents
- Cursing...etc !!

Difficulty sequencing and completing steps to accomplish specific tasks.

- Break task into manageable steps. Provide examples and specific steps to accomplish tasks.
- Avoid shifting from one uncompleted activity to another without closure
- Break task into manageable steps. Provide examples and specific steps to accomplish tasks.
- Define and highlight 'break points.' (Pomodoro !!)

Difficulty sustaining attention.

- If the child is easily distracted by stimuli.
- Reward the child for sustaining attention.
- Break activities into small units.
- Reward the child for timely accomplishments. Cue the child by using physical proximity and touch.
- Provide a quiet place or preferential seating. Eliminate clutter and distractions.
- Praise, reward, admire

Difficulty with interactions.

- This child may interact poorly with adults, defies authority, or engages in passive manipulation.
- Provide the child with frequent and positive attention and feedback when he/she demonstrates appropriate behavior or accomplishes tasks successfully.
- Talk with the child individually about the inappropriate behavior and its effect.
- Provide examples of why the behavior is inappropriate such as, “What you are doing is...” Or, “A better way of getting what you need or want is...”

Communication skills

- Developing social skills
- Listening skills
- Turn taking
- Play role game with the child
- Play role game with the whole family
- Give assignments to the whole family

Rules

- Make a game with the child
- Write it down
- Post it
- Show it to the parents
- Tell them to do the same thing at home
- Check !

For the speech therapist

- Sorry, you'll have to design your own program..
 - Because every CWS is different
 - Every child with ADD is different
 - And the parents are different
- But it should be child-centered
 - That's why assessment is so important
- So...take your time
- And enjoy spontaneous, wonderful ADD children
- They will teach you a lot about your own sense of time