Sluggish Cognitive Tempo: What do Clinicians Need to Know?

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Agenda
- Learning Objectives
- Conceptual overview (ADHD, SCT/CDD)
- History of SCT/CDD
- Patterns of comorbidity and symptoms differentiation (SCT/CDD and related disorders)
- Demographic differences and etiology
- Neuropsychological differences
- Break
- Assessment of SCT/CDD
- Current treatment for ADHD vs SCT/CDD
- Medication
- Behavioral Interventions
- Classroom accommodation
- Small and large group discussion of vignettes
Learning Objectives

1. Define and discuss the utility of Concentration Deficit Disorder (CDD)/Sluggish Cognitive Tempo (SCT) as a distinct construct for diagnosis and treatment
2. Recognize similarities and differences between CDD (SCT) and ADHD from a historical, etiological, symptomatological, and neuropsychological perspective
3. Summarize current research findings, including those examining the utility of this construct for use with diverse clinical populations
4. Identify and critique potential assessment tools for ADHD and CDD (SCT) symptoms
5. Identify and apply appropriate treatment interventions and accommodations for individuals with CDD (SCT) symptoms

Attention-Deficit/Hyperactivity Disorder: DSM-5 Diagnostic Criteria

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. Inattention
2. Hyperactivity and impulsivity

Both require that “[s]ix (or more) of the following symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities” (American Psychiatric Association, 2013).

Inattention

"Inattention manifests behaviorally in ADHD as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension.” (American Psychiatric Association, 2013, p. 61)
Criteria for Inattention
(American Psychiatric Association, 2013)

a. Often fails to give close attention to details of makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details; work is inaccurate)
b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading)
c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction)
d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)
e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines)

Criteria for Inattention, cont’d.
(American Psychiatric Association, 2013)

f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers)
g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones)
h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts)
i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments)

Hyperactivity and Impulsivity

“Hyperactivity refers to excessive motor activity (such as a child running about) when it is not appropriate, or excessive fidgeting, tapping, or talkativeness. In adults, hyperactivity may manifest as extreme restlessness or wearing others out with their activity.” (American Psychiatric Association, 2013, p. 61)

“Impulsivity refers to hasty actions that occur in the moment without forethought and that have high potential for harm to the individual (e.g., darting into the street without looking). Impulsivity may reflect a desire for immediate rewards or an inability to delay gratification. Impulsive behaviors may manifest as social intrusiveness (e.g., interrupting others excessively) and/or as making important decisions without consideration of long-term consequences (e.g., taking a job without adequate information).” (American Psychiatric Association, 2013, p. 61)
Criteria for Hyperactivity and Impulsivity
(American Psychiatric Association, 2013)

a. Often fidgets with or taps hands or feet or squirms in seat
b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place)
c. Often runs about or climbs in situations where inappropriate (Note: in adolescents or adults, may be limited to feeling restless)
d. Often unable to play or engage in leisure activities quietly
e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with)

f. Often talks excessively
g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation)
h. Often has difficulty waiting his or her turn (e.g., while waiting in line)
i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing)

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).
Specify if in partial remission; specify current severity (mild, moderate, severe)
ADHD: DSM-5 Diagnoses/Codes
(American Psychiatric Association, 2013)

314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met but Criterion A1 (inattention) is not met for the past 6 months.

Prevalence

- Approximately 5% of children and 2.5% of adults (cross-culturally; in U.S., diagnosed more frequently in the White/non-Latino population than in the Black/African-American and/or Latino populations) (American Psychiatric Association, 2013)
- 3:1 boy:girl ratio in childhood; in adulthood, this discrepancy narrows to 2:1 or lower

Common Comorbidities

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Autism Spectrum Disorder
- Tic Disorders
- Specific Learning Disorder
- Intellectual Disability
- Reactive Attachment Disorder
- Disruptive Mood Regulation Disorder
- Depressive Disorders
- Bipolar Disorder
- Anxiety Disorders
- Substance Use Disorders
- Personality Disorders
- Psychotic Disorders
- Medication-induced ADHD Symptoms
- Neurocognitive Disorders/Dementia
ADHD: Neuroanatomical and Neuropsychological Findings

- Neuroimaging studies have implicated a variety of brain structures and pathways in ADHD, including: the prefrontal/frontal and parietal cortical areas; striatum; basal ganglia; hippocampus; corpus callosum; cerebellum; and the pathways that connect them
- fMRI studies have shown decreased fronto-striato-parieto-cerebellar connectivity in children and adolescents with ADHD
- Some studies have found reduced volume in regions such as the parietal cortex, hippocampus, and cerebellum

(Purper-Ouakil et al., 2011)

ADHD: Neuroanatomical and Neuropsychological Findings (cont’d.)

- General conceptualization of the neurobiology of ADHD: dysregulation in noradrenergic prefrontal systems leads to insufficient regulation of dopaminergic subcortical structures (with the goal of pharmacological treatment to increase NE and DA levels in the prefrontal cortex)
- This conceptualization is more applicable to ADHD-HI and ADHD-combined
- Research suggests that Predominantly Inattentive ADHD is linked to fronto-parietal dysfunction, rather than the fronto-striatal dysfunction described above, and thus is a neurobiologically distinct disorder

(Diamond, 2005)

What is Sluggish Cognitive Tempo?

- Attention disorder
  - May overlap with ADHD
  - May have distinct features
  - Could be beneficial to conceptualize as a separate disorder
- No official criteria available to diagnose SCT
Terminology: SCT vs. CDD

Sluggish Cognitive Tempo (SCT)
- Term used to describe condition since 1980s
  - May be considered offensive and misleading
Replacement term: Concentration Deficit Disorder (CDD)
  - May be less offensive and misleading
  - May eliminate semantic confusion
- Despite suggestion: SCT is the term primarily used in the literature
- For the purposes of this presentation, CDD (SCT) will be used to describe this condition (Barkley, 2014)

Predominant Features
Features include:
Slow completion of tasks, effort that fades, becoming lost in thoughts, being withdrawn or apathetic, appearing sleepy or drowsy, inaccurate processing of explanations or questions, slow or sluggish movement, being under-active or hyperactive, lethargy, being "spacey" (mind is elsewhere), staring often, easily confused or mentally foggy, difficulty remaining awake and alert, frequent daydreaming, shy, socially withdrawn, and even socially anxious. (Penny, Waschbusch, Klein, Corkum, & Eskes, 2009)

Dimensional Conceptualization

<table>
<thead>
<tr>
<th>Motoric dimension</th>
<th>Cognitive dimension</th>
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<tbody>
<tr>
<td>Low movement</td>
<td>Daydreamy or spacey (mind is elsewhere)</td>
</tr>
<tr>
<td>Hypo-activity or underactivity</td>
<td>Easily confused or mentally foggy</td>
</tr>
<tr>
<td>Lethargy</td>
<td>Error prone (inaccurate processing of information)</td>
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<tr>
<td>Slow completion of tasks</td>
<td>Appearing sleepy or drowsy</td>
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<tr>
<td>Effort that fades</td>
<td>Difficulty remaining awake and alert</td>
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<td></td>
<td>Being withdrawn or apathetic</td>
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<td>Shy, socially apprehensive, and even socially anxious</td>
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Concept Overview

- 5.4% of adult population (potentially as common as ADHD)
- 30 – 50% of children in Inattentive group of ADHD may actually have CDD (SCT)
- Debate:
  - Separate type of ADHD?
  - Qualitatively different disorder?
  - CDD (SCT) comorbid with ADHD?
  - Confusion in labeling?
- Conceptualize ADHD and CDD similarly to the way we think about anxiety and depression
  - Worth keeping separate and conceptualizing as distinct disorders
  - Unique but correlated / can be comorbid
  - Over time the two disorders may start to converge (Barkley, 2014)

History

- Research in the 1980s
  - Proposal to construct two categories of ADD in the DSM-III
  - Include individuals with ADD with (+H) and without (-H) hyperactivity
- Limited research in support of differentiated categories for +H and -H
  - DSM-III-R eliminated these subtypes
  - Undifferentiated ADHD rather than ADD-H
- Continued research:
  - Supported differences between ADD+H and ADD-H
  - Possible manifestation of CDD (SCT) like symptoms within the ADD-H group (Barkley, 2014)

History, cont’d.

- CDD (SCT) items included in DSM-IV Field Trial for ADHD
  - Poor negative predictive power
  - Symptoms being identified may have been part of a separate attention disorder (Barkley, 2014)

Study:

- Factor analysis of 692 children
- CDD (SCT) differentiated from Inattentive symptoms of ADHD
- Findings suggest:
  - CDD (SCT) symptoms should be included into inattentive type
  - CDD (SCT) may be distinguished as a subtype of Inattentive ADHD (McBurnett, Pillfster, & Frick, 2001)
Lack of Research

- Research and measurement tools have been developed
  - More accurately delineate between symptoms
- CDD (SCT) continues to be understudied
  - Only about 50 published research articles in existence specifically on this topic
  - Compared to about 10,000 published articles on ADHD
- Demand for empirically-based research on this topic is likely to rise
  - Growing public awareness
  - Increased clinical referrals

(Barkley, 2014)

Symptom Differentiation

- Variability in clinical presentation
  - Heterogeneous inattentive group
  - 30 to 50% of individuals diagnosed with ADHD-Inattentive type (ADHD-I) may also present symptoms of CDD (SCT)
- DSM criteria may negate individuals who present with CDD (SCT) symptoms in the absence of ADHD symptoms

(Garner, Marceaux, Mrug, Patterson, & Hodgens, 2010)

Are CDD (SCT) symptoms tied to ADHD?

- CDD (SCT) symptoms may not be uniquely tied to ADHD
  - Example:
    - CDD (SCT) behavior symptoms among a population of pediatric survivors of acute lymphoblastic leukemia (ALL)
    - Compared ALL survivors with siblings as a control group
    - ALL survivors presented significantly more CDD (SCT) symptoms than control group
    - Elevated CDD (SCT) scores associated with lower achievement and intelligence scores
  - Results suggest
    - ALL survivors are vulnerable to CDD (SCT) symptoms
    - Symptoms may be a marker for cognitive late effects
    - Lends support for the CDD (SCT) construct requiring examination outside of the context of ADHD symptoms

(Reeves et al., 2007)
Are CDD (SCT) symptoms tied to ADHD?

- Study assessed relationship between:
  - CDD (SCT), ADHD, clinical diagnosis, various aspects of adjustment
  - Clinical sample of 322 children and adolescents with learning, emotional, and/or behavioral issues
- Confirmatory factor analyses of both teacher and parent ratings
- Provided evidence for three separate but correlated factors
  - Hyperactivity/impulsivity, CDD (SCT), and inattention
- CDD (SCT) symptoms:
  - Highest in individuals with ADHD-I
  - Present in individuals without ADHD
  - Correlated with internalizing, inattention, and social problems
- Further research needed into the clinical utility of CDD (SCT) construct

Contradicting Evidence

- Regression analyses of parent ratings
  - 228 children diagnosed with DSM-IV ADHD
  - Assessed how the differences among ADHD subtypes were altered with the incorporation of CDD (SCT) symptoms
  - Study suggests that adding CDD (SCT) symptoms into the DSM diagnostic criteria for ADHD would:
    - Have limited utility for differentiating meaningful subgroups of ADHD-I
    - Not enhance external validity of these subtypes

Patterns of Comorbidity

- CDD (SCT) related to higher rates of internalizing symptoms
  - Withdrawal, anxiety, and depression
  - Negatively associated with externalizing disorders
    - Oppositional Defiant Disorder (ODD) (Lee, Burns, Snell, & McBurnett, 2014)
- Individuals with ADHD
  - 11 times more likely to exhibit symptoms of ODD than the general population
  - Associated with higher rates of reading and math disorders, anxiety, and bipolar disorder
- May be an additive effect of CDD (SCT) symptoms when they co-occur with ADHD symptoms
  - Linked to higher rates of comorbidity with other disorders than when these symptoms were examined separately
Social Differences

- Individuals with CDD may be more **socially reticent**
  - Apprehensive, withdrawn, passive, shy, and uninvolved
  - Not for ADHD
  - Do not present like children with autism
    - Care about friends / not disinterested
    - May have a few friends

Demographic Differences

- No strong age, gender, or minority patterns (Garner et al., 2010)
- CDD (PDD) may have somewhat later age of onset than ADHD (Barthley, 2013)
- As previously noted, ADHD symptoms occur more frequently in boys than girls in childhood and adolescence. This difference is less pronounced in adulthood
- CDD symptoms more prevalent in males than females in childhood
  - No sex differences in adulthood
- ADHD may be more associated with some ethnic groups
  - Not the case for CDD to date
- CDD may be linked to:
  - Lower parental education, lower annual household income, and greater likelihood of a parent being out of work due to disability
- Adults with CDD symptoms may have less education and lower annual income
  - More likely to be unmarried and out of work on disability (Barthley, 2012)
- CDD could be more strongly associated with psychosocial stressors than ADHD

Etiology

- Multiple causes possible
- May be heritable
  - Less so than ADHD?
  - Unique environmental factors appear to contribute to symptoms (Moruzzi, Rijssijk, & Battaglia, 2014)
- Prenatal alcohol exposure
  - (Graham, Crocker, Deweese, Roesch, Coles et al., 2012)
- Treatment side effects from acute lymphoblastic leukemia (ALL)
  - (Reeves et al., 2012)
Neuropsychological Differences

- Limited research
- Fundamental differences in cognitive dysfunctions underlying symptoms
- ADHD:
  - Executive Functioning (EF) deficits
    - Self-regulation
    - Disinhibition
    - Time management and emotional regulation
- CDD (SCT):
  - Weak association to EF deficit dimensions
    - Organization and problem solving
    - Difficulty with accuracy of school work
    - Do not have issues with disinhibitions (May be overly inhibited and anxious)
  - Processing issues
    - Selective attention / Focused attention
    - Long term memory storage problems
    - Information processing
    - Slower motor speed
    - Variability of spatial performance

(Barkley, 2014)

Discussion Questions:

- Which diagnostic criteria for ADHD - Predominantly Inattentive Type overlap with CDD (SCT) as described here?
- Which diagnostic criteria for ADHD clearly distinguish it from CDD (SCT)?
- What other diagnoses in the ADHD Comorbidities list reviewed earlier might have shared features with CDD (SCT)?
Assessment of ADHD vs. CDD (SCT) vs. Other Comorbid Diagnoses

- Currently difficult to do, given the lack of formal diagnostic criteria for CDD (SCT)
- Is labeling/diagnosing an effective way to identify potential interventions?
  - Do we know whether this is applicable to CDD (SCT) given the lack of research on “best practice” interventions in this area?

Assessment: Observation

Purpose:
- To examine adaptive and maladaptive behaviors in naturalistic settings (if possible)
- To identify key behaviors and their frequency, duration, and/or intensity
- To compare behaviors exhibited by the individual being observed to those exhibited by others in the environment

Observation in multiple environments is preferable

Assessment: Interview

- Depending on the setting, age and capacity of the individual, and availability of other informants, can include self, parent/guardian, and/or teacher informants
- Include:
  - Biopsychosocial history
  - Family history
  - Current functioning
  - Strengths and weaknesses
Assessment: Rating Scales

- Can use same informants as interview; use of multiple informants is desirable
  - May be discrepancies across raters (different settings, different experiences)
  - Individuals may vary in the degree to which they perceive their own deficits accurately, but knowing how the individual perceives him/herself can be critical in designing interventions
- Omnibus scales that target internalizing, externalizing, and ADHD + CDD (SCT) behaviors should be used (e.g., BASC, CBCL, Conners CBRS)
- Single/limited construct scales, including ADHD and EF scales by Barkley and others (e.g., Barkley Deficits in Executive Functioning Scale; BRIEF; the Epworth Sleepiness Scale) can be used for more targeted information
- Rating scales that examine CDD (SCT) in particular are under development/validation

Assessment: Performance of Standardized Tasks

Cognitive features to assess, both to identify CDD (SCT) and to rule in/out other disorders, include:
- Response inhibition/impulse control
- Sustained attention/persistence
- Selective attention
- Processing speed
- Working memory
- Rate of learning/retrieval
- Academic skill acquisition and application

Assessment: Other Considerations

- Gather sufficient data to rule other comorbidities in/out
- Has the referral question been answered?
- How will the results be disseminated/used?
Current Treatment for CDD (SCT)

- The lack of research and diagnostic clarity regarding CDD impacts treatment options as well
- Research is ongoing to identify interventions specific to CDD (SCT)
- Interventions validated to treat symptoms of ADHD, social anxiety, and other related disorders are often used

Medication

- American Academy of Child and Adolescent Psychiatry’s recommendations for pharmacological treatment of ADHD: first-line treatment with FDA-approved drugs, including amphetamines (e.g., Adderall, Dexedrine, Vyvanse) or methylphenidate preparations (e.g., Ritalin, Focalin, Concerta, Metadate, Daytrana); for non-responders, NRDIs (e.g., Wellbutrin), tricyclics, or alpha-2-agonists (e.g., clonidine)
  - “Traditional” ADHD meds (amphetamines/methylphenidate) more effective for ADHD-HI
- Little is known to date about the efficacy of medication in treating CDD (SCT) in particular
  - Methylphenidate was not effective in one trial
  - SNRIs? There is some evidence to suggest that Strattera/atomoxetine is helpful in treating ADHD + internalizing disorders; Lilly has a trial underway to examine atomoxetine for treatment of SCT
  - Barkley suggests examining efficacy of Prestigl/modafinil (anti-narcoleptic)

Interventions: Academic

- In children and adolescents, special education (IDEIA eligibility) or Section 504 eligibility (accommodations/supports eliminating barriers to participation) should be considered
- 20% of students diagnosed with ADHD are also identified with learning disabilities and may require more intensive instruction targeting skill deficits (Spiel, Evans, & Longberg, 2014); degree of CDD (SCT)/LD comorbidity is unclear
- Identification of skill vs. performance deficits is important in order to target needs appropriately
- In a college population, CDD (SCT) is more predictive of academic difficulty, and more strongly associated with internalizing symptoms, than ADHD-Pi (Boekel et al., 2013)
Interventions: Socioemotional

- The social issues experienced by those with CDD (SCT) are different than those experienced by others who may receive social skills instruction/support.
- Skills may or may not be present in ADHD; skills are more likely to be intact in CDD (SCT) but performance may be affected by anxiety or lack of motivation.
- Interventions for CDD (SCT) may focus on increased application of skills or reduction of social anxiety.
- Address other internalizing/externalizing issues as needed.

Classroom Accommodations

Barkley’s (2008) nine principles for the planning and management of programs for children and teens with ADHD:

- Rules and instructions provided to children with ADHD must be clear, brief, and often delivered through more visible and external modes of presentation than are required for the management of children without ADHD.
- Consequences used to manage the behavior of children with ADHD must be delivered swiftly and more immediately than is needed for children without ADHD.
- Consequences must be delivered more frequently, not just more immediately, to children with ADHD.
- The type of consequences used with children with ADHD must often be of a higher magnitude, or more powerful, than those needed to manage the behavior of other children.

Classroom Accommodations (cont’d.)

Barkley’s (2008) nine principles for the planning and management of programs for children and teens with ADHD (cont’d.):

- An appropriate and often richer degree of incentives must be provided within a setting or task to reinforce appropriate behavior.
- Reinforcers or rewards that are employed must be changed or rotated more frequently to avoid habituation or satiation.
- Anticipation is key; think aloud, think ahead.
- Children with ADHD must be provided with more external cues about behavior and goal attainment than other children.
- Behavioral interventions only work while they are being implemented and require continued monitoring and modification for maximal effectiveness.
Classroom Accommodation Strategies

- Use of token economies with a variety of interesting reinforcers
- Clear and visible rules
- Provision of directions in multiple formats; checks for recall and understanding
- Cuing prior to transitions
- "Think aloud" modeling
- Self-cuing and self-monitoring strategies
- Provision of discreet external cues to avoid embarrassment
- Daily Behavior Report Cards to facilitate home-school communication
- Breaks for physical activity

Summary

- Video: Russell A. Barkley, Ph.D.

Vignettes

Please read the vignette assigned to you, and then, working in groups, please consider the following questions:

- What symptoms/behaviors described in the vignette are helpful in conceptualizing the case?
- What diagnoses/conditions would you want to consider?
- What assessment techniques would you use to gather additional information?
- Based on that information, what interventions/accommodations might be appropriate and helpful?
Vignette 1: Katie

Katie is a 15-year-old freshman at a local public high school, who has been referred for assessment to answer some questions that she has about her difficulties with focusing academically and socially. Although she has had difficulty throughout her academic career, Katie's parents have refused testing until now, preferring instead to have Katie repeat the first grade and resolve additional issues such as reading, writing, math, and science. Katie reports that starting and organizing work represents a significant challenge for her. During school assignments, Katie often finds it necessary to re-read passages multiple times in order to comprehend the material and describes herself as “losing focus” or forgetting what she has read. She frequently sits and remains focused or daydreams about other topics. Katie often requires more time than most of her classmates to complete assignments or assessments. She states that despite continually reminding herself to focus in class and in social situations, she frequently “zones out” and misses what others are saying. Katie reports that in these instances she perceives herself as looking and feeling attentive but she describes her mind as being “blank.” She expresses that in these instances she typically becomes anxious about asking for material to be repeated, as she does not want to be seen as uninterested or absent-minded.

Katie’s teachers and parents report that she does not have a history of behavior problems and has never exhibited hyperactive behaviors. Her teachers have described Katie as being well-behaved and quiet; however, she rarely participates in class discussions and appears to be apprehensive about asking questions despite her confusion about assigned material. Teachers have also reported that Katie’s academic level is not comparable to her age level and that her long-term memory and attentional abilities, yet standardized tests and observations of her classroom performance suggest that she has a slower processing speed and impaired output for writing tasks. Katie has taken a strong interest in music and art, easily focusing on singing and drawing for many hours.

Vignette 2: Aiden

Aiden, a 7-year-old in the 2nd grade, has been referred for assessment by his parents, who report considerable “frustration” due to Aiden’s continual “behavior issues.” They report that, compared to his older brother, Aiden tends to be “unmotivated.” His parents also expressed that Aiden often requires “multiple reminders to complete chores at home” and completes these tasks slowly, often appearing “spacey” while stopping frequently and staring throughout the task. Aiden’s parents state that he gets “more than enough sleep” yet often appears to be sleepy and confused. Recently, his teachers have reported that Aiden appears to have difficulty remaining awake and alert in class, saying that his “mind seems to be elsewhere.” When asked to repeat back information that has been presented, Aiden is unable to do so or does so inaccurately. He appears to be unable to recall what he has heard or read just a few minutes earlier. Aiden frequently needs more time to complete class assignments and has been caught copying the work of other students on more than one occasion.

Aiden presents as shy and socially reticent; however, he has maintained a few friends and displays age-appropriate interactions with his peers. Aiden’s mother has a history of anxiety and his father was diagnosed with a learning disorder when he was in elementary school.

Wrap-up Discussion/Questions

Thank you for your interest and participation!

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References


