Differentiating Cogmed Effects: ADHD, LD and WM deficits.

Charles Shinaver, PhD, PhD
Peter Entwistle, PhD

November, 2016

Agenda

• How does Working Memory, the Target of Cogmed, relate to ADHD.
• Understanding variation in the effects of Cogmed. Considering severity, co-morbidity & Rx.
• Differentiating the severity of ADHD-C from ADHD-I.
• Differentiating Learning Disabilities & Learning Problems.
• Potential limiting & facilitating factors to far transfer of Cogmed effects.
• Cogmed specific studies.
Cogmed Trains Working Memory.
What is Working Memory (WM)?

A system for temporary storage and manipulation of information, necessary for a wide range of cognitive tasks

To keep information in your mind for a short period of time (seconds) & use in your thinking

Processes all stimuli we encounter - updating

Delegates to different parts of our brain to take action - shifting

Allows us to block out unnecessary information - inhibition

Keeps us updated on what’s happening -- & focused on what matters

The Lack of Development of Working Memory (WM) in ADHD.
How VSWM became the target for Cogmed.

“Cogmed Working Memory Training: Reviewing the reviews” (Shinaver & Entwistle, 2014) - Understanding the Effects of Cogmed
Shinaver and Entwistle (2014): Evaluate Cogmed effects upon ADHD patients in light of empirical considerations: severity of disorder, comorbidity & control for medication effects (Rx). ADHD-I with no comorbidity is very different than ADHD-C with ODD & an LD. Treatment needs vary accordingly with any treatment...

ADHD is a heterogeneous disorder.

1. Presentations & Severity Varies: Combined (ADHD-C), Inattentive (ADHD-I) & Hyperactive/Impulsive (ADHD-HI).

2. Comorbidity Varies: Severe behavior disorders, oppositional defiant disorder (ODD), conduct disorder (CD), mood disorders to learning disorders.

3. Medication Status (Rx) Varies: Some are taking Rx other are not.
“Cogmed Working Memory Training: Reviewing the reviews”
(Shinaver & Entwistle, 2014)

Argument: Combined type ADHD (ADHD-C) is a more severe disorder than ADHD inattentive type (ADHD-I). The impact of this distinction has been underestimated in the Cogmed research literature.

Comorbidity is a critical factor to consider when evaluating effects of Cogmed as is true with any intervention. ADHD-C has more severe comorbidity. ADHD-I has more comorbid learning issues.

Control for medication effects (Rx), which can get complicated as ADHD-C and ADHD-I may have differential responses to Rx.

Is ADHD-C more severe than ADHD-I in children? Yes. More CD. With more CD & earlier referral age.
(Bilgic, et al., 2006)

Patient records of 266 children with ADHD between ages 4-18 years evaluated retrospectively.

Conduct Disorder (CD) was detected in 36.1%, Oppositional Defiant Disorder (ODD) in 25.9% and LD in 21.7% of the cases.

CD was most common among cases with ADHD-C and least common in ADHD-I.

Clinical referral age was found lower in children with comorbid disruptive behavior disorders (CD and ODD).

Maternal educational level was lower in LD cases.

Childhood hyperactivity/impulsivity linked to adult antisocial behavior.
(Lopez-Williams, 2005 Dissertation)

Key findings included marginally significant direct paths from childhood symptoms of hyperactivity to status (p < .10) and violent (p < .10) types of ASB (in adulthood), and (marginally) significant direct paths from childhood symptoms of impulsivity to status (p < .10) and violent ( p < .05) types of ASB (in adulthood). All four direct paths were large in magnitude…”

“Overall, symptoms of inattention had relatively little predictive value,” (as it related to later antisocial behavior in adulthood).

Both hyperactivity and more strongly impulsivity correlated to antisocial behavior. Inattention did not…
Is ADHD-C more severe disorder than ADHD-I in adults? Yes. More ODD, hostility, paranoia, suicide attempts & arrests.  
(Murphy, et al., 2002)

Adults (17-27 yrs) with attention deficit hyperactivity disorder (ADHD). 60 ADHD-C and 36 ADHD-I & community control group (n=96).  

Both ADHD Groups: Less education, fewer college grads, more likely special educational in high school, Dysthymic, alcohol dependent/abuse, cannabis dependent/abuse, and learning disorders, & greater psychological distress than the controls.  

Both ADHD Group: More likely took psychiatric medication and other mental health services than control adults.  

BUT: “The ADHD-C-type adults were more likely to have oppositional defiant disorder, to experience interpersonal hostility and paranoia, to have attempted suicide, and to have been arrested than the ADHD-I adults.”

Is ADHD-C more severe than ADHD-I in children? YES. Worse on attention problems, ADHD scale, Inattention, ODD, Hyperactivity & Ext. Surprising?  
(McCannally, et al., 2009)

n=177, 6-11 yrs. Participants were assigned to four groups based upon parent & teacher ratings: ADHD-C (n = 74); ADHD-I (n = 25); clinically referred without ADHD (n = 52); and controls (n = 26).  

The ADHD-C scored significantly higher than the other three groups on six Test Observation Form scales: (1) Attention Problems; (2) Oppositional; (3) Attention Deficit/Hyperactivity Problems scale; (4) Inattention subscale; (5) Hyperactivity-Impulsivity subscale; and (6) Externalizing.  

ADHD-C worse than ADHD-I, even on attention problems, inattention subscale and ADHD problems scale!  
The two ADHD groups also scored significantly lower than controls on all WISC-IV and WIAT-II composites and lower than those clinically referred without ADHD on WISC-IV Working Memory Index and Full Scale Intelligence Quotient.

ADHD-C is more severe than ADHD-I in children, BUT  
ADHD-I have more difficulty with academic achievement.  
(Wahrach, et al., 1998)

“The children with ADHD-I were rated as having less overall functional impairment, but did have difficulty with academic achievement.”

“The children with ADHD-I were older, more likely to be female, and had more comorbid internalizing disorders and learning disabilities. Individuals in the ADHD-I group were two to five times as likely to have a referral for speech and language problems.”
How is ADHD-I type different from those who are impulsive or hyperactive? Fewer conduct & substance use problems, more academic problems. (Lee, 2005, dissertation abstract)

Preadolescent girls (N = 228) with and without attention-deficit/hyperactivity disorder (ADHD), ages 6-12 years. Girls and their families were rigorously assessed 4.5 years later. Baseline predictors included ADHD, overt aggression, noncompliance, covert antisocial behavior (ASB), relational aggression, and social preference.

Hyperactivity-impulsivity (HI) were most predictive of conduct problems and substance use. Inattention symptoms most predictive of academic difficulties (lower achievement and more frequent special education placements).

How is ADHD-I different in children from those who are impulsive or hyperactive? More academic problems, fewer behavioral. (Wolraich, et al., 1998) County-wide study of ADHD in Tennessee. n=4323 students, 214 teachers, 10 schools. The prevalence rates were 16.1% for ADHD-all types, 8.8% for ADHD-I (I), 2.6% for ADHD-HI, and 4.7% for ADHD-C.

The rates of problems differed mostly between ADHD-I and ADHD-HI (30% vs 68%) for behavior and (56% vs 16%) for academics.

ADHD-I: Fewer behavior problems, more academic problems...

How is ADHD-I different from those who are impulsive or hyperactive? Less impaired. Girls, teens & Adults. ADHD-C, more common in elementary school-age children especially in boys. ADHD-I more common in girls and in adolescents and adults (Dunn & Kronenberger, 2003).

n=116 ADHD adults, (62) ADHD-C, (52) ADHD-I. 62 men 54 women. Compared measures of emotional intensity and social skills. Additional analysis was employed to examine if the findings were moderated by gender.

ADHD-C significantly impaired when compared to the ADHD/I. (Monahan, 2009, dissertation).
ADHD-C better Rx response than ADHD-I.
Arguably, Cogmed even more relevant.
(Hale, et al., 2005)

N=49 children with ADHD.
Robust Rx effects observed with increasing dose, better teacher ratings and direct observations of classroom academic performance and behaviour.

Types or presentations mattered.

ADHD-I among those more likely to show minimal or no response to Rx.
ADHD-C showed dramatic Rx effects.

Results suggest that neuropsychological impairment (ADHD-C vs. ADHD-I), but not baseline teacher ratings or classroom observations, can help clinicians determine the likelihood of medication response in children with ADHD.

To Further Complicate Matters ADHD changes over development.
(Willcutt, 2012, meta-analysis)

Inattention and hyperactivity-impulsivity stability over 5 year intervals.
Hyperactivity-impulsivity declines more.

Inattention more frequently persists. This suggests Cogmed is more relevant as those with ADHD age.

DSM-IV ADHD has “moderate stability over periods of up to 9 years, but the nominal subtypes are unstable in both systematic and unsystematic ways.”

How does WM of those with ADHD affect learning?
Poorer WM = more errors, slower learning, no automaticity.
(Huang-Pollock & Karalunas, 2010)

When a task has a low WM demand
Children with ADHD still make more errors and learn it more slowly.

When a task has a high WM demand
Children with ADHD don’t get to automaticity.

Result of these struggles: A distinct trajectory of less academic achievement.
Cogmed targets working memory which is highly correlated to only one dimension of ADHD: Inattention.

Does it make sense to evaluate Cogmed effects in the same way with a group that is predominantly ADHD-C in contrast to one that is predominantly ADHD-I?

ADHD-C has a similarly severe deficit of hyperactivity/impulsivity that is not a target of Cogmed. At least ½ their disorder is not addressed with Cogmed.

Could hyperactivity or impulsivity interfere with Cogmed for ADHD-C groups?

Willcutt’s et al., 2012 argues ADHD-HI is as an empirically negligible group with the exception of boys younger than 7 years old.

Is there a difference in severity between ADHD-C and ADHD-I with regard to severity of disorder that may affect the impact of Cogmed?

---

Learning disabilities.

(Reisberg-Bajzek, et al., 2010)

“Learning disabilities” refers to “roughly into two groups: specific learning disorders (LD), and general learning problems.”

“LD, like dyslexia or dyscalculia, refer to specific problems in a single domain of learning capacities or academic achievements.”

“Dyslexia is characterized by a specific and significant impairment in the development of reading skills (problems with accurate or fluent word recognition, poor decoding, poor spelling), while dyscalculia is characterized by a specific impairment in the acquisition of mathematical skills (Problems with processing of numerical information, learning arithmetic facts, performing accurate and fluent calculations).”

---

Consider Deficits associated with Dyslexia:
Poor Phonological Loop & Central Executive

(Barrow, et al., 2015)

“Poor readers” matched by age and gender with typically developing readers.

Measures: Phonological loop, central executive, visuospatial sketchpad & episodic buffer.

Poor readers were worse on phonological loop and Central Executive only.
Plot thickens: Processing speed, temporal processing and WM play a role in SLI. (Moll, et al., 2016)

N=99, 4 groups, reading disability (RD), math disability (MD), both, Typically developing.

There are high comorbidity rates between RD & MD.

All 3 risk factors related to poor attention: Processing speed, temporal processing & WM.

Control for attention and RD & MD differed, but both RD & MD had worse verbal memory than typically developing children.

RD worse processing speed but was restricted to nameable symbols.

MD associated with temporal processing and visuospatial memory deficits.

Meta-Analysis of oral language deficits in familial dyslexia (Snowling & Melby-Lervag, 2016)

Preschoolers: Phonological processing deficits, broader language skills (letter knowledge, phonological awareness & rapid automatized naming (RAN)) deficits.

Longitudinal studies: More severe impairments in preschool language than those defined as normal. Poor phonological awareness & literacy skills. Parents lower educational levels & read less frequently to themselves.

Pennington’s multiple deficits view of dyslexia (Carroll, et al., 2015)

Deficits in phonological awareness, print knowledge & rapid naming predict later reading difficulties.

N=267 children tested with wide battery of tasks associated with dyslexia. Then tested 2, 3, and 4 years later.

42 poor readers were later identified.

Deficits: Poor print knowledge, verbal short-term memory, phonological awareness and rapid naming were good predictors of later poor reading.

Also deficits in visual search and auditory processing present in a large minority of poor readers.

Almost all poor readers showed deficits in at least one area.

No single deficit characterized the majority of poor readers.

HENCE: Supported Pennington’s multiple deficits view of dyslexia. Multiple interacting factors combine to result in poor reading.

Intervening in only WM and/or STM may not address all deficits that have lead to poor reading.
Difficult to differentiate. Yet has significant clinical relevance.

“The term general learning problems refers to non-specific and possibly co-occurring disabilities in the following areas: 1) receptive language; 2) expressive language; 3) basic reading skills; 4) reading comprehension; 5) written expression; 6) mathematical calculation and reasoning; and 7) attention (Lyon, 1996).”

“The group of learning problems is a heterogenic group characterized by a broad range of symptoms driving diverse academic achievement problems. Although symptoms may (at some stage) not meet DSM criteria for ADHD or LD, they may be associated with sub-threshold psychiatric problems. Children with learning problems may be “overlooked” struggling students, meeting minimal academic standards, often caused by processing strength and weaknesses that adversely affect school achievement.”

It appears somewhat more likely that WM deficits may be a bottleneck among these students, but this a defined and poorly defined group making this unclear.

Improved WM has potential to have a notable impact upon learning, but there are limiting or facilitating factors.
The Far Transfer Challenge.

Skill/behavior 'Far Transfer'
- Reading comprehension
- Math skills
- Language development
- Improved rate of learning

Generalized Effects 'Near Transfer'
- On task behavior
- Reduced Cognitive Failure
- Following Instructions
- Attention/Concentration

Executive functions
- Working memory
- Planning
- Initiating
- Task monitoring
- Organizing

"WM may be necessary but not sufficient. May need domain specific skills, may need improved domain general executive functioning skills. Is near transfer necessary for far transfer?"

Can improving WM open the door to gains? It depends… factors which may limit or facilitate gains…

Limiting factors?
- ADHD-C?
- Comorbid disorders?
- Learning Disabilities?
- Learning Problems?
- Processing problems?
- Slow processing speed?
- Phonological awareness?

Facilitating factors?
- Dosing of Cogmed?
- Motivation?
- Rx?
- Cogmed-Plus/remediation?
- Domain general training?
- Domain specific training?

Van der Donk, et al., 2016 supports notion implicit in this table: Far Transfer (red) is more likely among those with moderate severity & Rx is a factor to consider.

<table>
<thead>
<tr>
<th>Study</th>
<th>WM article</th>
<th>ADHD-C</th>
<th>ADHD-HI</th>
<th>Rx%</th>
<th>MT</th>
<th>Cogmed%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holmes &amp; Gathercole, 2013 (trial 1)</td>
<td>NR NR NR NR NR NR NR</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Holmes, et al., 2009</td>
<td>100%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Dunning, et al., 2013</td>
<td>100%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Bergman-Nutley &amp; Klingberg, 2014</td>
<td>100%</td>
<td>Mainly Attentive problems/minor HI</td>
<td>Minor HI</td>
<td>NR</td>
<td>NR</td>
<td>Minor</td>
</tr>
<tr>
<td>Holmes &amp; Gathercole, 2013 (trial 2)</td>
<td>NR</td>
<td>100%</td>
<td>Low aca. Perf.=learning problems</td>
<td>NR</td>
<td>100%</td>
<td>NR</td>
</tr>
<tr>
<td>Dahlin, 2010</td>
<td>NR</td>
<td>33% diag. 60% rated inatt.**</td>
<td>NR</td>
<td>NR</td>
<td>9.5%***</td>
<td>0%</td>
</tr>
<tr>
<td>Dahlin, 2013 (not randomized)</td>
<td>33% diag. 60% rated inatt.**</td>
<td>22%</td>
<td>NR</td>
<td>NR</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>Klingberg, et al. 2002</td>
<td>NR</td>
<td>100%</td>
<td>NR</td>
<td>43%</td>
<td>NR</td>
<td>0%</td>
</tr>
<tr>
<td>Klingberg, et al. 2005</td>
<td>25%</td>
<td>75%</td>
<td>0%</td>
<td>0%</td>
<td>NR</td>
<td>0%</td>
</tr>
<tr>
<td>Hovik, et al., 2013/Egeland .</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>69.6%</td>
<td>NR NA/0%</td>
<td>0%</td>
</tr>
<tr>
<td>Green, et al., 2012</td>
<td>42%</td>
<td>42%</td>
<td>17%</td>
<td>67%</td>
<td>0%</td>
<td>NR</td>
</tr>
<tr>
<td>Van Dongen-Boomsma, et al., 2014</td>
<td>7.7%</td>
<td>80.8%</td>
<td>11.5%</td>
<td>0%</td>
<td>3.8%</td>
<td>0%</td>
</tr>
<tr>
<td>Beck et al., 2010</td>
<td>NA</td>
<td>71%</td>
<td>29%</td>
<td>NR</td>
<td>61%</td>
<td>NR</td>
</tr>
<tr>
<td>Chacko, et al., 2013</td>
<td>34%</td>
<td>66%</td>
<td>0%</td>
<td>27%</td>
<td>NR</td>
<td>50%/9% *</td>
</tr>
<tr>
<td>Gropper, et al., 2014</td>
<td>-</td>
<td>51%</td>
<td>NR</td>
<td>26%</td>
<td>57%</td>
<td>NR</td>
</tr>
<tr>
<td>Gray et al., 2012</td>
<td>-NR</td>
<td>100%</td>
<td>NR</td>
<td>100%</td>
<td>100%/0%</td>
<td>0%</td>
</tr>
<tr>
<td>Van der Donk, et al., 2016 supports notion implicit in this table: Far Transfer (red) is more likely among those with moderate severity &amp; Rx is a factor to consider.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NR**: Not recorded
N = 99. ADHD (n = 45), LD (n = 34), learning problems (n = 20). Ages (7-17), 25 sessions of Cogmed.

WM, ADHD DSM-IV rating scales BRIEF scales used to measure outcomes.

Hypothesis: “training effects may lie on a continuum with those of the LD group at the lower end and those of the learning problems group at the upper end.”

Results: Partly confirmed the hypothesis in that all groups improved significantly with ADHD children or children with learning problems showing the best results. NOTE: The ADHD group had a majority of ADHD-I children.


ADHD (n = 45), n = 7 taking Rx (6 stimulants, 1 Medikinet). Rx stable before and after Cogmed.

• ADHD-I (n = 25), Note: A majority of those with ADHD has this less severe type of ADHD.
• ADHD-C (n = 13)
• NOS (n = 7)

LD (n = 34)

• Dyslexia (n = 25), Note: The vast majority here are dyslexic, hence our focus on the literature on this group.
• Dyscalculia (n = 3)
• NOS (n = 6)

Learning problems (n = 20)

JM for all but n = 4 who did JM all of these preschoolers diagnosed with ADHD were free of Rx.

Note: Additionally, they re-ran analyses excluding children on Rx, children who did JM (n = 4) and children with dyslexia (n = 3) and main and interaction effects remained.

LD: Diagnosed by a registered clinical psychologist in the Netherlands (Dutch guidelines).

Learning problems: Without a DSM-IV diagnosis. “These children were experiencing academic achievement problems (lower grades than expected) and mixed neuropsychological impairments (memory- or attention problems in the classroom), as well as learning-related behavioural problems (Alloway & Alloway, 2010). Learning problems were diagnosed according to an official Dutch system that monitors academic achievement at school supplemented by the clinical opinion of the clinical psychologist and reports by parents and teachers about the child’s development.”

Exclusion criteria: 1) a medical illness requiring immediate treatment as this meant that participating in an intensive training would be too demanding; 2) a motor or perceptual disability preventing the subject from using the computer program; 3) no access to a personal computer with an internet connection at home or in school; 4) a lack of motivation (e.g. willingness on the part of the parents to participate, but not on the part of the child); or 5) a co-morbid (psychiatric) diagnosis.
Cogmed with children with Different Neurodevelopmental Disorders

(ADHD, LD, Learning Problems)

(Roording-Ragetlie, et al., 2016)

Outcome Measures:

Dutch versions of the ADHD rating scale (ADHD Vragen, Lijst, AVL; Scholte & Van der Ploeg, 2005). One index was for inattention and a second for hyperactivity/impulsivity. Completed by parents.

BRIEF (Behavior Rating Inventory of Executive Function checklist). Completed by parents.

WM capacity measured by two Cogmed components within the training program (Training index).

All three groups showed significant gains suggesting all groups profit from training:

- Inattention (p<.0001) Eta=.57 - near transfer effect.
- Hyperactivity/Impulsivity (p>.0001), eta=.33 - not target of Cogmed.
- WM (p<.0001), Eta=.90 - Target of Cogmed.

However, children with LD benefited less than the other groups on:

- Hyperactivity/Impulsivity
- BRIEF Total

Also post hoc Bonferroni analysis revealed that Inattention was statistically different between the ADHD and LD groups.

When looked at more closely, children in our study with learning problems showed a considerably higher baseline measurement regarding hyperactivity/impulsivity problems (meaning more problems) compared to children with LD. Perhaps the fact that there was less room for improvement in the LD group may explain the difference found in terms of benefit between these groups. Or these differences may be statistical error or due to the measures used.
Limitations: “A major limitation of this study is the absence of a randomized design and a control condition. Therefore, the positive results in this study were not controlled for unspecific factors, such as invested time and attention, therapist interaction, or brain maturation.”

Another limitation could be that the only WM measurement used in this study was the WM capacity improvement index measured by the Cogmed© computer program itself, which is not a pure clinical measure and is susceptible to practice effect.”

“... our study shows that Cogmed WM training might be (more) useful for children with relatively mild or subthreshold psychiatric disorders or learning disabilities at risk for a severe psychiatric disorder. This might prevent the development of a full psychiatric disorder or severe academic achievement problems. Our findings show that the “at-risk-group” of children profit from a relatively short, but intensive Cogmed training program. Therefore, low cost interventions such as Cogmed WM training could possibly prevent the development of severe neuropsychiatric disorders.”

Rx use is low which is partly related to how the Dutch mental health care system works there. Psychological treatments are offered as the first line of tx for children with mild ADHD.
ADHD Subtype as Predictor of Treatment Outcome in Cognitive Training for Children with ADHD, Near Transfer

(Vander Donk, et al., 2016)

**ADHD Subtype:**
Predicted & Moderated Parent Ratings of EF:
ADHD-C: BRIEF behavioral regulation index rated by parents & teachers showed a decrease in behavioral regulation problems both directly post Cogmed and at follow up.

ADHD-I: Steep decrease behavioral problems post Cogmed, but increase at follow up.

**Teacher Rating of Beh. Reg. Index & Metacognitive Index:**
ADHD-C: Decrease of problems over time (both post and follow up) & no difference between intervention groups.

ADHD-I: Decrease in problems over time.

**Summary:** ADHD-I group benefited more both short and long term. In short-term ADHD-I benefitted more from Cogmed in general in terms of parent and teacher rated behavioral regulation problems. Long-term ADHD-I benefitted on teacher rated behavioral regulation, metacognitive problems. ADHD-C still showed more problems than children with ADHD-I subtype over time.

Children in PAC intervention: Increase of problems at follow up.

---

Initial Cognitive Abilities, subtype & comorbidity as Predictors of Treatment Outcome in Cognitive Training for Children with ADHD.

(Vander Donk, et al., 2016)

**Initial VSWM:**
Children 'below average' and 'average' showed improvements over time. Children 'above average' showed a decrease in performance over time, but were still higher than the other groups at all time points.

**Subtype of ADHD & Comorbidity:**
Predicted word reading accuracy.

---

ADHD Subtype as Predictor of Treatment Outcome in Cognitive Training for Children with ADHD, Far Transfer.

(Vander Donk, et al., 2016)

**ADHD-C:** Improved on word reading accuracy directly post Cogmed and was maintained at follow up.

**ADHD-I:** Decrease in word reading accuracy post Cogmed, but improved at follow-up & even outperformed ADHD-C children. THIS IS SURPRISING AND FAIRLY UNPREDICTABLE.

This finding highlights an element of unpredictability in the change process and the timing of change.

The overall trends of data in this study generally supported our hypothesis based upon previous data.
“Does WM training lead to generalized improvements in children with low working memory? A randomized controlled trial”

(Dunning, et al., 2013)

810 children ages 7-9 given Automated Working Memory Assessment (AWMA), verbal WM (backward digit recall) and VS WM task Mr. X involving recalling a series of locations, interspersed with mental rotation decisions.

n=94 children at or below the 15th percentile on both WM tests with English as their first language (47 boys, mean age=8 yr, 5 m),

3 groups: Adaptive training, non-adaptive training, no intervention.

6 weeks of training. Then follow-up assessments.

Follow up at 12 months: 15 schools in adaptive, 19 in non-adaptive groups. Schools randomly assigned to adaptive or non-adaptive training.

Classroom-based tasks administered: following instructions, rhyme recall, sentence counting (processing), sentence counting (storage).

A Randomized, Controlled trial (RCT) (2)

(Dunning et. al., 2013)

Training: Conducted within school in GROUPS of 6-12 under a researcher's supervision. Children received small rewards like stationery items for every 5 training sessions completed. Not all motivational features were equated across the two programs.

Total time spent on task: was recorded in the Cogmed log and was comparable across groups 80% adaptive 82% non-adaptive. This was a response to criticism of previous research.
RCT (3) Impact upon WM
(Dunning, et al, 2013)

<table>
<thead>
<tr>
<th></th>
<th>Adj. vs non</th>
<th>Adj. vs no int.</th>
<th>Non-ad vs no int.</th>
</tr>
</thead>
<tbody>
<tr>
<td>WM</td>
<td>1</td>
<td>.71</td>
<td>.43</td>
</tr>
<tr>
<td>AWMA</td>
<td>1.32</td>
<td>.37</td>
<td>.57</td>
</tr>
<tr>
<td>VSTM</td>
<td>2.73**</td>
<td>.43</td>
<td>.63</td>
</tr>
<tr>
<td>WSTM</td>
<td>2.83**</td>
<td>.57</td>
<td>.77</td>
</tr>
</tbody>
</table>

*p< .05, **p<.01, ***p<.001.

RCT (4) Impact upon Class-based tasks
(Dunning, et al, 2013)

<table>
<thead>
<tr>
<th></th>
<th>Adj. vs non</th>
<th>Adj. vs no int.</th>
<th>Non-ad vs no int.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FI</td>
<td>2.59*</td>
<td>.71</td>
<td>.57</td>
</tr>
<tr>
<td>Rhyme recall</td>
<td>.59</td>
<td>.32</td>
<td>.26</td>
</tr>
<tr>
<td>Sentence counting</td>
<td>.59</td>
<td>.32</td>
<td>.26</td>
</tr>
<tr>
<td>Sentence counting (processing)</td>
<td>.59</td>
<td>.32</td>
<td>.26</td>
</tr>
<tr>
<td>Basic Reading</td>
<td>1.52</td>
<td>.36</td>
<td>.57</td>
</tr>
<tr>
<td>Written Exp.</td>
<td>1.99*</td>
<td>.69</td>
<td>.62</td>
</tr>
<tr>
<td>Attentional Omissions</td>
<td>.47</td>
<td>.19</td>
<td>.23</td>
</tr>
</tbody>
</table>

*p< .05, **p<.01, ***p<.001.

RCT (5)
(Dunning, et al, 2013)

Cogmed significantly boosted performance on untrained WM tasks in children with low WM.

This enhancement was substantial in magnitude and was partially sustained for 12 months.

Adaptively trained children made significantly greater improvements in tests of VS STM & Verbal and Visual Spatial WM than non-adaptively trained or those that received no intervention.

1st double-blinded RTC study on this key group of poor learners that meets stringent criteria for intervention research. Results reinforce earlier outcomes with low WM kids (Holmes, et al., 2009).
Classroom behaviors did not show sustained improvement at one year. At follow up accuracy in sentence counting (processing) correctly the number of words in a sentence did improve.

Suggested that scaffolding may be required for training to generalize and be effective in new situations (Wilson, 2008) (Cogmed Plus).

The greatest improvements in WM following training were observed in complex span measures strongly associated with children’s academic achievements in literacy and mathematics (Swanson & Siegel, 2001; Alloway, Gathercole, Wills & Adams, 2004). Response to research. It is possible that outcome measures lacked sufficient subtlety to detect changes that more process-oriented measures may find.

PRIORITY: Establish whether other training activities can be developed to promote the “application of these enhanced WM skills to less predictable memory-demanding situations in the classroom.”

<table>
<thead>
<tr>
<th>Study</th>
<th>WM deficit ADHD-I Attention problems ADHD-C ADHD-HI Rx% LD ODD/CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dahlin, 2010</td>
<td>NR 33% diag. 60% rated inatt.** NR NR NR 9.5%*** 0%</td>
</tr>
</tbody>
</table>
WM training effects on reading in ADHD or inattentive Children with learning problems (2) (Dahlin, 2010)

Table 1: WM training effects on reading in ADHD or inattentive Children with learning problems (2) (Dahlin, 2010)

<table>
<thead>
<tr>
<th>Time</th>
<th>Treatment group</th>
<th>Control group</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=10</td>
<td>N=10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>N=10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SD</td>
</tr>
<tr>
<td>0</td>
<td>7.0</td>
<td>1.8</td>
<td>6.5</td>
</tr>
<tr>
<td>1</td>
<td>8.3</td>
<td>1.9</td>
<td>7.5</td>
</tr>
<tr>
<td>2</td>
<td>8.8</td>
<td>1.8</td>
<td>8.0</td>
</tr>
<tr>
<td>3</td>
<td>9.2</td>
<td>2.0</td>
<td>8.5</td>
</tr>
<tr>
<td>4</td>
<td>9.6</td>
<td>2.2</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Children Identified by a lack of educational achievement who arguably in our context may fit the group categorized as having “learning problems”

Children with poor Educational Achievement (Trial 2, Holmes & Gathercole, 2013)

<table>
<thead>
<tr>
<th>Study</th>
<th>WM index</th>
<th>ADHD-I</th>
<th>ADHD-C</th>
<th>ADHD-HI</th>
<th>RX%</th>
<th>LD</th>
<th>ODD/CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holmes &amp; Gathercole, 2013</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>100%</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Low aca. Perf.</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>100%</td>
<td>NR</td>
<td></td>
</tr>
</tbody>
</table>

Children with poor educational achievement were identified as having low scores in reading, writing, speaking, and listening skills.

Subjects included 50 children aged 9–11 years who were subgrouped into three groups: ADHD-I, ADHD-C, ADHD-HI, and RX%.

The study aimed to investigate the effects of WM training on reading performance in children with ADHD, with a focus on low academic performance.
Data are presented separately because year 5 and year 6 have distinct status in the UK state education system. SAT’s are required in year 6 and optional in year 5.

The year 5 group was trained as one group of 25 supervised by the head teacher and a classroom assistant. (Whole class)

Year 6 was trained in two smaller groups (n=13, n=12) supervised by the same staff at the end of the school day.

<table>
<thead>
<tr>
<th></th>
<th>Year 5</th>
<th></th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trained Group</td>
<td>Comp. group &amp;</td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>1.48 (1.56)</td>
<td>2.36 (1.55)</td>
<td>.56</td>
</tr>
<tr>
<td>Math</td>
<td>1.36 (1.29)</td>
<td>-1.04 (2.88)</td>
<td>1.15</td>
</tr>
<tr>
<td>(standard deviation)</td>
<td>(standard deviation)</td>
<td>(standard deviation)</td>
<td>(standard deviation)</td>
</tr>
</tbody>
</table>

Children with poor Educational Achievement
(Trial 2, Holmes & Gathercole, 2013)

Cogmed & ADHD
10-12 year old ADHD children make and maintain significant gains in WM for 8 months. RCT
(Hovik, et al., 2013)

<table>
<thead>
<tr>
<th></th>
<th>WM deficit</th>
<th>ADHD-I</th>
<th>ADHD-C</th>
<th>ADHD-HI</th>
<th>Rx%</th>
<th>LD</th>
<th>ODD/CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>69.6%</td>
<td>70%</td>
<td></td>
<td>NA/0%</td>
</tr>
</tbody>
</table>

RCT results: Systematic training resulted in long term gains (8 months).
Evidence for both domain-general and domain-specific models.

Design: Randomized, Placebo controlled Trial, RCT.
Treatment vs. treatment as usual 8 month follow-up. Control group received special education treatment as usual & health care follow-up.

MEASURES: 6 measures of each form of WM, divided into auditory WM, visual WM, and Manipulation WM

RESULTS: All treatment subjects significantly improved on all measures of WM. Improved significantly more on Visual WM than auditory WM. Manipulation WM gain remained after controlling for increase in simple storage.
Gains were found in both domain general and domain specific areas.

Cognmed Training results in improved psychomotor speed & reading. RCT (Same subjects as Hovik, et al., 2013) (Egeland, et al., 2013)

<table>
<thead>
<tr>
<th></th>
<th>WM deficit</th>
<th>ADHD-I</th>
<th>ADHD-C</th>
<th>ADHD-HI</th>
<th>Rx%</th>
<th>LD</th>
<th>ODD/CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>69.6%</td>
<td>70%</td>
<td></td>
<td>NA/0%</td>
</tr>
</tbody>
</table>

Normalisation before Cognmed:
- No differences between groups regarding medications were found.
- The majority of subjects performed in the normal range or below on the CCP-II before Cognmed.
- On rating scales teachers rated them in the normal range and parents rated them in the highly symptomatic range.
- Children referred for medications may be more impaired.
- They hypothesized that children who have optimized their behavior due to Rx may show less treatment effect.
- Suggestion: Control for medication.

Summary
- Working Memory, among those with ADHD, tends to develop minimally whereas it increases substantially for typically developing children.
- To understand the varying impact of Cognmed one needs to consider the following issues:
  - ADHD-C is a more severe disorder than ADHD-I.
  - Co-morbidity can limit or interfere with the impact of Cognmed.
  - Rx for some students may be necessary along with Cognmed.
  - ADHD-I students tend to have more problems with academic problems than ADHD-C students.
  - Inattention tends to persist into adulthood whereas hyperactivity/impulsivity tends to wane.
  - More girls have ADHD-I than ADHD-C.
  - Learning Disabilities are often considered more severe than Learning Problems.
  - Learning Disabilities often include deficits in addition to WM deficits. As such after completing Cognmed additional remediation is often needed to get far transfer.
  - More girls have ADHD-I than ADHD-C.
  - Learning Disabilities are often considered more severe than Learning Problems.
  - Learning Disabilities often include deficits in addition to WM deficits. As such after completing Cognmed additional remediation is often needed to get far transfer.
  - There are several limiting & facilitating factors to far transfer of Cognmed effects.
  - Cognmed specific studies have found that among those subgroups that those with learning problems and ADHD tend to have stronger responses to Cognmed than those with diagnosis learning disabilities.
Thank you!