

## ECOC conference

### **Recognizing and Reaching Children with Learning Difficulties, AD/HD and Related Conditions across Languages and Cultures**

This one-day conference, sponsored jointly by Europe's Children Our Concern (ECOC) and ADHD Belgium, and part-funded by the King Baudouin Foundation, took place in Brussels on October 8. The event attracted an audience of some sixty people from a variety of backgrounds: teachers, child psychiatrists and psychologists, parents and others interested in the field of learning disabilities. They were welcomed by Richard "Chalks" Corriette, president of ECOC and Rita Bollaert, co-founder of ADHD-Belgium. Ms Bollaert explained that ADHD-Belgium is an umbrella organization comprising the Flemish, French, German and English-speaking AD/HD organizations in the country. Their main aims are to share knowledge, best practices and experts across languages and cultures; and to lobby the Belgian government, the EU and the school systems in order to raise awareness about AD/HD on a national level, so that those affected could have better access to medication, treatment, accommodations and education in Belgium.

The four speakers were:

**Dr Laurent Victoor from Belgium.** A child and adolescent psychiatrist and specialist consultant for children, teenagers and adults with AD/HD.

**Dr Steve Chinn from the United Kingdom.** An expert in dyslexia and mathematics, and dyscalculia, Steve has a background of forty years teaching in mainstream schools, in further education and in special education. He now travels extensively giving training courses and delivering lectures on these topics. [www.stevechinn.co.uk](http://www.stevechinn.co.uk).

**Sari Solden from the United States of America.** A psychotherapist in private practice, Sari has worked with adults with AD/HD for twenty years. Her specialisms include gender issues affecting women and girls with AD/HD, and inattentive AD/HD. For the purposes of this conference she brought with her, as special guest and co-presenter, Dr Ellen Littman.

**Dr Ellen Littman from the United States of America.** A clinical psychologist licensed in New York State, Ellen works across the spectrum of attention disorders, focussing on the high IQ AD/HD population. She specialises in women's and girls' issues.

#### ***"Individual Solutions for Individual Cases"***

Dr Laurent Victoor was the first speaker and gave a lively presentation on the symptoms of AD/HD. He used everyday examples to illustrate how challenging life was for children and young people coping with this particular condition, explaining how the filters that normally help a person to focus and concentrate do not work effectively for this group. He likened the experience to trying to see properly, if your eyesight is poor, without the use of glasses. He pointed out that AD/HD sufferers can learn to compensate in their behaviour in order to overcome everyday problems and used the example of how one of his patients never lost anything (although losing things is a classic symptom) – but only because he laid out all the things he needed in the same place every day.

Dr Victoor went on to consider the use of medicine, specifically Rilatine (the name used in Belgium for Ritalin), for alleviating the symptoms in cases of moderate to severe AD/HD, suggesting that the guiding principle should be: "Only treat when there is suffering." The goal should be to improve the quality of life for individuals and the success that they enjoy at school. Any prescribing should always be part of a multi-disciplinary approach and should be regularly checked. It was essential to also

understand the child – to know his or her psychological make-up - and to understand the environment within which he or she functioned. He acknowledged the controversy around Rilatine and other medicines and said he found it helpful to explain at the outset that Rilatine was:

- Not an alcoholic substance nor an amphetamine
- Not dependency-inducing
- Not growth-restricting (although it does lessen hunger)

Parents were often amazed at the change in their children, feeling that they were different people, but happy at the result.

Dr Victoor acknowledged that it was possible to avoid Rilatine by having very small classes (five at the maximum) and allowing a range of modifications when it comes to school examinations. But he also suggested that this was not possible in the majority of schools.\* Medicine, given in the correct dosage for each individual, can be “magic” he maintained. The older children among his patients managed their own treatment, deciding for themselves when a dose was necessary.

Questions centred on the particular situation in Belgium where teachers and other professionals have been slow to acknowledge AD/HD. “It’s just the fault of working parents” say some; or “it’s a condition that’s been invented in America.” Dr Victoor spoke of the lack of doctors that specialise in the condition and how many of his colleagues look down on the work that he does. “You’re the guy that drugs children,” some say.

However, several participants drew attention to the improvements that there have been over the last five years, with teachers being trained in teaching children with learning disabilities and parents and others organising lobby groups to press for action. People felt it was essential to keep spreading the message.

It was suggested that there was a clear difference between Wallonia and Flanders in their approach to AD/HD, perhaps echoing the difference between the Latin and the Anglo-Saxon. In the former case, it seems to be a matter of excluding the child from mainstream education by providing special schools, whereas in the latter the goal of inclusion is paramount. An interesting statistic shows that Flanders accounts for roughly four times the amount of Rilatine sales in comparison with Wallonia.

Dr Victoor was asked about who to send children to for a diagnosis and he acknowledged it was very difficult, because of the lack of specialists. He himself had too many patients.

Joanne Norris from ADHD Family Resources Brussels commented that her organisation has a regularly updated list of doctors who will treat AD/HD. Contact [adhd.resources@gmail.com](mailto:adhd.resources@gmail.com).

*\* In the conversations during the coffee break, a few teachers mentioned that such modifications are put into practice in the schools in which they teach. They recognised however that this was not the norm in Belgium.*

### **“Learning takes place within a relationship”**

Dr Steve Chinn continued Dr Victoor’s multi-dimensional theme, emphasising that with children who have difficulties with maths (because of dyslexia, AD/HD and/or dyscalculia) no one approach will fit all. There are many factors involved which all interact differently. The only sure fact is, “children are unpredictable”.

Steve made it clear from the start that he “doesn’t do methods”. There are no quick fixes and a key first step for the teacher, when problems occur, is to check out exactly what it is that is getting in the

way of learning. Mathematics is a complex discipline, threaded through with inconsistencies – there are three different ways to set out a division calculation, for example. Its language can be confusing and the requirement to carry out calculations at speed will induce high anxiety and almost certain failure in a child with special learning needs. Sometimes the problem can be traced to a visual issue – is there simply too much information on a page so that it is no longer plain what is required? Is the space on the page well organised so it's clear where you should write? Are the symbols clear? It can be the environment. Maybe that classroom, so beloved of teachers and parents, which shows all the many activities that the children are undertaking, that is rich in colour, shapes, words and numbers, is simply intimidating to the dyslexic and AD/HD child. Memory also plays a key part. Maybe the short-term/working memory is not functioning as it should, or maybe it's with the long-term memory, whose role is to build up the core of mathematical knowledge, that the problem lies.

Steve pointed out that the structure of a country's national curriculum is laid down by its government, and politicians do not necessarily understand the needs of children with learning difficulties. Parental (and teacher) expectations can also be hard, inducing anxiety which inevitably effects performance.

What can the teacher do? There are always factors to check. Can the child see and hear properly? Are the fonts that are being used clear to read? Experimenting with print and paper contrast and with background colour to see what works best can make a big difference. Understanding the student's learning style is also important and getting to know how they process information. Steve gave an example of working with one young girl. Asked what half of 50 was, she knew the answer immediately. When it was presented to her as  $\frac{1}{2} \times 50$  she didn't know. When asked which number was greater, 25 or 50, she didn't know and so answered "yes."

Speed is also a big issue and the pressure to perform quickly can be cruel. If the child is given considerably more time to come up with the answers this can greatly increase chances of success. Steve talked about two common thinking styles – the inchworm (step-by-step, reliant on formulas) and the grasshopper (intuitive, holistic). For the dyslexic child the inchworm approach feels much safer.

### ***Attention Deficit Disorder - Consistently Inconsistent***

As the final contributors to the conference, Sari Solden and her guest, Dr Ellen Littman, were also fully supportive of the whole child approach when treating girls with AD/HD. Early recognition is vital, they said, as is the role that education can play in giving healthy messages to these young people as they grow up. Thus encouraged, they are able to develop significant talents and strengths.

Dr Littman gave some useful background, explaining that the symptom of hyperactivity had first been identified at the turn of the 20<sup>th</sup> century and at that time was called "minimal brain damage" – a term that lasted until the 1950s. All the studies done in this period were on young white boys and the statistics gathered from this group formed the basis of the diagnostic manual used by the professionals. In view of this it is easy to see why the belief that "girls don't have Attention Deficit Disorder" was very prevalent. Similarly, because the symptoms of the boys that were studied tended to decrease markedly at puberty (unlike girls who show intense symptoms at this stage), it was thought that adults too could not be affected.

Knowledge moves on, but today, because many of the symptoms are common, there's a tendency to say "everyone has ADD". It is, of course, a continuum. Undoubtedly, much of the population have some of the tendencies – untidiness, lack of focus – some of the time. It only becomes a problem when the symptoms actually affect the way you are able to function in life. Diagnosing AD/HD is a complex matter and takes some time. Among the classic "red flags" that the professionals look for are pervasive disorganisation, a chronic inability to get started on tasks, anxiety and depression; the

impossibility of working out how to tidy up; daily living tasks that become difficult to carry out and give rise to social and school problems.

The speakers went on to explain that there are three main types of AD/HD:

- Predominantly hyperactive/impulsive type
- Combined hyperactive, inattentive type
- Predominantly inattentive type (which can include restlessness)

and then spoke specifically about girls and young women, many of whom tend to fall into the latter category and can be easily overlooked as “daydreamers.”

However, it is not a simple matter of daydreaming – in reality life with AD/HD can be extremely tough. Young girls who live with it often have difficulty forming cohesive relationships; they tend to focus on their perceived deficits, and are prone to negative self-talk and making wrong choices as they seek to compensate. Risk behaviours – drug taking, promiscuity – can appear highly attractive as they provide immediate stimulation to engage the brain. Eating disorders are common. The neurotransmitter, Serotonin, which we now know is often low in people with AD/HD, is present in carbohydrates – pasta, chocolate, cakes etc –so overeating can seem to present a solution.

Sari and Ellen moved on to look at the various ways that girls with AD/HD can be helped. The goal, they said, was to create a life that works for the individual they are treating – a life that allows her to become more of what she is. Medication can be useful, they acknowledged, as it gives the brain a consistency of thought that can be relied upon. In addition, teachers, family and friends can:

- Make the environment predictable and safe
- Show that they value difference: expect respect and show respect
- Avoid always rushing to the rescue. Instead suggest useful strategies, such as more time to assimilate information or the reframing of a particular experience
- Counter the daily assaults on self-esteem by giving attention and affection
- Become an advocate, helping to spread knowledge and understanding.

The two presenters ended on a positive note. “The people that come to see us frequently say - make me normal. We always point out that people with ADHD can be incredibly cool. They often have huge energy, great problem solving abilities and a rich stream of creativity. We can give many examples from the worlds of business and the arts of respected and successful men and women who also live with AD/HD.”

Questions from the floor opened with one on the situation in Belgium where it was thought that work on AD/HD was not really welcome or understood. Sari and Ellen were quick to point out that there is still huge resistance in the USA. However, they saw the internet as an extremely useful tool in this situation. Individuals are able to contact one another direct, pass on information, provide support and organise lobbies. As with the earlier sessions, others also commented on the changes that are afoot in Belgium with an increasing number of teachers asking for information.

Another questioner noted that it is not only girls that have the inattentive, daydreaming-type of AD/HD and Sari confirmed that boys do fall into this category too. She also advised that when it is a question of both the mother and the daughter having AD/HD – not that rare an occurrence - it is best to start treating the mother first. It’s also a good idea to seek outside help – either from family members or a paid worker.

The conference ended with a rousing call from ECOC’s president for involvement and commitment. Working together, it’s possible to learn how to be creative within the rules, to influence the decision makers and to bring about the sort of inclusive education which benefits all children, not just those with AD/HD and learning difficulties. Certainly the conference speakers are doing their bit to carry the

message worldwide. Next ports of call for Dr Chinn were Singapore and Dubai, Sari Solden was journeying on to London and to Germany and Ellen Littman was bound for Sweden.