Apathy and impulsivity after traumatic brain injury

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Introduction.– Apathy and impulsivity are two disorders frequently encountered after severe traumatic brain injury (TBI). However, there has been little research on the underlying nature of these behavioural modifications.

Objective.– To assess components of apathy and impulsivity after TBI, their psychosocial consequences, and the burden experienced by the relatives.

Method.– 38 close relatives of severe TBI patients were asked to complete four questionnaires: the UPSS impulsivity scale, short version [1], the apathy inventory [2], the Sydney psychosocial reintegration scale [3] and the Zarit Burden Inventory [4].

Results.– TBI patients showed on the UPSS significantly higher levels of urgency, lack of premeditation, and lack of perseverance, and a significant decrease of sensation seeking, as compared with their pre-injury status (P < .05). Apathic symptoms were reported, concerning the three dimensions of apathy. Psychosocial problems, and the relatives’ burden both significantly and positively correlated with loss of initiative (P < .01) and with all dimensions of impulsivity (P < .05), except with sensation seeking. A positive significant correlation was found between lack of perseverance on the one hand and lack of initiative (P < .01) and loss of interest (P < .05).

Discussion.– TBI patients showed, in comparison with pre-injury, a significant increase of both impulsivity and apathy. These modifications were significantly correlated with psychosocial problems and the relatives’ burden. The underlying cognitive and motivational bases of these changes need to be further studied.

References


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was most often good, as all the scales successfully discriminated children with ABI from matched typically developing children.

**Discussion.**– Overall, few measures were found; eight were still experimental tasks which did not provide manuals or norms, including all four tasks using observation of actual performance in a natural environment. Executive functions were better represented in ecological assessments, with relatively more standardised scales available. Further studies are needed, to validate the tasks that are still experimental, and to better evaluate the usefulness of most scales for assessing children with various acquired brain conditions.

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**Assessment of executive functions in children diagnosed with a developmental dyspraxia: Comparison of conventional neuropsychological approach and a more ecological approach**

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**Keywords:** Developmental dyspraxia; Developmental coordination disorder; Executive functions; Ecological task

**Introduction.**– The various cognitive models of developmental dyspraxia (DD) are still very controversial (role of perceptive analysis disorders, planning, mental representation, gesture programming). Yet, executive functions play a major role in the child’s cognitive development.

**Objective.**– To assess executive functions in children diagnosed DD, using a combination of standardized paper-and-pencil neuropsychological tests and ecological tests.

**Methods.**– Inclusion criteria: children aged 8 years to 12 years 5 months at the time of the study, for who DD had been diagnosed between January 2008 and August 2009. Exclusion criteria: verbal IQ < 70 and dyslexia.

**Assessment tools.**– Paper-and-pencil neuropsychological tests (Trail Making Test; subtests of the NEPSY: tower, auditory attention, verbal fluency; Marquet-Doléac test of matching images); more ecological “paper-pencil” tests (Six Part Test; subtests of the NEPSY: tower, auditory attention, verbal fluency; Marquet-Doléac test of matching images); more ecological “pencil-paper” tests (Six Part Test, 2 sub-tests of the Rivermead Behavioural Memory Test), 2 dysexecutive questionnaires answered by the parents: the Behavior Rating Inventory of Executive Function and the Dysexecutive Questionnaire for Children, and finally an ecological task performed in an open-ended environment: the Children’s Cooking Task (CCT) (Chevignard et al. 2009). In the CCT, children were compared with matched controls.

**Results.**– 13 children participated (11 boys; mean age 10.3 years). In the neuropsychological tests, the group exhibited slow processing speed and impaired performance in visual-spatial tasks, which was expected. Impaired planning and inhibition were found, whereas flexibility was within the normal range. Questionnaires highlighted executive disorders in everyday life in more half of the cases. Impaired planning and inhibition were found, whereas flexibility was within the normal range. Questionnaires highlighted executive disorders in everyday life in more half of the cases. Impaired planning and inhibition were found, whereas flexibility was within the normal range. Questionnaires highlighted executive disorders in everyday life in more half of the cases.

**Discussion and conclusion.**– The assessments used in this study consistently suggest that children with DD suffer executive functions disorders. The ecological tests seem to be more sensitive to a dysexecutive syndrome than the conventional tests, as previously known in adults or children with acquired brain injuries.

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**Communication impairment in daily living in stroke patients with aphasia**

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**Keywords:** Aphasia; Communication; Recovery; Prognosis

Although aphasia has been largely studied as a linguistic impairment, little is known about the communication activity limitation that aphasic patients may suffer in daily living.

**Aims.**– Providing further information about communication activity in stroke patients with aphasia.

**Patients and methods.**– Prospective, multicentric cohort study of patients with aphasia consecutively included after a first documented stroke. Patients were examined within the first month post-stroke, then 12 to 18 months later at their homes. Assessment included 2 stroke severity scale: the Orogogo score (OS) and the Barthel Index (BI), a comprehensive and well-known aphasia battery, the BDAE, a communication questionnaire, the ECVI, and a depression scale designed for aphasic patients, the ADRS.

**Results.**– One hundred and sixty four patients were included. At the date of follow-up, 34 were dead, 19 were lost for follow-up and 11 refused the second assessment. Among the 100 others, 24% suffered a severe aphasia (BDAE severity score 1 and 2), 12% a moderate (BDAE score 3) and 64% a mild aphasia (score 4 and 5) at follow-up. The mean communication score was 64 ± 32 on the ECVI. Talking the first especially with unknown persons, conversation on abstract topics, using a phone, reading and writing administrative documents,