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## **Misidentification of Behavioural Disorders in Able Dyslexic Children**

### **Challenging Behaviour**

Some children presenting a great challenge to teachers, who find it difficult to cope with their classroom behaviour, have been identified as having emotional or behavioural problems. In fact, they are often very able dyslexic individuals whose teachers - and other people around them - do not sufficiently understand or accept behaviours that are manifestations of dyslexia in learners who may also be intellectually or creatively gifted. When neither dyslexia nor high ability is identified and explained, these children often choose to act in such a way that might attract help.

Unfortunately, this does not always work - an apparently capable child who appears to be depressed, unmotivated, failing in school and functioning poorly in the family, who may present violent, disruptive outbursts will most probably be referred for assessment to the family GP or the school's behaviour support team - who are unlikely to consider whether dyslexia may be present. By the time an educational psychologist is consulted, any dyslexia has been ignored or misunderstood and the child labelled as stubborn, self-centred, unsociable, disruptive or withdrawn and only social/emotional /behavioural strategies are requested.

### **Dyslexia masked by ability**

Many able dyslexic children experience another form of misidentification. Their dyslexia is obscured because, with their high cognitive ability, they are able to cover up or compensate for their problems, so parents and teachers mistakenly think that they are simply of low-average ability with little interest in some aspects of learning. They achieve at an age-appropriate level, so neither their dyslexia nor their high ability is identified - resulting in a lack of appropriate support and challenge in the curriculum, often leading to loss of interest in conventional learning and a focus on unusual activities or 'dropping out' or associating exclusively with low achievers or the disaffected. Even though parents and teachers are satisfied with their attainment, gifted dyslexic children are not, and

### **Misidentification**

Misdiagnoses are sometimes made by well-meaning clinical professionals - doctors, psychologists and counsellors - who are unaware of characteristics of able dyslexic children which may mimic or be co-morbid with conditions such as ADHD, Obsessive-Compulsive Disorder, Asperger's Syndrome, Oppositional Defiant Disorder or clinical

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depression – sometimes resulting in young people with dyslexia being given unnecessary medication and inappropriate counselling/therapy.

This medication, counselling and/or therapy is designed to change (or modify) behaviour so that the youngsters will behave within 'acceptable' limits in school, or the family, or so that they will accept their situation. If children/young people are given labels that may harm their self-esteem and result in treatment that is unnecessary and even harmful to them - the root cause of their difficulties – the dyslexia - remains unidentified and unsupported.

There is a small group of – possibly intellectually gifted - dyslexic children who do suffer from very real disorders, but if neither they nor the treating professionals are aware of their dyslexia or high ability, any medication and counselling may be appropriate to the disorder, but not effective while the dyslexia remains unidentified.

### **Why dyslexia is not always identified in able and gifted children**

While GPs and other health care professionals may not be expected to learn about the behavioural, emotional and learning characteristics of dyslexic and gifted children, it is assumed (often incorrectly) that all teachers and psychologists have had this training. While some education professionals are fully conversant with the characteristics and intellectual diversity of dyslexic children, and about their typical social, emotional, and behavioural characteristics and needs, the classroom teacher is not usually aware of these. This lack of information and training of education (and health-care) professionals is the largest single reason for any failure to identify or misdiagnosis of dyslexia.

Even the physiology of dyslexic and gifted children may differ from their age-peers - they may have more allergies, sleep problems and uneven rates of development; they may suffer from 'existential depression' - when they feel that they do not fit in the family or the classroom – even wondering whether they are 'mad'.

Dyslexia in able teenagers is most often misidentified as a behavioural disorder. The diagnostic process may be inappropriate, undertaken by staff/practitioners who do not have the time or opportunity to investigate the whole person - psychological testing, for example, may be carried out in isolation from the context of other sources of information.

In order to produce a comprehensive profile of a learner, consideration of some of the subtle environmental factors that affect behaviour is essential – including an analysis of the behavioural 'triggers' e.g. for a refusal to cooperate in the classroom, could quickly indicate dyslexic difficulties.

Misidentification of dyslexia as emotional or behavioural disorders may happen because time constraints lead to snap decisions being made and individuals labelled and treated without adequate understanding of the circumstances that lead to manifestations of the 'problem' behaviour.