Disorder of written expression: A case report

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Abstract

Disorders of written expression often accompany reading or other learning difficulties. Not enough research has been carried out in isolated written expression problems in confrast isin other learning areas. In fact, it is debatable if isolated disorder of written expression exists at all. Associated features include low self-esteem, social problems and increased dropout rate at school. The diagnosis of written language disorder can help point the way toward necessary treatment and support. We report a case of disorder of written expression because of its rarity.

Key words: *Learning Disorder, Disorders of written expression, Dissociative Seizure, Bedwetting*

INTRODUCTION

Proficiency in written expression skills can be viewed as the culmination of a child's education. Writing is a complex task requiring the mastery and integration of a number of sub-skills. The process of writing connects cognition, language, and motor skills. Some children have difficulties in one aspect of the process, such as producing legible handwriting or spelling, while other children have difficulty organizing and sequencing their ideas. Difficulties in one area can delay skill development in the other areas, as practice of all writing skills may be impeded. Children often experience this disorder as thoughts that move faster than their hand can translate them into written ideas on the page. Children with written expression difficulties can find essential activities at school, such as note taking, to be insurmountable tasks. A person with a learning disability (LD) may experience a cycle of academic failure and lowered self-esteem[1,2] Having these handicaps or living with someone who has them can bring overwhelming frustration[3]

CLINICAL SUMMARY

The case of a 13 yr old boy, a student of standard VI in an urban setting. who is a right handed individual is presented He appears to be a normal child for his age he talks freely, enjoys playing cricket with his friends, is capable of self help skills like feeding, bathing, dressing etc. He was brought to the psychiatric OPD by his parents with complaints of poor academic performance since early schooling i.e. 1996. In addition it was also reported that the child exhibited temper tantrums, defiance and seizure like episodes when pressurized to perform better in studies. The seizure like episodes were characterized be tightening of limbs, up rolling of eyes and verbalizations that a ghost was coming to catch him. These symptoms had been present since last 4 years. Further exploration revealed symptoms of bedwetting, fearfulness, suicidal thoughts, and school refusal since last 3 years.

Family history revealed that he was the younger of two siblings. He had an elder sister who was 14 years old and was studying in ninth standard. Her academic achievement had been above average since early schooling. There was no family history of any mental illness or mental retardation. Relations were cordial. The child was delivered normally at term in 1992. He achieved early developmental milestones normally. He was immunized as per schedule. By 1995 years he had sufficient vocabulary to communicate his needs and his bladder control was satisfactory.

The child was admitted in a play school in 1996 where he adjusted well. He could easily learn a few poems, names of months, fruits, vegetables etc. However, when he went to Grade I, in 1997, the problem started. Whenever the teacher dictated alphabets, he wrote

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nothing on his slate or notebook. He resisted any attempts at help in writing and would merely start crying when scolded. He could not learn to write any alphabet on dictation even after one year of schooling. His parents were then advised to withdraw their ward from the school citing reasons that the child was a retarded one. The child then stopped feeding properly, became irritable and slept poorly. He was withdrawn from the school and kept in their native village in till 2000. He was also subjected to exorcism. During this period the child learned to write all the alphabets correctly with help from his elder sister. However, he was unable to form words on dictation. He learnt to write numbers and perform simple calculations.

In 2000, another attempt was made to initiate formal schooling but he continued to have serious difficulty in dictation writing. During exams he just left his answer sheets blank. Though he continued to be promoted along with his classmates till standard VI, he started manifesting temper tantrums, defiance, school refusal and seizure like episodes, whenever he was reprimanded for poor academic record or compared with other children. In addition he started bedwetting and became very shy in front of strangers.

Physical examination was unremarkable. Mental status examination revealed a kempt but shy individual who made adequate eye contact, followed simple instructions. There were no features to suggest any overt depression or psychosis. His IQ was 105 as tested by Bhatia Battery of Performance Test of Intelligence, which was within the normal range. However, a simple speech sample on oral dictation made the diagnosis quite clear (Figure

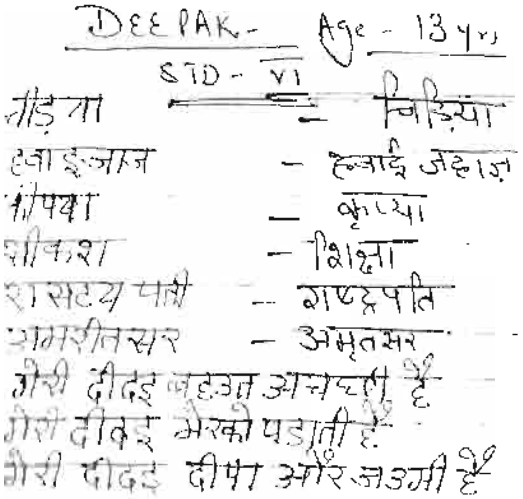

Figure 1 : Words on the left side are written by the child where as the words on the right side are written by the examiner.

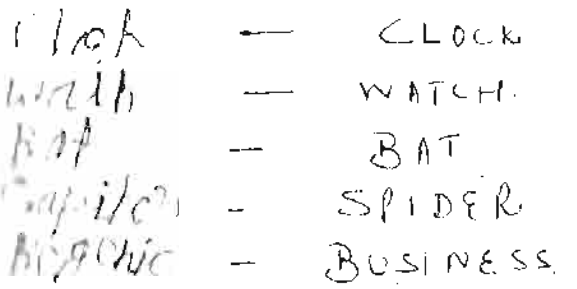

Figure 2 : Words on the left side are written by the child where as the words on the right side are written by the examiner.

1&2). It is of importance to note that this child had received formal education for more than 7 years in a school of suitable standard and child's spelling mistakes were of a significant nature. After ruling out probability of mental retardation (IQ 105), autism (good social reciprocation, no repetitive behavior and good oral skills) and attention deficit hyperkinetic disorder (normal activity and attention level), a final diagnosis of Dissociative Seizure and Learning Disorder (Disorder of Written expression) was made.

DISCUSSION

According to DSM IV TR (Diagnostic and Statistical Manual of Mental disorders fourth edition, text revision), the essential feature of Disorder of Written Expression is writing skills (as measured by an individually administered standardized test or functional assessment of writing skills) that fall substantially below those expected given the individual's chronological age, measured intelligence, and age-appropriate education (Criterion A). The disturbance in written expression significantly interferes with academic achievement or with activities of daily living that require writing skills (Criterion B). If a sensory deficit is present, the difficulties in writing skills are in excess of those usually associated with it (Criterion C). If a neurological or other general medical condition or sensory deficit is present, it is coded on Axis III. There is generally a combination of difficulties in the individual's ability to compose written texts evidenced by grammatical or punctuation errors within sentences, poor paragraph organization, multiple spelling errors, and excessively poor handwriting. This diagnosis is generally not given if there are only spelling errors or poor handwriting in the absence of other impairment in written expression. Compared with other Learning Disorders, relatively less is known about Disorders of Written Expression and their remediation, particularly when they occur in the absence

of Reading Disorder. Except for spelling, standardized tests in this area are less well developed than tests of reading or mathematical ability, and the evaluation of impairment in written skills may require a comparison between extensive samples of the individual's written schoolwork and expected performance for age and IQ. This is especially so in the case of young children in early elementary grades. Tasks in which the child is asked to copy, write to dictation, and write spontaneously may all be necessary to establish the presence and extent of this disorder. Disorder of Written Expression is commonly found in combination with Reading Disorder or Mathematics Disorder. There is some evidence that language and perceptual-motor deficits may accompany this disorder [4]

The prevalence of Disorder of Written Expression is not well delineated. Disorder of Written Expression is considered rare if the child does not have any other learning disabilities. There is little information on the Etiology of Disorder of Written Expression. It is postulated that there must be an automatization of most of the lower level mental activities for skilled writing. These lower level mental activities guide handwriting, spelling, word choice, and the construction of textual connections, specifically connections between sentences. The writer's attention can focus on the content, organization, and clarity of the task if these activities are functioning. One can shift attention between levels of mental processing without losing control of the text. Difficulties with lower level mental activities appear to be the source of problem in expressive writing disorder [5]

Formal methods of assessment and measurement of expressive writing have been developed[6], but adequate clinical screening can be obtained from samples of copied, dictated, and spontaneous writing. In evaluating disorders of written expression, it is worthwhile to screen for developmental coordination disorders and other motor abnormalities.

Although obtaining a diagnosis is important, even more important is creating a plan for getting the right help. Because LD can affect the child and family in so many ways that help may be needed on a variety of fronts educational, medical, emotional, and practical. But since children with disorders of written expression do have specific learning needs, it is important to provide special programs for them. Genuine remedial therapy is possible. [7] Educational interventions traditionally have consisted of alternative writing formats and skill building. Giving more time to write, providing assistance of computers with special emphasis on pictures or multimedia can help in their leaning. It is important not to segregate the affected child merely on the pretext of learning disability as it creates a sense of isolation and inferiority. It doesn't help parents to look backward to search for possible reasons. It is far more important for the family to move forward. The main emphasis lies in finding strengths and building the child's skills on those rather than fretting about the deficits. It does help in promoting the child's self esteem and his grooming as a normal and confident individual. [3]

REFERENCES

1. Bernstein BE, Luttinger HJ. Learning disorder: Written expression. *eMedicine* (serial on internet). 23 May 2006. (Cited 26 Sep 2006). Available from http//www.emedicine.com
2. Silver BL. Developmental learning disorders. In *Child & Adolescent Psychiatry. A Comprehensive Textbook*. Lewis M (ed). 3rd Ed. Philadelphia: Lippincott, William & Wilkins; 2002: 621-629.
3. Moore C. *Resources Guide for Parents of Children with Mental, Physical, or Emotional Disabilities*. Rockville, MD: Woodbine House; 1990.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: APA; 2000.
5. Uhry JK, Shepherd MJ. Writing disorder. *Child Adol Psychiatric Clin NA*. 1993; 2: 207-220.
6. Brown MB, Giandenoto MJ, Bolen LM. Diagnosing written language disabilities using the Woodcock-Johnson Tests of educational achievement-revised and the Wechsler Individual achievement test. *Psychol Rep* 2000; 87: 197-204.
7. Popper CW, Gammon GD, West SA, et al. Disorders usually first diagnosed in infancy, childhood or adolescence. In *Textbook of Clinical Psychiatry*, Hales RE, Yudofsky SG (eds). 4th ed. Washington DC: American Psychiatric Publishing; 2003: 833-974.