Letters to Editor

Dyslexia and Substance Abuse: The Under-Recognized Link

Sir,

World Federation of Neurology defines dyslexia as a disorder of reading in the presence of average intelligence, conventional instruction, and socioeconomic status.[1] Dyslexia is the most common learning difficulty. Prevalence estimates vary widely and range from 6% to 17% of the school age population depending on the severity of reading difficulties.[2] Not much is known about the relationship between learning disabilities and substance abuse but what is known is that learning disabilities increase the likelihood of drug abuse.[3] Understanding this comorbidity is important as it may affect the severity of the clinical picture, specific treatments and interventions.

Many reasons are postulated about the association of substance abuse and learning disabilities. For one, risk factors for adolescent substance abuse are very similar to the behavioral and emotional consequences of learning disabilities. Emotional problems, low self-esteem, and problems in peer relationships are common associated features of dyslexia.[4] Thus, dyslexia may indirectly lead to substance abuse by generating the types of behavior that lead adolescents to abuse drugs. Another reason for the association is through the common comorbidities that both the disorders share. Dyslexia rarely occurs in isolation and attention deficit hyperactivity disorder (ADHD) is the most frequent psychiatric disorder associated with dyslexia. Across studies estimations of dyslexia among children diagnosed with ADHD range from 10% to 40%.[5] Children with both dyslexia and ADHD are at a phenomenally increased risk for substance abuse and legal convictions if they do not receive appropriate interventions.[6] Conversely, there is also some preliminary evidence to suggest that individuals in substance abuse treatment have a higher incidence of learning disabilities than the general population.[7]

The important question is what needs to be done about this. Perhaps it can be summarized as alert, prevent and treat. Greater emphasis needs to be placed upon the early identification of dyslexia[8] and it is important to alert clinical psychologists, psychiatrists, pediatricians, parents and school teachers that learning disabilities may increase the risk for substance abuse. It would be essential to provide early remediation treatment for this problem to prevent the behavioral adverse effects and subsequent increased risk of substance abuse. Children with dyslexia and other learning disabilities should be screened for substance abuse, and those who start abusing drugs must receive treatment to deal with both their problems which may require specialized treatment settings. However, currently there is a lack of appropriate prevention and treatment services, and there is strong empirical evidence to highlight that the needs of this population have rarely been addressed.[9] Finally, there is a lack of research that has explored substance abuse by people with dyslexia and other learning disabilities in general. Hence, there is an urgent need for tailored research in this area to determine etiology, pathways of development and appropriate preventive and treatment measures.

Sonali Jhanjee
Department of Psychiatry, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, India

Address for correspondence: Dr. Sonali Jhanjee,
E-24, West Ansari Nagar, AIIMS Residential Campus,
All India Institute of Medical Sciences,
New Delhi - 110 029, India.
E-mail: sonali_arj@hotmail.com

REFERENCES
1. Critchley M. The Dyslexic Child. Springfield, IL: Charles C. Thomas; 1970.
2. Fletcher JM, Lyon GR, Fuchs LS, Barnes MA. Learning Disabilities: From Identification to Intervention. New York: Guilford; 2007.
3. Substance Abuse and Learning Disabilities: Peas in a Pod or Apples and Oranges? The National Center on Addiction and Substance Abuse at Columbia University, 2000.
4. World Health Organization. ICD-10, International Statistical Classification of Diseases and Related Health Problems. 10th Revision. Geneva: WHO; 1992.
5. Del’Homme M, Kim TS, Loo SK, Yang MH, Smalley SL. Familial association and frequency of learning disabilities in ADHD sibling pairs families. J Abnorm Child Psychol 2007;35:55-62.
6. Learning Disabilities: Multidisciplinary Research Centers,
Letter to Editor

Consultations can Produce not Just Equanimity, but Happiness

Sir,

'All we need to be really happy is something to be enthusiastic about', stated Charles Kingsley (1819-75), clergyman, historian and writer, whose novels greatly influenced the social life of the Victorian England. This concept goes a fair way to explain hobbies and fan clubs. It is here proposed as playing a part in some abnormal illness behaviour (AIB).

Somatic symptom disorder is characterised by excessive thoughts, feelings or behaviours related to somatic symptoms. Illness anxiety disorder is characterised by preoccupation with having or acquiring a serious illness in the absence of somatic symptoms. Factitious disorder is characterised by the falsification of physical or psychological signs or symptoms and deception. All such conditions may be included under AIB—'an inappropriate or maladaptive mode of experiencing, evaluating or acting in relation to one's own state of health, which persists, despite the fact that a doctor (or other recognised social agent) has offered accurate and reasonably lucid information concerning the person's health status and the appropriate course of management (if any), with provision of adequate opportunity for discussion, clarification and negotiation, based on a thorough examination of all parameters of functioning (physical, psychological and social) taking into account the individual's age, educational and cultural background'.

Drawing on ethological and clinical experience, such conditions/behaviours have been designated 'care-eliciting'.

The individual is believed to perceive a deficiency in what is supplied to them by the social environment. Such fearful individuals frequently present to the doctor in quest for human interaction and reassurance that their health matters are under control. Some individuals are enthusiastic about (intensely interested in) their health. Intellectualisation is available to avoid uncontrollable affective experience in the case of unfavourable facts.

While interaction with the doctor relieves fearfulness and apprehension, Kingsley's concept suggests such interactions in which health is the focus of discussion can take patients beyond equanimity, to the region of real happiness. This is subtly often overlooked and may help explain some frequent, unnecessary clinical presentations.

Saxby Pridmore
Professor of Psychiatry, School of Medicine, University of Tasmania, Tasmania, Australia

Address for correspondence: Dr. Saxby Pridmore, Professor of Psychiatry, School of Medicine, University of Tasmania, Hobart - 7000, Tasmania, Australia.
E-mail: s.pridmore@utas.edu.au

REFERENCES
1. Pilowsky I. Abnormal illness behaviour. New York: John Wiley & Sons; 1997. p. 25.
2. Henderson S, Byrne D, Duncan-Jones P. Neurosis and the social environment. Sydney: Academic Press; 1981.
3. Mack J, Semrad E. Classical Psychoanalysis. In: Freedman A, Kaplan H, editors. Comprehensive Textbook of Psychiatry. Baltimore: The Williams and Wilkins Company; 1967. p. 269-319.

Access this article online
Website: www.ijpm.info
DOI: 10.4103/0253-7176.162905