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THE MIRAGE OF THE PERCEPTUALLY HANDICAPPED SYNDROME

It is very popular today to make the diagnostic inference of perceptual-motor dysfunction to explain learning and behavioral disorders of many children. Indeed, judging from frequency of appearance of such terms as Dyslexia (Park, 1953), Learning Disabilities (Masland, Sarason, & Gladwin, 1958), Reading Retardation (Hermann, 1959), in the literature, the popularity of the perceptual cripple as a primary causative agent in deviant child behavior has attained best-seller prominence. The following article presents a critical appraisal of the perceptuomotor disturbance concept by focusing upon the diagnostic process and the treatment procedures.

Appropriate programs of management should evolve from a positive diagnosis (Aldridge, 1966). Perceptual handicap is often diagnosed by an absence of deviant findings in purely psychogenic and interpersonal areas of functioning or by incomplete findings to account for the child's behavior. Such a process of diagnosis by exclusion is as invalid as diagnosing cancer because signs of tuberculosis, pneumonia, etc are absent. As a result of this situation, the perceptual handicap concept becomes a "wastebasket" designation for poorly understood behavior.

Further, the diagnostic inference of perceptual handicap is usually made on the basis of behavioral observation (for example, hyperactivity, distractibility, aggressiveness, motor awkwardness) via a clinical interview (Senn, 1968). To validate the clinical impression, psychological tests are administered. Because in many cases the tests measure closely the same behavior as seen in the interview, the chances of agreeing with the clinical diagnosis are high. The circular nature of this process is obvious.

To this point, the reader may have received the impression that the author denies the existence of perceptual handicap as a causative factor in behavioral disorders of children. Such is not the case. However, even in children with perceptual handicap, (established by a clinical diagnosis which has been substantiated by independent laboratory findings) anxiety due to feelings of inadequacy, incompetence, and helplessness play a prominent role in the disturbance. In short, the child always has an emotional reaction to his disability. This fact naturally leads into a discussion of present treatment procedures for the child with a perceptual handicap.

The view of the child's perceptuomotor disability as an isolated event distinct from his feelings about his handicap results in a treatment regimen limited to remedial training of the specific handicap with little attention paid to the whole child. Although these specialized training techniques may be beneficial in ameliorating the specific perceptual deficit, they do nothing directly for the child's emotional well-being. Indeed, even if the perceptual retardation is helped by the remedial program, it may have become so much

a part of the child's defensive structure that its improvement may precipitate great anxiety. Further, since feelings of anxiety attendant upon being handicapped are almost always present, these children may be more vulnerable to the development of significant emotional disturbances than others. All of these important considerations point to the oversimplification inherent in a treatment program geared solely to the removal of the perceptual handicap with little or no recognition given to the child's emotional welfare. Since this is the preferred mode of treatment in so many child guidance clinics, an examination of its potential source of gain is necessary.

Treatment begins with the parent's phone call to the psychologist. This is their admission that a problem exists and a sign of their desire to do something about it. Although the parents' involvement in the later treatment program is minimal, the organic understanding given to them of their child's learning and behavior problems serves to reduce both theirs and the child's stress. No longer do they view their child's failure to learn as being due to "laziness" and/or willful disobedience. Since their child is handicapped, their expectations of adequate school performance are tempered. (The danger of the child developing a "rotten" self-image and hiding behind the mask of perceptual cripple requires careful handling.) Thus, indirectly the child's emotional needs are helped by the demonstration of his parent's concern for him and by their easing up on pressures for achievement.

The child-therapist relationship is the core of any treatment program. The therapist works with the child, not just perceptual handicaps. Thus, a good relationship by providing intrinsic affection and unconditional acceptance is likely to be the crucial source of gain even more than the remedial training for the perceptual handicap.

In this vein, it will be recalled that the early employment of electroshock with schizophrenics was very successful but that its subsequent usage with later patients proved ineffective. Might it not have been the factor of the doctor's high attention to his patient because he was trying out a new technique which contributed greatly to the initial success of electroshock treatment? Similarly, it may be that much of the efficacy of perceptuomotor remedial training can be accounted for by the effect of attention (Hawthorne effect).

To sum up, this paper has emphasized the importance of a positive diagnosis of perceptual handicap, rather than a "wastebasket" diagnosis. The tendency to separate the child's handicap from his feelings about it is reflected in the treatment process. Generally, current treatment methods have only a rehabilitative aim directed solely at the child's handicap. There exists little concern with the totality of the child's development in his total environment. Rather than a strict adherence to a single form of treatment, a much more flexible response in terms of therapeutic techniques is essential.

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