Questions People Ask About Dyslexia

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Dyslexia and treatment of the dyslexic child concern professionals in many disciplines. In the following pages, questions frequently asked about dyslexia are answered by a pediatric neurologist, a pediatrician working with children with learning disabilities, an ophthalmologist, a speech-language pathologist, a pediatrician working in a neuropsychiatric research unit, a psychiatrist, a clinical psychologist, and an educator.

Q. Dyslexic children often come into conflict with parents and teachers because of their problems. Sometimes they are labeled “hyperactive” or suffering from “minimal brain dysfunction.” Could you comment on what these terms mean, from your viewpoint as a pediatric neurologist?

A. Educators and physicians are often confronted with such youngsters. These are children who do not meet their parents’ or teachers’ expectations despite average or superior intelligence. Either they fail to learn the basic skills — reading, spelling, and writing — or they are demanding, disruptive, and unable to remain still long enough at home and at school. Sometimes both types of conflict are present in the same child, adding insult to injury.

The label “dyslexia,” or developmental reading disability, can be used when the child fails to learn to read, despite adequate teaching and in the absence of mental retardation and visual or auditory handicaps. Such a diagnosis can be well estab-
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used to encompass a certain group of children with behavioral characteristics that separate them from the average child.

There is no convenient label to encompass the two varieties of children in conflict: those with difficulty reading, etc., and those who do not fit in the social order of home or school. To make up for this deficiency in nosologic classification, the vague term minimal brain dysfunction (MBD) came into vogue about 15 years ago. A controversy developed around this unfortunate term, because it seemed unnecessary and confusing to some and to others a convenient label for a heterogeneous group of children in conflict. MBD has been used for practically any childhood behavior disorder resulting in referral to pediatricians, psychiatrists, neurologists, psychologists, and child guidance centers. Carrying this form of reasoning to the absurd, one could use the term maximal cerebral dysfunction for all the neurologic disorders that require admission to a neurologic intensive-care unit (Reye's syndrome, acute viral encephalitis, lead encephalopathy, etc.).

In my opinion, MBD is a totally vague term

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without even the descriptive value of a diagnostic denomination of a syndrome, such as "hyperactivity-impulsivity-distractibility," or a simply stated chief complaint, such as "refusal to go to bed." Its boundaries are so ill defined that one could easily include a normal child when his behavior seems unacceptable to intolerant parents or tired schoolteachers. Unfortunately, this use of the term MBD is not uncommon.

Some have never accepted the term MBD. Instead, they use other terms they believe to be more specific and would offer no objection at all if the term were totally dropped from medical, psychological, and educational use.*

Others, however, have become accustomed to using the term as a diagnostic label and will object if attempts are made to drop it; they would find it difficult to substitute more specific names when writing a diagnosis.

As for the parents, I believe they are being deceived when they are told that their child has MBD. There really is no such child, and they will be well served if we tell them exactly that and seek to explain to them what the child's real problem is.

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Q. Dr. Richardson, you are a pediatrician who has worked for many years with children with developmental disorders. Does the term "minimal brain dysfunction" have any relevance in discussions about dyslexia?

A. Some physicians have applied the term minimal brain dysfunction to children of normal intelligence who exhibit learning and behavioral disabilities associated with neurologic abnormalities. This concept includes the notion that hyperactive behavior is the most common and remarkable presenting symptom in the child with MBD. Admittedly, children with subnormal intelligence, sensory deficits, environmental deprivation, or other handicapping conditions may demonstrate similar symptoms, but a child must have at least average intelligence and be free of sensory defects if MBD is to be used as the primary diagnosis.

The term specific learning disability (SLD) is preferred by educators to describe these children. The educators, of course, are more interested in educational diagnosis and remediation than in medical diagnosis and treatment. As Dr. Duane pointed out in the opening article of this issue, SLD is the term defined by Congress in enacting Public Law 91-230, the "Education of the Handicapped Act" of 1970. That law specifically excludes "children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or environmental, cultural, or economic disadvantage."**

Essentially, children who have specific learning disability are those whose learning problems are not primarily the result of other known handicapping conditions; they have such extreme difficulty in achieving what is expected of them (in comparison with other children of similar age and expected ability) that they require special remedial instruction.

However, as Dr. Gomez has noted, MBD is such an umbrella term that it is almost useless — unless the person's presenting symptoms are also specified. For example: "The primary diagnosis is minimal brain dysfunction (or specific learning disability), manifested by fine motor incoordination, perceptual motor disorder, poor short-term auditory memory, deficits in language comprehension and use, and severe discrepancy between intellectual potential and school achievement. This is compounded by impulsive behavior, marked distractibility, and short attention span. Family dysfunction is a contributory factor. The child requires a special remedial program over and above regular developmental education."

The preschool child, still busy developing in his own particular cocoon, presents quite a different problem and should be considered separately from the school-age child. Many children in this age group deviate markedly from what might be called "normal" development, and the extremes within


** The inclusions and exclusions of the law are worth knowing, since they govern whether or not a remediation program for children with learning disabilities will be eligible for federal funding.
the range of normal variation are quite far apart. It is a mistake to consider a normal child at the lower end of the spectrum to be disabled simply because he is lagging behind others. He is not disabled, and will not be, unless he is enrolled prematurely in a school featuring an inflexible, assembly-line program that is too advanced or otherwise inappropriate for him.

Remember that a child under six or seven years of age may have normal intelligence, but his perceptual maturation or his neurologic integration may not be precisely at chronologic or mental age level. Such a child may well be crippled more by inappropriate teaching and programming (dyspedagogia, if you like) than by any intrinsic problem.

The preschool child who demonstrates deviations in development should be provided with learning experiences designed to meet his individual needs. It is inappropriate to call unreadiness a disability and to assign such a child automatically to the special education class. Careful psychoeducational assessment and appropriate teaching are required. Regular teachers must learn to teach irregular children — especially in the primary grades.

Does a diagnosis of MBD have any relevance at all for the preschool child? Yes, I think so — under certain circumstances. If the preschool child has a history of possible prenatal insult, has exhibited hyperkinetic behavior* from infancy, has reached the developmental milestones in an aberrant manner, demonstrates mild abnormalities in the neurologic examination, and also has electroencephalographic irregularities, I believe the diagnosis of MBD would probably be indicated and medical treatment should be considered.

In school-age children, whether they are labeled as having MBD or SLD, patterns of dysfunctional behavior are demonstrated. But there will be similar groups of findings in disorders of coordination, language, attention span, and perception. The common theme among such children is that they demonstrate evidence of normal intellectual potential, combined with school failure and specific learning disabilities. Some may also demonstrate the findings of hyperkinesia, with impulsivity, distractibility, and short attention span. (However, many hyperactive children are not learning-disabled. In some cases, the better term would be


Suggested readings on dyslexia for parents and teachers . . .

The Rights of Parents and the Responsibilities of Schools
Public Law 94-142
$6.00
* * *
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hyperreactive.) Most of the children will also demonstrate secondary emotional disorders and family dysfunction.

Developmental dyslexia, or specific reading disability, is one of the learning disabilities. The word "dyslexia" was first coined in Germany about 90 years ago — several years before the syndrome we now refer to as dyslexia was even described. If one looks to the Greek for the derivation, the etymology would be dys ("bad" or "difficult") + lexis ("pertaining to words" and derived from lexis, "a way of speaking"). The Latin derivation may be more informative, although the spelling would change: dis ("inability") + legere ("to read").

In either case, developmental dyslexia is a specific language-learning disability characterized by a child’s inability to learn to read adequately in spite of normal intelligence, normal sensory apparatus, and regular or conventional teaching methods. It is usually familial and predominantly but not exclusively male. The pathognomonic signs are an inability to associate sound with specific graphic symbols and difficulty in mastering the sequence of both written and spoken language (the Greeks and Romans were both right). Children with specific developmental dyslexia are less apt to show the disorders of coordination and attention seen in children with other kinds of learning disabilities.

An increasing number of studies now suggest that dyslexia is causally related to deficiencies in verbal processing. Thus, children who lag behind their peers in general language ability, such as those who have difficulty with grammatical transformational rules or who cannot perceive the syntactic redundancies and invariants, can be expected to have difficulty in one or more aspects of reading.

When dyslexia is viewed as a language disability, it is easier to understand children who begin to demonstrate major problems in written-language expression around the fourth or fifth grade although they have learned to read fairly well. These children cannot "get it down on paper." Studies have shown that some poor readers may comprehend meaning but are inefficient in retaining verbal details, such as grammatic markers and specific sequences of letters or words. Such youngsters would have difficulty in employing "a verbal code" for efficient information storage and retrieval, with resulting difficulty in written expression. Unfortunately, too many dyslexic children, unidentified in the early grades, are labeled "lazy," "sloppy," or "unmotivated" when they are unable to complete their written work in the middle school. The pediatrician must become more aware of this problem.

As stated elsewhere in this section, early identification and remediation of children with dyslexia and specific learning disabilities requires a multidisciplinary approach, including representatives of pediatrics, neurology, psychology, speech-language pathology, special education, and, frequently, psychiatry.

With appropriate teaching — often over a lengthy period — the dyslexic can learn to read and express himself in written and spoken language, especially if he is average or above average in intelligence. Specific educational (remedial) techniques have been devised to help him. The most successful methods stress a multisensory, phonetic, and structured linguistic approach. Prognosis is directly proportional to the innate intelligence of the child, early identification of the problem, specific appropriate remediation, parental support, and the child's determination.

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Q. What is the role of the ophthalmologist in the determination and treatment of dyslexia?

A. The ophthalmologist is often the first physician to be contacted by the parents when they learn that their child is doing poorly in school. Both the parents and the teacher may conclude that the child's inability to learn as quickly as his peers or to read and write properly is due to some failure in the visual system.

The ophthalmologic examination is probably an excellent place to begin in such circumstances, since it is necessary to determine whether there is a visual defect — be it refractive in nature, caused by an ocular-muscle imbalance, or suggestive of underlying neurologic abnormality.

Pediatricians should realize, however, that ophthalmologic deficits are only rarely found to be
the cause of learning disabilities. And once the correction of any overt defect is made, the pursuit of “visual training” is fruitless.

The ophthalmologist is accustomed to routinely seeing patients with refractive errors, ocular muscle imbalance, amblyopia, nystagmus, and other visual defects — patients who have no learning disabilities in spite of these problems. To place the blame for a learning disability solely on a defect in the visual system, therefore, is an exercise in futility.

The ophthalmologist’s role is to reassure the parents of the dyslexic child, to explain any defect in vision, and to admonish them not to pursue expensive ocular “tests” or “treatments” that have no corrective value for the child’s learning disability.

The ophthalmologist, in consultation, should apprise the pediatrician, the neurologist, the psychiatrist, and the psychologist of any existing visual problem and treatment for it that he has recommended or given, with the realization that his role is supportive and not curative.

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Q. Dr. Darley, can speech pathologists help dyslexic children?

A. Yes. Speech-language pathologists may help in several important ways. One way is to apply formal and informal screening and diagnostic procedures for analysis of phonologic-morphologic, semantic, and syntactic rules and then to interpret the results of these tests and thus clarify any relationship that may exist between oral-language deficits and problems in reading, writing, and arithmetic.

A second role of the speech-language pathologist is to train children in all aspects of linguistic processing. We do this not as teachers engaged in conveying subject-matter content but, rather, as clinicians facilitating the acquisition of skills that constitute “primary linguistic activity” and the “linguistic awareness” necessary for reading.

Language-speech pathologists may also assist parents, teachers, and other specialists by providing information about the nature and process of language acquisition and by working with them to establish a setting in which the child will have a maximum opportunity to learn these skills and obstacles to learning will be minimized.

As a speech pathologist, I naturally hope that members of our profession will have the opportunity to play these roles by being included in plans for the early identification of children at risk for developing learning disabilities, as well as in the planning of programs for their remedial education. If a child is to learn to read, he must first have a functional language system at his disposal. In Kavanagh’s words, “reading is parasitic on language.” Or, as Venezky puts it, “reading is translating from written symbols to a form of language to which the person can already attach meaning.”

Most of us acquire this grasp of the logic of the language code early, apparently because we have a fantastically effective hearing mechanism that receives and decodes language that has been encoded into speech. A child usually “cracks” this speech code in his early months. By the time he goes to school, he typically has an impressive linguistic sophistication (which, of course, is a prerequisite for reading). Rees has summarized what this sophistication entails.

He must possess an integrated set of internalized rules that enable him to produce sentences he has not spoken before and to understand sentences he has not heard before. These rules may be characterized as semantic, syntactic, and phonological. . . Describing the language user’s competence as knowing the rules of the language does not imply that any of this knowledge is conscious. . . Although the preschool child can apply rules to encode and decode meaning in sentences, to recognize and construct the syntax of sentences, and to analyze and organize the spoken form of the utterance, neither the child nor the adult can ordinarily specify the rules he follows in so doing. The language user possesses a well-established set of rules for comprehending and producing language as well as a set of strategies for applying these rules, all of which must operate automatically for smoothly integrated linguistic performance. 

To move efficiently through the next step — learning to read — the child must have what Mattyngton has called “primary linguistic activity.” This is the ability to apply the internalized, unconscious rules he has absorbed to the understanding,
formulation, and expression of sentences. The child must also have developed "linguistic awareness," the ability to think and talk about his language and to use it as a tool for acquiring new skills.

Educators usually assume that a child possesses an intact oral-language system when he enters school. But not all children do, and their failure is signaled by early learning difficulties. Here is where the speech-language pathologist can play an important role in salvaging such a child as a learner. The speech-language pathologist is by training equipped to deal with speech and language generally. Included in his area of competence is knowledge of what constitutes the normal acquisition of those phonologic-morphologic, semantic, and syntactic rules I mentioned earlier. He also knows how to administer a large battery of tests for appraisal of the child's performance in all three of these linguistic areas. And the speech-language pathologist appreciates the fact that learning-disabled children have, in Stark's words, "highly individual physical, psychological, linguistic, and academic profiles." That is, the performance of each child must be assessed with regard to his own special cognitive style," and training recommended that will help him overcome his disability.

Speech-language pathologists do not concentrate their attention only upon a child's articulation problem that may happen to coexist with a learning problem. They may, however, work on articulation and thus train the child to recognize that spoken words can be segmented into phonemic units, a step towards the "linguistic awareness" the child needs in order to learn to read. They do not simply test hearing and help the child cope with an overt hearing loss; they will help the child with many aspects of auditory processing: to listen, to discriminate between phonemic units, to analyze spoken units, to synthesize sequences of phonemes and words, to order language units sequentially, and to handle adeptly more and more of them — in other words, to do many of the things involved in the child's primary linguistic activity.

To recapitulate, speech-language pathologists have several important roles to play in helping the dyslexic child. If the child is to receive maximum benefits, they should be included in the multidisciplinary approach, which has as its goal the early identification and remediation of children with developmental learning disabilities.

Q. Can stimulant therapy help in the management of children with developmental dyslexia?

A. The developmental deficits that can lead to impaired school performance in a child of normal intelligence are of two types: the lack of ability to perform the mental operations involved in learning to read and write (the developmental dyslexias) and an inadequate ability to maintain mental concentration on a given task (hyperactivity).

The usefulness of stimulant therapy is well validated for the hyperactive group but not for the dyslexics. There are, however, two reservations...
that must be made. First, the diagnosis of developmental dyslexia is not always easy, and it is sometimes possible to mistake children who are in fact suffering primarily from an impulsive and distractible learning style for children who have developmental dyslexia. Second, a child with this disorder may also have an impulsive and distractible learning style.

Let us consider first those children whose impulsive and distractible approach to learning is impairing their school performance. Not all of them seem hyperactive. In fact, some of them appear to be hypoactive. So, in school-age children, the potential usefulness of stimulant therapy should never be rejected on the basis of motor evaluation alone. Instead, if the child is truly hyperactive (and therefore one who may be benefited by the use of stimulant therapy), careful questioning of parents and teachers should reveal other manifestations of the syndrome — the impulsive, distractible, immature, or aggressive approach these children have both to problems of learning and to living in general. Such an impulsive learning style certainly can induce substantial reading backwardness in a normally intelligent child who is not in the least dyslexic.

A single dose of a stimulant drug in an appropriate amount may enable such a child to substantially raise his low scores on a standard achievement test within an hour or two after receiving the medication — perhaps even to a normal range. Many of these children will have previously exhibited some of the reversals and rotations that are taken to be hallmarks of dyslexia, owing to inadequate concentration on the task of writing rather than to any processing problem; administration of the stimulant quickly and completely dispenses of such problems.

These children, then, exhibit not a lack of knowledge but, rather, underperformance. In treating any child about whom there is a suspicion of dyslexia, I believe it is crucial to identify the extent to which there is underperformance rather than true reading unreadiness.

So much for the hyperactive children who are not dyslexic. What about children who are both dyslexic and hyperactive? In such cases, the administration of stimulant therapy can significantly improve school performance and, of course, help the child in social situations. An additive-free diet may also help. But it will leave untouched the dyslexic component of his life, and this will have to be treated by customary educational remediation.

When the physician thinks there is a possibility that both hyperkinesis and dyslexia exist, I believe it is best first to determine the extent of the attentional disorder. The proper use of stimulant therapy in such a child should yield a new and more stable baseline if hyperkinesis is in fact present. If the child's reading performance is still substantially below what should be expected in view of his age and intelligence, this is the point of departure for a remedial program in reading and writing.

There are, therefore, children who have normal intelligence and normal powers of concentration but who still find it unusually difficult to learn to read or write. These are the pure dyslexics, and they will not be helped by stimulant therapy.

In establishing the diagnosis, however, it is essential to rule out the alternative possibility that school failure has an attention-based component. If such a component exists, stimulant therapy will often correct it, leaving the remaining reading or writing disabilities amenable to remediation.7

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Q. How common are psychiatric problems among dyslexics, and which problems occur most often?

A. Psychiatric disturbances are about three times more frequent in children with specific reading-retardation problems than in a control school population, according to the epidemiologic studies by Rutter among both rural and urban populations in England.8 Antisocial disorders were the most common, although neurotic patterns were also found.

Association, of course, does not indicate cause; both the reading problem and the psychiatric disorder could reflect common predisposing factors underlying each. But clinical experience suggests that the reading disorder itself can be a major source of psychologic stress for the child. Poor self-concept, performance anxiety, and a negative attitude toward school will further impair learning.

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Some dyslexic children respond to the presentation of reading materials with conditioned anxiety. Others become angry and rebellious.

Leon Eisenberg, M.D.
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Q. What would be the primary indicators for formal psychiatric intervention in a dyslexic?

A. There are two kinds of indications that a dyslexic reader may need psychiatric care: symptoms that impair personal development and symptoms that interfere with his response to remedial reading instruction.

In the first instance, the child merits psychiatric attention with or without a reading problem, because his emotional and behavioral problems are interfering with his growth and causing him distress. When symptoms are of this severity, it is quite unlikely that academic help alone will suffice. Almost always, the family as well as the child must be involved in the treatment program.

When the symptoms do not impair personal development but, rather, interfere with the child's response to remedial instruction, we are dealing with a more situation-specific symptom. The clinical picture will be that of a child who appears to be doing relatively well at home or with friends out of school but who is so anxious in the teaching situation that his inner preoccupation and inability to pay attention render the teacher's efforts futile.

In these cases, behavior therapy or psychotherapy sessions may succeed in helping the child redeploys his energies. The psychotherapist will, in a sense, become the lightning rod for the emotional tensions of the child, and the reading therapist will then be free to focus on the cognitive problem.

Psychotherapy alone will usually not correct the reading disorder, if the child is truly dyslexic. In tandem, these forms of treatment are mutually facilitating. As emotional distress diminishes, reading progress is greater; as reading improves, the sense of potency and self-control increases.

Leon Eisenberg, M.D.

Q. Can chemotherapy play a part in the treatment of the psychiatric problems of the dyslexic?

A. There is no evidence that chemotherapy is effective in itself in the type of case described. Some clinicians believe that "antianxiety" agents may augment psychologic care for the neurotic child and that "stimulants" may facilitate progress in the distractible child. I am unaware of any controlled trials that would confirm this opinion.

Leon Eisenberg, M.D.

Q. What is the role of the psychologist in the evaluation of developmental dyslexia?

A. If a psychologist is working independently, his clinical evaluation should cover at least six areas — general intelligence, academic skills, personality or emotional development, family and social history, interpretation of results to the client and to parents or teachers, and a written report of findings and recommendations. However, if the psychologist is working with an interdisciplinary team, his contributions are likely to be in the form of sharing his thoughts and recommendations. Such a team will usually consist of some or all of the following: psychiatrist, psychiatric social worker, neurologist, educational specialist, speech-language pathologist, and perhaps others.

The psychologist's responsibility is to contribute information about both the quantity and quality of the dyslexic's specific responses to the various tests he administers. A reliable measure of quantity is needed so the person's performance can be compared objectively with normative data for his age group. The quality of responses will enable the psychologist to better interpret the dyslexic's strengths and weaknesses in specific areas and add weight to the usefulness of his final judgment.

The psychologist who is evaluating someone with developmental dyslexia needs to be well acquainted with the wide range of behavioral characteristics of dyslexic persons, as they have been described in the literature since the late 1920s. Dr. Richardson, earlier in this discussion, has commented on the etymology of dyslexia. Granting that the word means a "difficulty in coping with words," the examiner will want to be extremely sensitive to the manner in which the dyslexic hears and speaks spoken language.8

There is an inherent difficulty when one attempts to use most of the tests now in common use to measure the skills of dyslexics. Almost all of these tests require as prerequisites two skills many
dyslexics have trouble with — the facile processing of auditory instructions of varying lengths and then acting on the basis of these instructions, either by replying orally or by performing intricate manipulative tasks.11

Delay in the acquisition of speech at an early age is often followed by difficulty in acquiring a reliable spoken vocabulary or memory of the "right" word. Furthermore, very subtle symptoms, rather than obvious deviant speech — such as stuttering, lisping, and the like — are the hallmarks of the dyslexic's difficulty with oral expression.12-14 Problems noticed might be wrong order when sequencing sounds, phrases, or sentences; difficulty in processing multistep instructions; reversals of meanings of words in general (hasten-hesitate) and especially time or space words (up-down, since-before, around-between); instability of syllables (japhama, gespetti); syllable confusions in compound words (pavewalk-sidement; megitate for vegetate-meditate); mild aphasiclike behavior showing momentary "loss of words"; or auditory-processing delays. Such symptoms can be observed by the trained listener. Moreover, retrieval of "facts" from the memory bank poses great difficulty at times, particularly if a fact has anything to do specifically with time (such as questions about the calendar) or space (such questions as 'Where is . . .?' or "How far is . . .?"). The knowledge may be stored accurately, but retrieving and expressing it in words is likely to be a difficult problem for the dyslexic. Many, having blundered through garbled phrases and been laughed at by their peers, become silent and inhibited; although their IQs may be normal or above normal, teachers may misjudge them as being less bright than more linguistically facile peers.15

When the dyslexic is tested at the next level of "language learning" — reading, writing, and spelling — other specific signs of a lag in learning may show up. These, too, are unique and distinguish the dyslexic's style of performance from that of other underachievers; they may be present even when spoken-language ability is well developed. If no educational diagnostician is present, the psychologist should be able to administer the appropriate academic tests to a client of any age, for the crippling effects of an educational problem may be a subtle or obscure factor in the dyslexic's more obvious presenting symptoms that ostensibly led him to seek help.

Working with the educational diagnostician as another member of the team, the psychologist shares his conclusions about the dyslexic's poten-

tial for academic achievement and juxtaposes these with the measured level of learning. This is important; a child with intact senses and reasonably adequate cultural opportunities should be able to acquire academic skills on a level commensurate with his intelligence, not merely his chronologic age or grade level. This is as true of dyslexics as of others; they should be given the opportunity to achieve up to their innate potential.

Personality testing can indicate the person's emotional growth and suggest appropriate behavioral adjustment now or in the future. As Dr. Eisenberg has noted, academic failure at any age can corrode a person's personality and self-esteem, leaving the dyslexic increasingly vulnerable to stress. For example, a normal reaction to a problem of everyday life may, in the dyslexic, become exaggerated as he attempts to adjust emotionally to almost constant frustration and anxiety over failure. And so the dyslexic in the classroom may respond to his dilemma by choosing "fright, flight, or fight," noncompetitive withdrawal or denial, a don't-care attitude, or rebelliousness — the acting-out of nonconforming behavior. None of these is a productive life style.

If the psychologist is experienced with the rehabilitation or re-education of dyslexics, he may be able to offer some remedial or (if it is in time) preventive teaching strategies. Early diagnosis is always to be preferred, as Dr. Duane has pointed out. In that way, appropriate educational measures can be started so that the child can be spared the complications of academic failure — complications that can be of lifetime duration.

In short, the psychologist — along with others — assists in the refinement of the diagnosis of developmental dyslexia by assessing both obvious and subtle ramifications of the person's difficulty with language learning. He assesses the person's probable potential for learning and compares this with achievement. And he suggests specific procedures for the teaching or educational rehabilitation of the dyslexic person, whatever his age may be.16,17

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Q. Dr. Sheridan, as a teacher do you feel that most educators have realized the significance that dyslexia plays in contributing to inadequate achievement of some students and of outright failure of others?

A. I practiced my profession as an English teacher for 36 years, both at secondary schools and at Carleton College. I must admit that during many of those years it was customary to treat students who could not spell as if they were moral lepers.

Bad spellers were bad because they were slothful, indifferent, or stupid. It was easy for all teachers, not simply those whose professional responsibility was the training of impeccable spellers, to recognize bad spellers immediately, whereas in other areas of developing skills, the detection of a lack of growth was much more subtle and difficult.

Teachers have always encountered students who could not spell, did not articulate clearly, had trouble receiving spoken directions, or had untidy notebooks and chaotic notes. And they have traditionally subjected such students to punishment for their "stupidity" and "inattention." When a child is humiliated often enough, even though he senses that in other spheres of activity he can hold his own with his peers, he becomes convinced that there must be something seriously wrong with him.

When I look back upon the years of my reproaches to students struggling in a freshman composition course, I am filled with remorse. I have later met many of these students — students whose secondary-school education was blameless yet whose papers were routinely failed because they exhibited three or four misspelled words — and have been abashed to discover in them successful professionals, in spite of the handicap of their dyslexia. But it was only recently that this handicap was described for a wide audience and therefore only recently that educators have come to understand that poor spelling does not necessarily mean a poor mind or a poorly developed moral sense.

Beyond the elementary school, much education takes place in the form of lecture and directions orally given. Under these conditions, students with the handicap of a specific language disability are under a severe disadvantage. However, although information about this handicap has by now been given national dissemination, I have yet to see in the classrooms that I have visited any significant changes in teaching techniques that make use of a multisensory approach that is bound to be of value to all students, not simply those with a specific learning disability.

Education is slow to change. It has its shibboleths. When it does change, it changes in a radical sweep, from the narrowest kind of workbook grammar instruction all the way to electives in college making. The middle ground — the ground on which students develop their skills and powers, the ground on which teachers use all techniques at their command to help individual students learn — is a barren one.

Those who are not altogether ignorant about specific learning disabilities may fall into a second camp, the doubters. I have heard expressed many varieties of skepticism from flat denial that there is such a condition as dyslexia to more restrained protest that what is identified as dyslexia is actually the product of emotional disorder. Learning magazine* recently published a long descriptive account of national attitudes towards dyslexia, explaining the origin of some skepticism to be discontent with easy diagnoses of dyslexia that palmed off onto children defects that really should have been laid to poor teaching. Doubtless this has been so.

Those who put the blame exclusively on emotional problems fail to take into account the converse cause-and-effect relationship — namely, that dyslexia may produce emotional maladjustment. Until educators recognize the existence of a learning disability that prevents intelligent students from living up to their potential and take steps to improve teaching techniques, our society will continue to suffer from an enormous waste of intelligence and talent.

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Q. Are current training programs for teachers adequate to provide the necessary information?
A. In the past, prospective teachers who had

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been informed about the existence of learning disabilities were rare. At present, more and more recognition is accorded to the effects of such disability on students' learning capacity. Although information is now much more available, it would be misleading to state that it is generally distributed.

More often than not, prospective teachers are not informed about the signs and remedies. This is certainly the case in the preparation of English teachers, the one group that is most likely to have to deal directly and continuously with the impediment of dyslexia in the teaching of their subject.

Very few English teachers are aware of the problem, and those who are know little or nothing about the developing techniques for teaching language-disabled students effectively. States that have elaborated certification requirements have already imposed so large a burden of courses required in the education of teachers that there is little time for anything extra. It is unfortunate, but nonetheless true, that information about learning disabilities is regarded as something extra, rather than as information of the most fundamental kind. Yet, ironically, those who struggle with their teaching techniques in order to make their subject very clear to dyslexic students will also be better teachers of students who do not suffer disabilities.

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Q. What can be done to meet the educational needs of dyslexic students?

A. While the lower schools are not as aware as they should be of the needs of dyslexic students, the colleges and universities are even more remiss. The college board that administers verbal, mathematic, and achievement tests for college applicants has gone so far as to allow dyslexic students to take untimed tests. However, once these tests are taken and the student begins to look for a suitable college, he will discover very few colleges prepared to accept or to help him. Thus, the dyslexic freshman who does get admitted to a college arrives there with little prospect of support in developing his learning skills, and a shyness ingrained by earlier academic humiliations prevents him from a very aggressive choice of subject matter.

Higher education needs to know more about dyslexia. The academic world must acknowledge its responsibility to help learning-disabled students achieve their potential by adopting specific techniques for the improvement of their reading and writing skills, skills on which so much college-level instruction is based. We will never know how many potentially successful adults have been lost along the way because educators were unaware of their inarticate struggle against their handicap. But we cannot use ignorance as an excuse any longer.

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REFERENCES


