Specific Language Disability—dyslexia, developmental dyslexia, word blindness, strephosymbolia—or whatever label is preferred for the intelligent children with communicative disorders has been explained in the following way by Dr. Raymond Clemmons, Department of Pediatrics, University of Maryland School of Medicine:

An exact definition of specific language disability is not possible since the disorder ranges in degree from the very mild to the extremely severe. The key point, however, is that reading and language skills are definitely out of keeping with overall intellectual capacities and that this difference persists in spite of competent instruction over adequate periods of time with pedagogical methods which are successful in the majority of children. It is in this regard, namely the failure to learn at the usual rates by the usual pedagogic methods, that the term “specific” is appropriate.

Without necessarily knowing causes or having the background for understanding the problem, teachers long have been aware of the Specific Language Disability syndrome. Its familiar symptoms are characteristics of some 10-20% of children whose achievement in reading, writing, spelling and both oral and written language is not commensurate with intelligence or abilities in other areas such as science and mathematics. Even without diagnosis teachers can recognize some of the symptoms that occur in the SLD syndrome, all of which, however, are not necessarily found in any one child.

A child:
- may be a very poor reader, failing completely.
- may read below intellectual capacity and ability to comprehend what is spoken or read aloud by someone else.
- may lose the thought in the struggle with the mechanics of reading, insert or omit words, guess, ignore phrasing, punctuation marks.
- may learn to read, or to read well enough to “get by” in elementary school only to collapse when junior high is reached.
- may read at “grade level” but not commensurate with intelligence.
- may avoid reading if possible and not read for pleasure.
- may read, but fail in spelling.
- may not read or spell.
- may learn to spell a “list” of words sufficiently well to “pass” on weekly tests, but forget them all by Monday to make way for the new list.
- may be unable to spell previously “memorized” words in dictated sentences or in propositional written expressions.
- may leave out or insert letters, misplace, add or omit whole syllables.
- may have poor use of syntax, prefixes, suffixes.
- may have adequate ability to express self orally, but almost none for written expression.
- may mispronounce, misuse or fail to retain words for verbal use.
- may lose concept by misreading or misunderstanding similarly appearing or sounding words—country-county; historical-hysterical.
- may have difficulty understanding what is read aloud or in comprehending directions.
- may have difficulty answering questions or in describing something which carries over into unsatisfactory written work.
- may struggle to recall sequential movement patterns necessary for automatic letter formation, resulting in poor and disordered written work.
- may know how to form the letters, but not to recall which letters to use in spelling so penmanship and neatness suffer.
- may be unable to remember words and phrases as they are dictated.
This list, while incomplete, will undoubtedly call forth mental pictures of many children whose struggles have frustrated the best efforts of excellent teachers using conventional methods successful with the majority. To these language difficulties may be added poor behavioral and attitudinal and emotional problems, feelings of inadequacy, loss of self respect and tragic, indeed, loss of status among peers. Sometimes parental disappointment, blame or condemnation compounds the problem. Unfortunately, when there is unfamiliarity with or misconception of Specific Language Disability by school personnel, language problems may be considered secondary to the emotional overlay. Writes Elena Boder, M.D., Associate Clinical Professor of Pediatrics, School of Medicine, U.C.L.A. in Los Angelesii:

….The older child referred to the clinic as a “non-reader” had invariably proved to have specific dyslexia. The application of this term to the child by school personnel has therefore come to be viewed by the writer as virtually diagnostic....

….Specific dyslexia, like the anxiety it produces, appears in may disguises and mimics many behavioral disorders; or example, dyslexic children are more frequently referred to the neurology clinic for behavior problems rather than for a reading problem. Their reading disorder tends to be viewed as secondary to their behavioral problems and they are, therefore, often misjudged as being poorly motivated, not interested in reading or uncooperative.

Too often the reasons for inadequate performance have been sought in purely psychological or extraneous influences affecting the child such as home, social or economic environment, poor teaching, irregular school attendance. Certain negative influences, where they exist, cannot be disregarded, but it is of equal importance to note the number of children who do learn in spite of their subjection to the same kinds of negative influences.iii

Fortunate it is for SLD boys and girls of the present and future that leaders within the various disciplines of medical, psychiatric and educational fields are bringing their forces together to interrelate the findings of each. The need for this is pointed out in what Dr. Ralph Rabinovitch, Director of Hawthorn Center, Northville, Michigan, has to sayiv:

….So often the school social worker or pediatrician refers the child with the hope, and even expectations, that the psychiatric clinic will find the learning problem to be due to an “emotional block” and that through the magic of psychotherapy, perhaps limited to a few interviews, the child will be “released” to learn adequately. Such unrealistic expectations have, unfortunately, been fostered in part by the attitude of some of our own colleagues in child psychiatry and related fields who have been prone to overgeneralize dynamic formulations. The problem is far more complex; and the understanding of the large mass of reading problems which we see represents, I believe, one of the major current challenges to our field.

To many, Specific Language Disability is believed to be of biologic or endogenous origin, predetermined by familial (some say hereditary) neurological disorganization in the central nervous system’s handling of language symbols, and not to be blamed on anyone—not the parent, not the child, not the teacher and not the school system. It is just the way some are born.

Development of cognition as expressed through language depends upon a “three-fold” language pattern—the automatic association or linking of stimuli as they are carried over visual-auditory-kinesthetic sensory channels to the cortex of the brain, under control of the central nervous system. There, the incoming impressions carried over these modalities of “input” go through a complex process of integration for storage in association with concept and past stimuli, being held somehow for delayed recall and then formed into motor patterns so they can be sent over sensory channels of “output.” This is an important learning for SLD teachers because presenting new steps is not enough. Children need help with the integrative process by fostering associations, strengthening A-V-K linkages, and how to recall, with practice in so doing. Practice is not just “assignment,” but often requires the teacher to stand by to give help where the need is indicated. To prevent mistakes, not to correct mistakes, is an essential approach for good SLD teaching.

Teachers learn that somehow, in SLD children, certain maturational language patterning has failed to reach full functional physiological development, spoken of as “neuro-physiological dysfunctioning.” For the large majority, this “patterning” for language perception, integration and recall follows well ordered paths that serve man’s language needs throughout life. Dr. Wilder
Penfield, neurologist, tells us they are usually established by approximately twelve years of agevi.

When developmental lags occur some children fail to reach certain anticipated points in the over-all patterns of maturation. Dr. Lauretta Bendervii points out that:

…Areas of the brain cortex serving such specifically human functions related to unilateral dominance as hand preference in using tools and in writing, and in learning processes for speaking, reading, spelling and written language show a wider range in time of maturation than do other maturational habit patterns……

There may be delay, but where there is no known brain damage or impairment, there can be response to structured patterning. Developmental lag which persists on beyond acceptable periods of delay may be due to specific language disability which may not correct itself without help in coping with the disability. With this in mind, teachers should not overlook or minimize the need for structuring and patterning each progressive learning step.

Dyslexic or SLD children’s problems are at last being brought into focus, their needs recognized. When the etiology is fully understood, education will continue to have the final responsibility for the success or failure of these children. This is expressed by Dr. Wilbur Mattison, Jr.* “We have no difficulty finding the dyslexic child. How to provide adequate training or retraining is our problem.” Medical and psychiatric research can bring about better understanding and knowledge of the dyslexic or SLD children, but education must provide the therapy.


References

* Dr. Wilbur Mattison, Jr., Member of Board of Directors, Charles Dorsey Armstrong Memorial Foundation, Menlo Park, California.

