

Dyslexia or Dysteachia?

Reading problems are rarely the result of a biological abnormality.

By Louise Spear-Swerling and Robert J. Sternberg

Many issues in the field of reading disability (RD) are hotly disputed — and not the least of these is the extent to which RD actually exists.

Many educators, as well as the general public, tend to think of RD—especially its medical-sounding equivalent, dyslexia — as “diseases” that can be objectively diagnosed. According to this view, RD is analogous to an illness such as measles or rheumatoid arthritis. It resides within the individual, a person either has it or does not have it, and differential diagnosis can determine the presence or absence of the disease as well as suggest a treatment.

In the view of most researchers, however, RD is not an all-or-none phenomenon. In the view of these individuals, such medical disorders as obesity or hypertension provide better analogies to RD than do all-or-none illnesses like measles. Just as hypertension exists on a continuum with normal blood pressure and can vary from mild to severe, RD exists on a continuum with normal reading and can vary greatly in severity.

The fact that a disorder exists on a continuum rather than as a discrete entity, such that the borderline between disordered and normal functioning is somewhat arbitrary, does not necessarily imply that the disorder itself is trivial. Hypertension, for example, clearly puts one at risk for stroke and heart disease.

However, analogies involving medical conditions, whether to hypertension, measles, or some other disorder, fail to capture some crucial aspects of RD diagnosis. Identifying RD is not really like diagnosing a medical ailment, in part because RD identification is not an objective process involving reliable measurements.

For example, in the case of hypertension, although physicians might disagree about whether borderline

hypertension should be treated, generally they would not disagree about what constitutes borderline hypertension. Nor would there typically be a need to question the reliability or validity of blood pressure readings.

For schoolchildren diagnosed with RD, the situation is far different. Guidelines used for identifying children with RD are vague and may be interpreted quite differently from jurisdiction to jurisdiction. A child who is identified as having a RD in one area might not qualify for services under the regulations of a different area; a child labeled RD in one town might not be considered RD in a neighbouring town, achieving a dramatic “cure” just by moving!

Identification may further depend on the specific tests used which, like regulations and guidelines, can vary from place to place. To complicate the situation even more, IQ and achievement tests lack the reliability or validity of many measurements employed by physicians, such as weight or blood pressure readings.

Furthermore, special-education referral and placement tend to be determined, in great part, by factors that may have little to do with the child’s intrinsic abilities or disabilities. These factors include gender, race, and classroom behaviour, and are particularly important in the case of mild handicapping conditions such as emotional disturbance.

Thus, a youngster who is a behaviour problem in the classroom and also has reading difficulties, is more likely to be referred for special help than a youngster with an equally serious reading difficulty who is quiet and compliant.

Moreover, although hypertensive patients can expect to derive clear benefits from treatment, the overall treatment benefits for youngsters with RD — if *treatment* is defined as

special-education placement — are much less clear. Indeed, there is a depressing degree of consensus among researchers that special education and placement have often been ineffective not only for students with learning disabilities but for other kinds of students as well.

Perhaps the most fundamental weakness in analogies between medical ailments and RD involves the notion of an intrinsic biological abnormality as the cause of the disorder.

For example, although in most cases the exact etiology of hypertension is unknown, this phenomenon is one that can be described in biological terms, with reference to specific biological mechanisms that are consistent across individuals. Some cases of hypertension, for example, have a known biological cause, such as kidney disease.

The same cannot be said for the majority of children who are labeled as having RD, in spite of the long-standing assumption that the difficulties of children with RD are biologically caused. Some children with RD may indeed have problems stemming from an intrinsic biological disorder, but these children are clearly a minority of the children actually *labeled* as disabled readers.

To say that the learning-disabilities field has been overzealous in seeking biological explanations for children’s learning problems is putting it mildly. The pendulum can stand a few good pushes away from the extreme of biological-deficit views.

(Adapted with permission from Off Track: When Poor Readers Become “Learning Disabled”. Dr. Spear-Swerling is professor of special education at Southern Connecticut State University. Dr. Sternberg is professor of psychology and education at Yale University.)