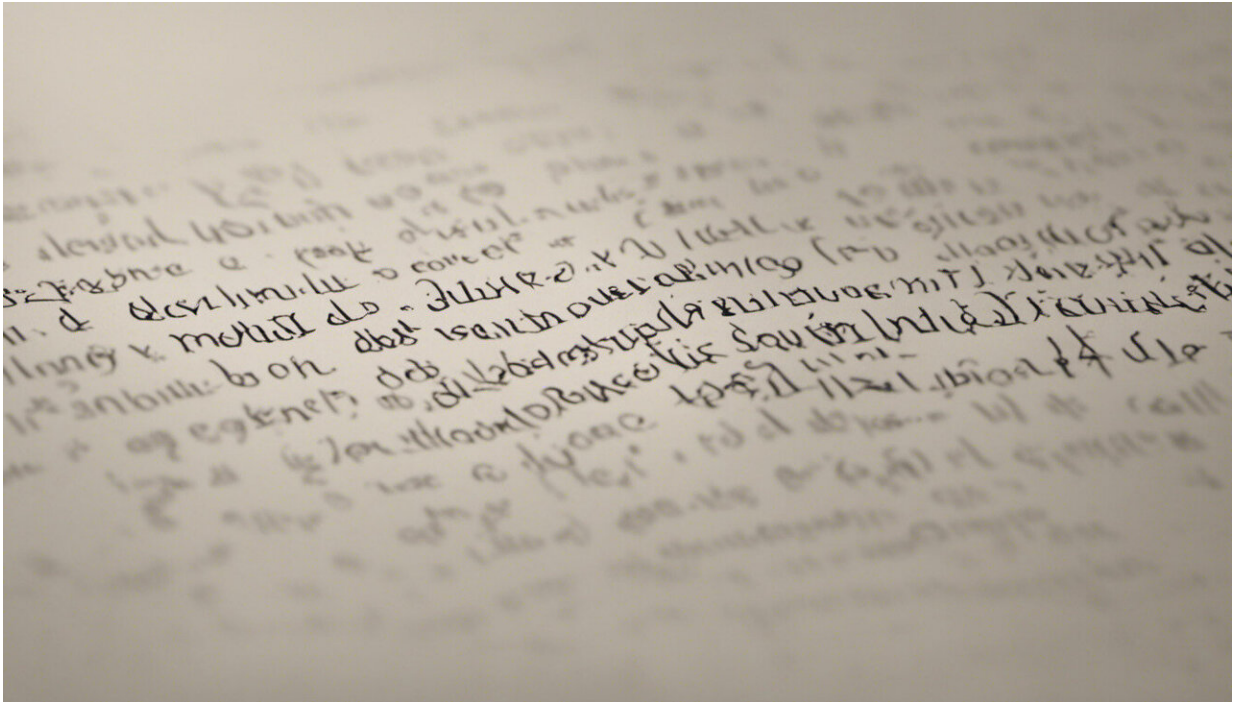


Should we do away with 'dyslexia'?

March 21 2014, by Anne Castles, Kevin Wheldall, And Mandy Nayton



Credit: AI-generated image ([disclaimer](#))

In their recently published book, [The Dyslexia Debate](#), Joe Elliott and Elena Grigorenko controversially call for the term "dyslexia" to be abandoned. They argue it is an imprecise label that does nothing to assist the children to whom it is applied.

So what is wrong with the term "[dyslexia](#)"?

No-one is denying the reality of [children's](#) reading difficulties, or that these need to be identified and treated as early as possible. What is in question is whether we should give the label of "dyslexia" to children with [reading difficulties](#).

It is important to note that reading ability falls on a continuum in the population; it is normally distributed like height or weight. Thus, deciding whether a child does or does not have dyslexia will always involve applying an arbitrary cut-off.

In this sense, a diagnosis of dyslexia is similar to a diagnosis of obesity. It is quite different from a diagnosis of, say, measles where it is clear when someone has it and when they do not.

No agreement on diagnosis

Elliott and Grigorenko argue that applying the label of dyslexia is unscientific because there is no universally agreed set of criteria for its diagnosis. What one clinician might call dyslexia, another might not.

Some apply the label to any child who struggles with learning to read. Others apply it only when the reading difficulty is accompanied by strengths in other intellectual domains. Still others diagnose dyslexia when the reading difficulty is associated with particular cognitive "markers" such as phonological or visual deficits.

Even within these different definitions, there is variability associated with where the cut-off for an impairment is applied. Consequently, estimates of the prevalence of dyslexia range from 3% to 20% of the population.

It is true that the term "dyslexia" has been used in a wide variety of contexts over the years, and this has led to considerable confusion. We

think three particular factors have contributed to the problem:



Credit: Unsplash/CC0 Public Domain

First, there has been a failure to distinguish between *research* and *clinical* uses of the term. Researchers often select samples of "dyslexics" with very specific profiles. They do so in order to answer particular research questions, or to control for non-relevant factors.

They may select their sample to have average or above IQ, so that this factor does not influence their results. Similarly, researchers may decide that, for their experimental purposes, "dyslexia" will be defined very generously, as those students scoring below one standard deviation from the mean on a test of reading (approximately 16% of the population). This does not mean that any of these criteria should necessarily inform a

clinical diagnosis of dyslexia.

Second, there has been a tendency to conflate symptoms and causes within definitions of dyslexia. Sometimes it is defined purely in terms of the presenting problem – a reading difficulty – with the diagnostician remaining agnostic as to its underlying cause. In other cases, the definition incorporates a theoretical position as to why the reading difficulty arose in the first place. With a wide range of possible causes of dyslexia, there are consequently many definitions.

Third, the term is widely used, and very frequently misused, by non-experts in the field and by the mainstream media. The label is particularly popular with promoters of unproven dyslexia "cures", including nutritional supplements, exercise regimes and coloured glasses. This only adds to the confusion.

So is it the case that there is no agreed set of criteria for the clinical diagnosis of dyslexia? This may be an overstatement. Experts in the field have reached a substantial degree of consensus about what is meant by the term and how it should be defined in a clinical context. Dyslexia is widely viewed as *a severe reading difficulty that persists despite high-quality evidence-based instruction*. This is enshrined in documents such as the [Rose Report](#) in the UK, and the [Australian Dyslexia Working Party](#) report.

This definition has two key features. First, it makes a distinction between children who are struggling with reading because they have not had appropriate instruction, and those who are struggling despite having had sufficient opportunities. Second, it focuses the diagnosis at the level of reading itself.

Scientists have come a long way in developing detailed theories of the reading process. These have been translated into reliable clinical

assessment tools. Armed with these tools, clinical experts are in a position to provide a scientific diagnosis of dyslexia. Whether the term "dyslexia" or another label is used, this small group (perhaps 3-5% of the population) exists and can be identified.

Diagnosis doesn't alter the remedy

Elliott and Grigorenko's second key point is that a diagnosis of dyslexia does not have any implications for treatment. Again, they are broadly correct.

Let's say two children present at a clinic: one has fallen behind in reading because of extended school absences; the other is struggling despite high-quality instruction. The latter child might well be diagnosed with "dyslexia" and the former most likely not. Yet the programs of intervention put in place for each child would probably differ very little.

The most effective thing we can do for each of these children is to provide them with systematic, intensive evidence-based reading remediation, targeted at the gaps in their reading skills.

So does this mean that a diagnosis of dyslexia (or some other label) is unnecessary and redundant? Again, this may be an overstatement.

Although the nature of the treatments provided to these children will be similar, their length and intensity may well be quite different. Our first child should respond quickly and well once the required intervention is given; our second child may need intensive and ongoing support.

That treatment is similar across the spectrum of a condition does not mean there is no justification for giving a label to those at the extreme end. Doing so can identify the most severe and at-risk cases, in the same way that a diagnosis of "obesity" can identify the most severe and at-risk cases along the continuum of weight, and a diagnosis of "hypertension"

can identify the most severe and at-risk cases along the continuum of blood pressure. Such labels focus attention and resources where they are most urgently needed.

The quibbles about terminology remain. Many clinicians do not like the term "dyslexia" because it medicalises the condition. They prefer terms like "reading disability" or "reading impairment".

Others counter that medical terms are more visible and attract resources to a problem that may be less forthcoming if other labels are used. Professor Dorothy Bishop from Oxford University notes this concern seems to be borne out in the case of the much less visible condition of "[Specific Language Impairment](#)".

Finally, the [diagnosis](#) of dyslexia can have a positive effect on the parents and children involved, validating their concerns.

For these reasons, there is considerable divergence in the field as to which label is preferred, even among the authors of this piece. However, ultimately, deciding what label to use to identify children who struggle with learning to read is not nearly so important as ensuring they receive the support that they need.

This story is published courtesy of [The Conversation](#) (under Creative Commons-Attribution/No derivatives).

Provided by The Conversation

Citation: Should we do away with 'dyslexia'? (2014, March 21) retrieved 26 April 2024 from <https://medicalxpress.com/news/2014-03-dyslexia.html>

This document is subject to copyright. Apart from any fair dealing for the purpose of private

study or research, no part may be reproduced without the written permission. The content is provided for information purposes only.