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ABSTRACT

This paper describes how some children with learning problems feel about themselves; points out some possible witches' tales regarding understanding and communication with such children; and discusses some clinical opinions that have been developed at the Child Center, Kentfield, regarding these children. The contents of the paper include: a discussion of the lack of generally agreed-upon data concerning the cause of reading problems; a look at some of the possible pitfalls for the physician who works with children who have reading problems; a discussion of factors that tend to make the low-imagery child feel dumb and inadequate; a discussion of data from the Child Center that suggest some ways to help the low-imagery child learn; and a look at the use of input via tactile, vibration, and motor pathways to help children with reversal problems. (WR)

1972 WITCHES' TALES AROUND READING PROBLEMS

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Not long ago two men were overheard having a conversation at the end of the day in a bar in a small California community. Bill was telling Frank how much he likes his new job and his position of being an executive.

Frank scratched his head and said, "What do you mean you are an executive? With your new job with the sewer company, all you do is, I hate to use the word, is shovel shit all day."

But Bill insisted he was an executive, and went on to explain why. Bill said, "You see, I really am an executive. I'm on a three-man crew. I shovel shit to the No. 2 man, he shovels shit to the No. 3 man, and the No.3 man puts it on the truck." Frank then said, "But how does that make you an executive?" Bill replied, "Well, don't you see, I'm an executive because I don't have to take shit from anybody."

The dilema that the child has with a reading problem is very similar to that of Bill in the story. The child feels he is at the bottom of the pit, and attempts to make valiant efforts to disguise this self-imagery.

I have three goals in mind in terms of my remarks:

1. I will attempt to describe how some of these children feel about themselves.
2. I will attempt to point out some possible witches' tales in regards to our understanding and communicating with these children.

3. I will attempt to share some subjective, clinical hunches in terms of relating to these children that have been developed by my colleagues and myself at The CHILD Center, Kentfield, California.

My interest in reading problems began in 1931 when I was six years of age, in the first grade, and was having great difficulty learning to read.

I had a tendency to reverse numbers as well as letters. I was one of those who read the word "was" as "saw" and "dog" as "God". I had problems with both visual and auditory perceptions and rote memory.

I was in the bottom of the low reading group, and I felt like a dummy.

My parents were told that the public school thought I had normal intelligence and I should have my eyes checked. My eyes proved to be normal. The inference was left that I was lazy and that I wasn't trying hard enough.

The feelings that began to develop inside of me then were feelings of being dumb, inadequate, inferior to others, and these feelings persevered into my adult life.

Whatever academic successes I had later I felt were phoney because I felt like a modern car rental agency, "Mr. Avis," whose slogan is, "I try harder." I also could not learn to add without using my fingers, which did not add to my self-esteem.

I was really a "mixed bag" because, in addition to having perceptual problems and secondary emotional reactions to them, I also had some primary emotional problems.

My family, being Jewish, put great stress on academic achievement. I had two older brothers who, in my eyes, were quite bright and went sailing through their schooling with excellent grades and little effort. I went to the same public schools that they had attended. When I came along, the teacher would almost invariably say, "Oh, I remember your brothers so well; they were such good students and got such good grades. How nice it is to have you in my class."

What that comment meant to me was, "I expect you to get all A's; and by so doing, I will accept you and give you my love. If you are not like your brothers in terms of their brightness and grades, I will reject you." Well, I knew that no way could I read or be like my brothers; and, in addition, I didn't want to be. I felt like a loser from the moment I met my new teacher. I then began to think of other ways of getting approval, such as becoming the personality kid and the clown and manipulating myself into becoming class officer. In so doing, I could try to hide from myself and others my secret; namely, that I was dumb and inferior. I had the feeling of being a second-class citizen and of not being as competent as others. My motivation for academic achievement became quite fragmented.

I have a sneaky hunch that one of my motivations in going into the field of psychiatry, under the guise of helping others, was stimulated around some of these early learning experiences; and, hence, my desire to find out what made me tick so that I might feel at one with myself.

I have tried to put a few of my personal guts on the table to make the following threefold points:

The first point was that I wanted to try to paint a brief

picture of what a kid feels like inside who has a learning problem. The second point was that I don't believe that my situation in 1931 was a unique one, although I thought it was then; and in 1972 there are probably just as many children who have reading problems and have similar feelings around their difficulties in learning to read.

The third point is that in 1972 the number of children who are not helped by our special methods of remediation is probably about the same as it was in 1931, some 41 years ago.

In February, 1971, the National Research Council on Reading Problems stated that 5 to 20 percent of children in public schools who have reading problems are not helped by our present special methods of remediation.

In our modern high schools today, it looks as if about 5 percent of the students are reading on a second- and third-grade level.

In the last 41 years since 1931, there has been an abundance of literature and research by educators, physicians, and a variety of scientists, but it doesn't seem to me that there have been any major breakthroughs that everyone would agree on.

These remarks do not mean that we are not helping these children today or that we may not be more effective in certain areas. It does raise a question; namely, is it possible that the average teacher of reading was as effective in 1931 as the average teacher is today?

Perhaps it is a witch's tale to think because of our increased sophistication in knowledge about these children that we are doing a much more effective job in helping them. The mute question might be, "Are we really taking a good enough look at those children we don't help, and what really happens to them later on?"

Because one is aware of new twists in methodology such as color reading, task analyses, behavior modification, phonetics, the Sullivan method, precision teaching, the Fernald method, eye exercises, hypnoses, drugs, contractual agreements with students, psychotherapy, performance contracting with outside-of-school educational contractors, "you-name-it methods," it is tempting to assume that because it is new, it is better and more effective.

It is truly terribly frustrating for the child, his parents, his teacher and physician, and others who are trying to help him to recognize that in 1972 there is no objective, generally agreed-upon data concerning the cause of reading problems or general agreement in terms of objective evidence that a certain methodology is helpful.

The complicated nature of this problem was stressed by a recent article by Symmes in the January, 1972, issue of Orthopsychiatry titled "Unexpected Reading Failure." She stressed the difficulty of the various variables and problems in selecting the particular population to study that would allow for reduplication of the studies on a scientific basis.

Perhaps it is this complexity of etiology and methodology for helping these children that makes the area of reading problems such a fertile ground for Christian-Science type of testimonials of success. Perhaps it shouldn't seem too strange that we don't hear too much in the literature about our failures.

I would like now to try to make a bridge to some possible pitfalls for the physician who chooses to enter this quicksand arena of controversy, the area of children with reading problems.

Some physicians today still cling too closely to the medical model

and then try to apply it to the educational area, which at times results in more confusion, a lack of clarity, and an increased frustration for the child, parents and teacher.

It is my contention that medical schools still have a tendency to create feelings of ... omnipotence on we physicians, which tends to make us act as super-authorities on diagnosis and treatment. When this omnipotence in the form of a medical expert gets involved with a child with a reading problem, the physician may have a tendency to put labels on kids which directly or indirectly infers superior knowledge on the medical-educational treatment.

It seems to me rather rare that we physicians add succinct, practical information that results in dramatic, direct benefit to the child with a reading problem. Yet the inference is frequently made or assumed that the physician has some superior knowledge or something in his hip pocket that is going to prove to be of immediate help.

It has been my experience that the physician frequently becomes the false Messiah. Even when the individual physician happens to be openly honest and direct about his competencies and limitations, the cultural aspects and assumptions are still so great that a kind of unconscious witches' tale develops that the doctor really has some kind of magic, mysticism, or knowledge that will rescue everyone that's involved in the frustration of helping the child with the reading problem.

Although I believe psychiatric treatment can be helpful to some of these children, the psychiatrist also is in danger of becoming a part of the above-mentioned witches' tale. When answers are not obvious as to why a child isn't learning to read, the psychiatrist's office may

become a dumping ground. There are times we psychiatrists bite the bait, because you don't have to be terribly astute to pick up some emotional problems in a child who is having trouble learning to read; but very frequently these are secondary emotional problems due to his not learning to read rather than due to a primary emotional problem.

If we look at the child with the developmental learning problem, or if you prefer the label, dyslexic child, his reading, in my opinion, rarely shows improvement primarily as a result of psychiatric treatment.

I wish to emphasize that these children look different in the classroom than they do in the physician's office. If one spends any time with teachers, they will tell you that they rarely find practical help from the physician who sees the child in the confines of his office. When a physician in any of our disciplines sees a child in the learning situation in school where the action is, collaboration of a different flavor may begin.

Let us move on now to part three, some clinical hunches and subjective feelings about these children and our interaction with them.

To me these children appear to be on a continuum. There are those children who enter school who have been spoiled and overly gratified by their parents. They have difficulty in dealing with deferred gratification when they are not able to read immediately.

There are those children whose parents are overly demanding of academic achievement and whose children use lack of achievement in school as a displaced method of showing hostility toward the parents.

Then there are those children who simply are not ready to read from a neurological maturational standpoint in the first grade, and have no emotional problems until the system of education creates some.

Another group of children that there has not been too much comment on in the literature are those children who have delayed neurological maturation and perceptual problems in the first three years of school. A number of these children, by the time they are in the third or fourth grade, have normal perceptual apparatus but have developed a negative feeling about their ability to learn to read; and, if you will, an emotional block about their ability to learn to read.

Yet, many of these children continue to get bombarded by special perceptual techniques which leads them to believe, indeed, they are not able to learn to read.

There really seems to be so many subgroups of these children that it becomes difficult for us to agree about whom we really are talking about.

By far, the majority of children with reading problems that come under by scrutiny seem to be a "mixed bag". By this, I mean they suffer from a combination of mixed perceptual problems with secondary emotional problems, as well as having some primary emotional problems.

It is this latter group of children that is my chief interest.

I would be hard put to put these children in any known specific category. Already recognizing that generalizations are dangerous, it would seem that by the time many of these children come to the physician's attention, they seem to have a poor self-esteem. Their ability to deal with stimuli from the outer world, as well as their inner world, seems loose and fragmented. They give the impression of being unglued, and seem to be subtly asking for help in gluing themselves together. Putting it another way, their perceptual apparatus

seems like Swiss cheese in that there is a combination of solidity and holes to their personality makeup. In school, these children may feel like a jigsaw puzzle that has been thrown up into the air.

Other factors that make these children feel dumb and inadequate, besides not learning to read, are delay in learning to tie their shoelaces, difficulty in differentiating right from left, delay in riding a bike, delay in telling time, and in rote, sequential memory that results in difficulty in learning the alphabet, their phone number and address, their timetables, and the days of the week and the months of the year. Other factors that add to their feelings of inadequacy are spatial confusion and the inability to spell and write legibly. At the same time, these children may be able to tell you how man got to the moon with more clarity and precision than most adults. These kids are filled with incongruities that make them feel fragmented. To me, it is the responsibility of the medical profession that we don't let our medical system fragment these children any more than they are already fragmented.

The CHILD Center has some soft data that suggests that some of these children think and learn more effectively vertically than they do horizontally. For example, some of these children have a vertical reversal in that they draw a person picture by starting with the feet, then the body and then the head. Some of these same children seem to read better vertically than horizontally.

We have also found that in consultation as well as teaching, it seems to be frequently helpful to allow the child to be the teacher and to learn from him what is his best style of learning.

Parents of these children are oftentimes made to feel erroneously

guilty about their child's reading problems; and as a result they often unconsciously reject their child, which compounds an already complicated problem. Interview techniques that help get the burden of guilt off the parents' back and that tend to emphasize the positive assets of their child frequently prove beneficial in that it tends to raise the self-esteem of both the child and the parent.

For a good many of these children, it seems helpful to communicate with them in concrete language and to stay away from subtle abstractions. A good number of these children are deficient in auditory sequencing and in auditory recall. Frequently a false assumption is made that the child simply is tuning you out or being defiant. Hence, it seems important to give them only one direction at a time because they simply are not able to integrate three directions at a time.

This factor is important to reckon with in school, at home, and in the physician's office. With these children, the use of gesturing in the communication process is often found to be helpful.

For some of these children, it is our hunch that it may be best to defer all exposure to reading for a few years. Whatever exposure a child has to the educational process, it seems to us best done in a manner where one feels there is going to be an 80 percent chance of success and positive feedback. For some children, exposure to almost any of the reading techniques results in failure.

It, therefore, becomes apparent that many of these children do better being exposed to problem-solving techniques rather than exposure to symbols that one has to integrate that results in the process of reading.

Let's try to take this thought into the ophthalmologist's office.

As we know, visual acuity problems are very rarely found as a cause of the child's inability to learn to read.

I would like to be so bold as to suggest to the ophthalmologist that he might not limit himself to the question of whether the child can't read because of eye pathology. I would like to stimulate the ophthalmologist's curiosity into wondering what kind of learning experience might be there in the office in terms of the eye examination for a given child. Isn't it really possible that a child can learn something that he didn't know before from the ophthalmologist other than his eyes are okay? I happen to think so. I feel that a child can learn something in terms of problem-solving around the function of his eyes and how they're related to his body that will be beneficial to him when he leaves that office.

Many children tend to give me the feeling that they feel like an object being manipulated by the medical doctorwhen they go to his office, and they frequently feel nothing of value is really learned. This seems to be particularly true when the individual doctor spends most of his time talking to the parent rather than listening and talking with the child.

These children seem to need a sense of closure. It seems important to review the purpose, the whys, the whats, the hows, and what has been accomplished and give him a sense of closure. They need to know where they are, and they need as much feedback as possible in all their sensory modalities.

In my opinion, most of these children to not need direct psychiatric services. Their prime need is to have enough individualization to insure the educational process is being 80 percent

successful. When this has been accomplished, one frequently sees hyperactivity disappear without any use of drugs...

The emphasis in recent years has been to help these children as soon as we can, even before they enter school. This emphasis has resulted in the child in junior high school and high school being neglected, as many of their parents will tell you.

The junior high and high school student, because of the rigidity of the educational system, frequently get F's because they can't read the question, can't spell or write legibly, and not because they don't know how to think or because they don't have the information. Their dropping out of school because of a sick, unrealistic system may be more of a sign of health on their part than any kind of inferred sickness on their part.

It is our feeling that more emphasis should be placed on the child's best sensory modality. If his best channel is auditory perception, he should have a tape recorder. Some of these students should not be exposed to any written tests, but should only be given oral tests. These devices can make the difference between a successful or totally unsuccessful educational experience. Can you really imagine how it must feel going to high school and being told you have normal intelligence, basic skills of a third grader in terms of reading, writing and arithmetic, and told to cope and compete with your peers? How would it feel to be shoved into a regular history, science, or English class and expect to function like all the rest of the kids?

Another factor to be reckoned with is that the amount of exposure these students get to vocational training in the State of California is like spitting in the ocean. Vocational emphasis in the educational

process for these students is desparately needed.

It is also my impression that further research is needed to questioning the possibility that faulty vitamin utilization might affect the metabolism of adrenal hormones, and hence affect the brain and interfere with the perceptual functioning. The CHILD Center is contemplating research to determine whether mega-vitamin therapy may alleviate perceptual difficulties in these children.

The last experience I want to share with you has ~~to do with~~ a small pilot project I did around perception that was titled "The Combined Use of Hypnosis and Sensory and Motor Stimulation in Assisting Children with Developmental Learning Problems." It was published in the November, 1970, issue of the Journal of Learning Disabilities,[1] and the project was funded by the Babcock Foundation of Marin County, California.

Some of these children seem to have no visual imagery; they do not dream and they don't seem to be able to hold or retain a visual symbol in their mind.

I was studying children who had reversal problems. I had the notion that one might be successful at treating some of these children as if they were blind. One then had to get input into the brain by other pathways other than vision. This notion was along the lines of Dr. Paul Bach y Rita, that the brain was plastic and was capable of integrating input from the skin as visual imagery.

To help these children with their reversal problems, we used input via tactile, vibration, and motor pathways that seemed to be effective in a small group of control and experimental children.

The point I am trying to make is that perhaps we have to find for

some of these children other pathways to get information processed into the brain, with the possibility that the brain will integrate that information into visual imagery.

A plan to extend this notion will be implemented sometime this summer or fall.

Last week I talked with Dr. Bliss, President of the Telesensory Systems, Inc., of Palo Alto, California. He has agreed to let the CHILD Center use one of his $5,000 optacon machines for research purposes. The optacon is a portable electronic aid for the blind that transforms printed material into patterns of raised pins under the user's fingers.

We plan to use the optacon with sighted children who have good visual acuity but poor visual perception and imagery to investigate if they might be able to learn to read using this methodology.

In conclusion, I wish to emphasize again that I don't believe any of us have the pearls of wisdom that leads in a magical way to these children learning to read. Most of us are still involved in a trial-and-error approach. Hopefully, we can all recognize this fact, and continue to do our best at pooling our findings and expanding our multidisciplinary approach to these problems.

I will now end with a brief story in respect to the dignity of these children and how frequently they are ten steps ahead of us.

Some time ago I was seeing an eight-year old girl in evaluation who had a reading problem. She drew a picture of a typical country scene--a pretty house, a path, a garden, green grass, blue sky, and a yellow sun in the left-hand corner. Then she drew another yellow sun in the right-hand corner.

In a rather naive, casual way, I commented, "Gee, there are two suns, I wonder how come?"

She then looked up to me with her pretty blue eyes and said, "Oh, Dr. Jampolsky, I just wondered if I could confuse you."

I immediately assured her that she could.