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ABSTRACT

Reading clinics that are part of the service mission of a college or university evolved out of a medical model. Such clinics serve as research centers to investigate and study readers at risk, offer training facilities for undergraduate and/or graduate students who seek to gain expertise in the diagnosis and treatment of reading difficulties, and serve as service agencies for assisting readers at risk. The two major services include diagnostic assessment and tutoring. The basic and underlying fundamental nature of the diagnosis and treatment of reading difficulties has not progressed at a rate consistent with knowledge of the reading process. Significant and fundamental parallels exist between the wellness concept and the notion of literacy. Future reading clinics might be based on wellness principles, including: reading is more than a particular set of behaviors; reading centers on habits and attitudes; reading involves the whole family; and reading involves risk-taking. The whole area of assessment is in drastic need of a fresh approach based on current knowledge of the reading process. Traditional reading clinics need reconceptualization. The new agenda may mean the demise of the medically based model of reading disability and the development of Reading Wellness Centers that provide literacy services to a wide range of readers. (RS)

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FROM TRADITIONAL READING CLINICS TO WELLNESS CENTERS

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Northern Illinois University

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Curriculum and Instruction
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From Traditional Reading Clinics to Wellness Centers

My aim in this paper is to rethink the concept of reading clinics. I begin with historical background of the traditional reading clinic. From there, I will offer a perspective for changing the basic nature of reading clinics. That perspective draws heavily upon principles that are fundamental to the concept of physical wellness. I shall present some of these principles and suggest a few ways they could influence the restructuring of reading clinics for the 21st century. My reflections are intended to serve as a stimulus for others to develop more detailed proposals for how reading clinics of the future might look if they were based on wellness or wholeness principles.

Traditional Reading Clinics

Harris (1968) notes that the first report of a case of reading disability was made by Dr. W. Pringle Morgan. The year was 1896. Early attention to reading difficulties appears to have been undertaken by the medical field. By the early 1920's, however, books on reading disabilities were being published (e.g., Gray, 1922).

Reading clinics can be classified as full-time remedial schools (e.g., Frostig), medical clinics (e.g., Orton), and those developed by colleges and universities. Harris (1968, p. 163) notes that "the first clinics specializing in reading difficulties were begun under the auspices of graduate schools of education and included the reading clinics at the University of Chicago and Boston University. These became centers for the training of reading specialists and remedial teachers, and college reading clinics now number in the hundreds." In some of these clinics, multidisciplinary teams help to achieve the major purposes of the clinics.

Clinic Purposes and Services

The services provided by clinics depend, at least in part, upon the purposes for which they were established. Since my central focus is college and university reading clinics, I will restrict discussion to such clinics.

There appear to be three major purposes that guide reading clinics at colleges and universities. First, clinics serve as research centers to investigate and study readers at risk. Research may involve possible causal factors, assessment to determine the reading difficulty, or efforts to remediate problem areas identified. Second, clinics offer a training facility for undergraduate and/or graduate students who seek to gain expertise in the diagnosis and treatment of reading difficulties. Third, clinics serve as a service agency for assisting readers at risk. The two major services include diagnostic assessment and tutoring.

Diagnostic Assessment. The process of diagnostic assessment is usually quite formal and clinical in its approach. After referral by parents and/or the school, the clinician, under the direction of a university faculty member who supervises and helps guide the assessment process, undertakes a careful evaluation of the client's reading and related behavior. Formal case studies and reports are common outcomes.

The clinician studies available data (e.g., parent and school forms; other reports) prior to meeting with the client. The diagnostic assessment usually includes the administration of formal and informal tests to determine the client's intellectual functioning, present reading achievement, strengths and weaknesses in reading, interests and attitudes, attention and concentration, and related areas. Screening tests for hearing and vision are also given. Interviews with the client and parents (if the client is a minor), along with a careful study of other reports and assessment data, are used to explore and possibly identify factors contributing to the client's reading difficulty. Major areas often considered include intellectual, physical, emotional, environmental, and educational factors. Such areas were also suggested by Betts in 1936.

Once all the data are collected, the clinician prepares a report. Harris and Sipay (1990, pp. 388-389) and others suggest major headings for the assessment report along these lines: objective data (eg., name, school, test data), reasons for referral, health data, home background, student's

personality, school history, interpretation of reading-assessment results, summary of diagnosis, and recommendations for remedial treatment. Other suggestions for writing, evaluating, and making case studies can be found in Abrams (1988), Richek, List, and Lerner (1983), and Salend and Salend (1985). Resulting case reports are usually sent to the parents and the school. The case reports often serve as a basis for tutoring.

Tutoring. College and university reading clinics often contain physical facilities for tutoring clients who have been referred. The results of the diagnostic assessment, contained in the case report, serve as the basis for the client's tutoring program. It is not unusual for reading clinics to provide individual or small group tutoring. Such tutoring is done by university students during a term or semester.

The program will generally include objectives or goals and use a wide variety of methods and materials. Plans are developed which include a careful record of the tutoring and the client's response to the various lessons and activities. If appropriate, periodic conferences or conversations with the client's parents and/or classroom teacher are an integral part of the tutoring program. Because the tutoring program is part of a university course, there is usually provision for regular meetings between the tutors and university supervisor to discuss the client's progress and to develop additional strategies that are aimed at strengthening the client's reading.

Near the conclusion of the semester or term, a tutoring report is prepared. This report often contains the following information: objective data (e.g., name, school, number of sessions), background information, general observations, client's reading ability, program to improve client's reading ability (e.g., a description and evaluation of the methods and strategies used), and suggestions for the client's continued growth in reading. The tutoring report may also contain test and retest scores to help provide evidence of changes in the client's reading, attitude, or other relevant behaviors. For minors, a copy of the final report is sent to the parents and the client's school. Older

clients receieve the report directly. Follow-up conferences with the parents and classroom teacher may also be done.

Basic Conclusion

Reading clinics that are part of the service mission of a college or university have evolved out of a medical model. I acknowledge that there are variations to this basic approach; nevertheless, based on my experience in several different reading clinics, discussions with colleagues at other colleges and universities, and a review of textbooks in our field, I believe that the basic and underlying fundamental nature of the diagnosis and treatment of reading difficulties is not at great variance with that proposed by Clarence Gray in 1922. Unfortunately, our strides to help readers at risk have not progressed at a rate consistent with our knowledge of the reading process. Perhaps it is time for some dramatic changes.

Reading Wellness Centers

Schroeder and Smith (1991, p. 1) note that "significant and fundamental parallels exist between the wellness concept and the notion of literacy." They present and discuss a number of tenets of wellness and relate them to reading. Future reading clinics might be based on some of these principles adapted from Schroeder and Smith:

1. Reading is more than a particular set of behaviors; it is a way of life.
2. Reading embraces the physical, emotional, spiritual, intellectual, and social dimensions.
3. Reading depends not only on skills, but centers on habits and attitudes.
4. Reading involves personal choice.
5. Reading involves the whole family.
6. Reading involves risk-taking.

7. Reading instruction should help students solve problems, make decisions, and take actions by themselves.

If some of these principles are to become the basis for future Reading Wellness Centers, professionals must free themselves from the constraints of the past and think creatively. Some of that thinking should consider personnel, assessment, and instruction as the traditional reading clinic is reconceptualized. Robinson (1946) suggested and used multidisciplinary teams to investigate and remediate clients' reading difficulties. Today's reading clinics often fall short of a team approach. Public schools have some models for their staffings that may provide some valuable insights for using interdisciplinary teams in Reading Wellness Centers.

The whole area of assessment is in drastic need of a fresh approach based on current knowledge of the reading porcess. The traditional case-study approach in the clinical model may need to give way to more holistic assessments that honor insights from the classroom teacher and that use materials from the student's usual instructional environment. The use of sample lessons (Harris & Sipay, 1990), developed many years ago, may be adapted for current use. Perhaps the most fundamental changes in assessment will involve the fusion and unification of assessment and instruction. The implications of this change for most traditional reading clinics are tremendous because of separate courses for diagnosis and remediation; moreover, some states currently require separate practicums in diagnosis and remediation. The unification or reconceptualization of such courses probably would have both practical and political implications.

Rethinking instruction and the physical environment in which it takes place poses still more challenges. Small rooms designed for one-on-one tutoring may need to give way to learning environments where students are involved in group processes and cooperative ventures in learning. Instruction might use materials from the classroom and focus on strategic learning. Tutors would become coaches who help students assume responsibility for their learning. Modeling and scaffolding

would become key words in planning and implementing instruction (Paris, Wasik, & Turner, 1991). Pieces of instruction should be integrated into the larger goal of reconstructing meaning.

In a recent review of reading disability research, Wixson and Lipson (1991, p. 539) argue that "Progress in understanding reading disability can occur only if future research evolves from a more meaningful perspective." Traditional reading clinics need reconceptualization. The new agenda may mean the demise of the medically-based model of reading disability and the development of Reading Wellness Centers that provide literacy services to a wide range of readers.

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