

Script

Intro

Hello, my name is Hannah Lovell. As you can see by the title of the poster displayed, the Additional Learning Need (ALN) I have chosen to discuss is dyslexia. I have chosen this ALN as a family member has been recently diagnosed. As a result, I wish to gain a better understanding. Furthermore, when I was younger, I also struggled with reading and writing difficulties and have always wondered if it is mild dyslexia which has gone undiagnosed. It was important to me to make my poster accessible to people with dyslexia therefore, I have chosen soft pastel colour backgrounds with a dark clear font, as according to both the British Dyslexia Association (2014) and Dyslexia Scotland (2023) this has been proven useful. Some History behind the word Dyslexia itself, it was first coined by Rudolf Berlin in the year 1887. Dyslexia is a Greek word dys meaning difficulty and lexia meaning with words as stated by Lexxic (2023) and University of Oxford (No Date).

So, what is dyslexia you might ask? Dyslexia is defined as a learning difficulty that affects the development of language and literacy related skills. The person is likely to be born with dyslexia and it carries lifelong effects. It is portrayed through difficulties with rapid naming, processing speed and memory just to name a few (British dyslexia association ,2021). In addition, the automatic developmental skills may not match up with the child's cognitive ability in other areas as also stated by the British dyslexia association (2021). To summarize NHS (2024) agrees with this definition by stating that dyslexia is a reading, writing, and spelling difficulty.

Whilst researching I have found some key findings and statistics that I feel are important to share with all of you to gain an insight on this ALN. According to Elias (2023) research shows that 10% of the UK population is believed to be dyslexic and that it is more common in boys than girls. Similarly, UK Government (2017) also state the same findings however further research shows that dyslexia is a common

co-occurring ALN alongside other ALN's and often runs in families as it has been seen to link with genetics.

Diagnosis

Helen Arkell Dyslexia Charity (2021) states that like most ALN's dyslexia is different for everyone and as a result difficult to diagnose. Furthermore, every child is unique and therefore will show dyslexia in an individual way. Dyslexia can change over a long period of time because of the environment and the demands being placed on the child. Through diagnosis it alerts practitioners to the fact that dyslexia are more than just a reading and writing difficulty (Kelly and Phillips, 2016). NHS (2022) agrees with this statement by stating that it is hard to diagnose dyslexia especially in young children as the signs and symptoms are not always obvious. The signs of dyslexia in early years include difficulty learning nursery rhymes, even rhythm, difficulty with fine motor skills and often trips over ect (Lawrence, 2009; Handler, 2016).

How is dyslexia diagnosed? According to Helen Arkell Dyslexia Charity (No Date) Dyslexia can be diagnosed through assessments once a caregiver notices and highlights the signs to professionals such as and additional learning needs co-Ordinator (ALNCO). Then a diagnostic dyslexia assessment can be carried out. This assessment is for children whose literacy difficulties persist after appropriate intervention and support is given. In additional a formal diagnosis may be needed. Usually, a diagnosis assessment for dyslexia is carried out when the child is age 7 to 8 as the assessor can take the previous interventions into account. A diagnostic assessment can be carried out by a qualified dyslexia specialist or an educational psychologist and is often provided by local authority or the school setting (Helen Arkell Dyslexia Charity, No Date). The barrier to this is that the child may change their behaviour around people they are not familiar with according to Heiervang *et al.* (2001). The diagnostic assessment entails observing the child in their learning environment around key adults and asking the child to take part in a series of tests examining reading and writing capabilities (NHS, 2022). There are however barriers to a diagnosis such as staff, money and waiting lists (Cunningham, 2021). To expand, British Dyslexia Association (No Date) states that on average it takes 3

hours to assess a young child for Dyslexia that is after the up to a year waiting list. Diagnosis is important according to Andresen and Monsrud (2022) so that the child receives the right support, and educational interventions are likely to be more effective. Welsh Government (2018) also agrees with this statement by saying the earlier the ALN is identified and diagnosed the sooner the support can be provided. On one hand, according to Makela *et al.* (2009) Diagnosis is also important as people tend to be more understanding once a child has a diagnosis. However, on the other hand, O'Connor *et al.* (2018) disagrees with this statement by stating that Labelling children has a negative impact on the child's social identity and self-esteem.

Statistics

If we all refer to the poster, the table at the bottom shows us that in the years 2022/2023 majority of children with dyslexia are school actioned this means that the class teacher identifies the ALN and provides interventions as part of the school's curriculum. It is relevant as this provides an insight to dyslexia in Wales and how it is most commonly diagnosed (Dewis cymru 2020). The chart was a source by Welsh Government (2023a). However, research shows that staff are Inadequately prepared therefore, lacking training and awareness in ALN. As a result practitioners may not feel confident and are scared to get it wrong (Knight, 2018). I can definitely say I am. According to smeets and roelveld (2016) some practitioners are less willing to accommodate students with ALN for these reasons.

Barriers

I am now doing to be referring to the section on barriers in my poster. Barriers for ALN's can be both medical and/or social. The term medical model of disability was coined in the 1950's and is linked to the medical profession also ALN as a condition (Hogan, 2019). Toro, Kiverstein and Rietveld (2020, p.1) states that disability is something to be diagnosed, treated, and cured through normalization. In addition, Guevera (2021) agrees with this by stating that disabilities are seen as defects that require treatment. To critique this, disabilities and ALN's cannot be cured, and children have to be supported through them to receive the best possible outcome

(UK Government, No Date). There are many barriers to dyslexia as a condition which cannot be cured such as the cognitive barrier of difficulty focusing resulting in being prone to distraction. The child may put pressure on themselves knowing that they have to write and will do anything to get out of work. Work avoidance tactics can be displayed though sharpening pencils, looking for books and outburst of temper causing disruptiveness for the other children (Syal and Torppa, 2019). Furthermore, dyslexia can then lead to depression or anxiety according to Armstrong *et al.* (2017, p.12) as children with dyslexia are seen to have poor self-esteem.

Dyslexia as a condition also has a barrier of poor memory retention ability as in short term. The effects of poor short-term memory may result in the child forgetting books/ PE kit and being punished as a result according to Marino *et al.* (2007). An experienced practitioner should have the knowledge in dyslexia and understand that this is caused by the condition and not punish the behaviour. If the child has poor short-term memory, they may struggle to pay attention as stated by think Neurology for kids (2024).

The Social model of disability was developed in the 1983 by Mike Oliver (Sense ,2024). The social model states that children's learning opportunities are limited by the environment, and not by their ALN (Burchardt, 2004). To expand, the mainstream classroom can be seen as a barrier for children with dyslexia for numerous reasons such as the lack of access to specialist dyslexia support and other children learning at a faster pace (Pollock, Waller and Politt, 2004). In addition, the child with dyslexia may not have the confidence to speak out and ask questions when being taught as a group (Leseayne *et al.*, 2018). To counteract, Swansea Council (2023) disagrees with this statement by voicing that all children with ALN will have their needs met in a mainstream classroom (Lamport, Graves and Ward,2012).

An enabling environment should be provided by the practitioner ensuring that materials and open-ended play is put in place to promote children with dyslexia (Welsh Government ,2023b). As according to Nancy and English (No Date) a multi-sensory environment is best for children with dyslexia. When planning activities priority should be based around what the child can do and not what they cannot, also building on their interests according to UK Government (2020). To expand, the child

with dyslexia should also be assessed in a way that suits their needs for example, through more creative activities, sometimes this is not met in a mainstream classroom (Douglas *et al.*, 2015). There are laminations in the traditional classroom such as whiteboards and textbooks according to Absolutely Education (2024) and (Welsh Government ,2012). However, one of the aims in the new curriculum for Wales is to support enterprising and creative contributors which promotes the need of children with dyslexia as they are usually more visual and creative learners. Assessments will now also be built into everyday practice (Welsh Government ,2023c).

Research shows that the Warnock report 1978 changed the education system by sending all children into mainstream (Brahm Norwich ,2019). Maxwell *et al.* (2020) disagrees with this by stating mainstream is not for everyone. In addition, in the year 2005 Warnock later changes her mind and brings back special teaching facilities (Warnock and Norwich, 2010). This shows that she came to terms with a one size fits all do not approach does not work. To summarise the mainstream classroom is a barrier for children with dyslexia for numerous reasons.

Support Strategy's

My chosen support strategy to support children with dyslexia is a multi-sensory room. A multi-sensory room is defined as an immersive experience through the activation of different elements such as lighting, music, textures, and objects according to the multi-sensory blog (2019). For example, elements that may be found in a sensory room are bubbles, ball pit, trampoline, sand, lava lamp and projections among other elements. It is an appropriate support strategy for children with dyslexia as it has been seen to improve fine motor development, social skills, communication, improving and boosting intellectual activity (Unwin, Powell and Jones, 2021; Stephenson, 2002). The main benefit of a multi-sensory room is that it allows children to awaken memories through familiar textures according to UK Government (2022). This will support children with dyslexia due to their poor short-term memory (Wales dyslexia, No Date).

On the other hand, there are barriers that we must acknowledge to a multi-sensory room. The negatives include staffing, for example if the staff member is included in the staff to child classroom ratio, then settings may not have that extra staff member to take children out to the multi-sensory room. There is also the possibility that leaving the classroom draws attention to the child. As a result, this could then lead to potential bullying. Cost is also a massive barrier, all settings might not have the budget and the extra space to provide the children in their care with these rooms (Welsh Government, 2021). Accessibility may also be an issue if the room is already occupied by one child, then another child will not have access to it (Grace, 2019). Maria Montessori states that if it benefits all children then why we are not giving the opportunity to all (Mushamba, Burney and Kent, 2017). This can be applied in this case as multi-sensory rooms are beneficial to all not just children with ALN.

I have first-hand experience with this support strategy and have previously used this when supporting a child with another ALN. I have observed that it helps to regulate a child's emotions and promotes curiosity. If we did not have interventions like multisensory rooms then we would see an increase in Underachievement, Low self-esteem, and Poor motivation (Hebert *et al.*, 2018; Loveland-Armour, 2024). In order to boost self-esteem and motivation praise should be given (Ainscow and Hargreaves, 2016). I believe that this support strategy would be beneficial to children with dyslexia. However, Snowling (2013) states that there is no intervention that benefits all children and as a result there is a variety of responses. If this does not benefit the particular child, you are caring for then an alternative support strategy should be put in place. Snowling (2013) also states that it is good practice to ensure that interventions are multi-sensory. Kelly and Phillips (2016) also agree with this stating that successful programmes are multisensory.

Conclusion

To summarize all the points made, dyslexia has been around since 1887 and is defined as a difficulty regarding reading, writing, and spelling. Diagnosis and early intervention are key to provide the child with the support they require. There are both

social and medical barriers to ALN's such as the condition itself and the environment. Furthermore, support strategies such as sensory activities should be put in place and carried out effectively to reach the desired outcome for the child. If you require further information, I suggest looking at the British Dyslexia Association website as I found this extremely useful and an easy read.

Thank you all for Listening, any questions you would like to ask?

Question: Thank you for your insight to dyslexia. When discussing support strategy's, you only mentioned the multi-sensory room were you able to find anymore?

Answer: Yes, I'm glad you asked. I was also able to research a little bit about textured touch and trace cards as this helps to support the reading, writing, and spelling side of dyslexia. The cards promote correct letter formation through coloured dots and arrows (Hossain *et al.*, 2022).

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