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INTRODUCTION

The word Dyslexia 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). 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. In addition, the automatic developmental skills may not match up with the child's cognitive ability in other areas as stated by the British dyslexia association (2021). 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 additional learning need (ALN) alongside other ALN's.

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 diagnosing it alerts practitioners to the fact that dyslexia are more than just a reading and writing difficulty. 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, difficulty with fine motor skills and often trips over (Lawrence, 2009; Handler, 2016). Dyslexia can be diagnosed through assessments once a caregiver notices and flags the signs. A diagnostic dyslexia assessment is for children whose literacy difficulties persist after appropriate intervention and support is given, 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 is carried out by a qualified dyslexia specialist or an educational psychologist and is often provided by local authority or the school (Helen Arkell Dyslexia Charity, No Date). The diagnostic assessment entails observing the child in their learning environment around key adults and asking the child to take part in numerous tests examining reading and writing capabilities (NHS, 2022). There are however barriers to a diagnosis such as staff, money and waiting lists (Cunningham, 2021). Diagnosis is important according to Andresen and Monsrud (2022) so that the child receives the support, and the more effective educational interventions are likely to be.



SUPPORT STRATEGY

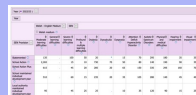
The chosen support strategy to support children with dyslexia is a multi-sensory room. A multi-sensory room is defined as an immersive experience through the activation of different elements according to the multi-sensory blog (2019). For example, elements that may be found in a sensory room are bubbles, a ball pit and lava lamp. It is an appropriate support strategy for children with dyslexia as it has been seen to improve fine motor development, social skills, and 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 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 (Welsh Government, 2021). If practitioners 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). To boost self-esteem and motivation praise should be given (Ainscow and Hargreaves, 2016). Snowling (2013) states that it is good practice to ensure interventions are multi-sensory Kelly and Phillips (2016) also agrees with this stating that successful programmes are multisensory.

(Source: Denby, No Date)

What dyslexic people see

STATISTICS

This graph shows that in 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 diagnosed.



(Source: Welsh Government, 2023)

BARRIERS

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 and 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 must be supported through them to receive the best possible outcome (UK Government, No Date). There are many barriers to dyslexia as a condition such as the cognitive barrier of difficulty focusing resulting in being prone to distraction. The child may put pressure on themselves knowing that they must 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, this could 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. 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 (Leseys *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).

"The only disability in life is a bad attitude" Hamilton (No Date).

CONCLUSION

To summarize all the points made on this poster dyslexia 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. Furthermore, support strategies should be put in place and carried out effectively to reach the desired outcome for the child.