



Contributory Factors.

Dyslexia is a neurological difference with educational implications. The first symptom noticed is usually a literacy difficulty. However, many aspects of body, mind and individual circumstances may be contributory factors. They should be considered when assessing for dyslexia.

Checklists, screening, assessments by post and computerised assessments are not likely to take these into account. Long, detailed, expensive multi-disciplinary assessments are not always necessary.

An experienced psychologist or specialist teacher will ask if the following contributory factors have been checked.

Assessors may notice signs and suggest further investigation in relevant areas.

1. Birth history.

Were there any problems before, during or after birth, e.g. a premature birth?

2. Family history.

Are others in the family dyslexic? There is usually a genetic factor in developmental dyslexia, though other family members may have varying symptoms and severity.

3. Educational history.

Has school experience been of the usual kind? Are Special Needs recognised? What intervention has there been? To what extent has it helped?

4. General health.

Have there been any long illnesses, involving school absence? Could there be any undiagnosed conditions, e.g. mild epilepsy or petit mal, which may look like inattention and gaps in continuity? A physical injury or a stroke may indicate acquired dyslexia.

5. Vision.

School medicals are not enough. Has vision been checked by an optometrist? Does the testee lose his place when reading or make many reversals? Is the testee light sensitive or does the print blur or appear to move? (See [Eyes and dyslexia](#).)

6. Hearing.

Has hearing been checked? As a young child, did the testee have 'glue ear' which may have hindered auditory perception of sounds in words?

7. Speech and language.

Have there been delays or deficits in speech and language development? This includes pronunciation of words, vocabulary development, and complexity of spoken language and understanding of language heard. Is there a tendency towards dysphasia? Would a referral to a speech and language therapist be advisable?

(See Related organisations: Speech)

Is English the first language of the testee and in the home? This could have implications for test results, even for visual/spatial aspects of cognitive ability for which oral instructions are given.

8. Co-ordination.

Is the testee clumsy or accident-prone? Does this affect gross and fine motor movements? Does it include awareness of one's own body in space in relation to people and objects? How about anticipation of the movements of others, e.g. in team games? Is there a tendency towards dyspraxia?

(See Related organisations: Dyspraxia.)

That would be a possibility if verbal ability is considerably higher than visual-spatial skills in ability tests. Would a referral to an occupational therapist be advisable? Left-handedness is not significantly higher in dyslexics but life is harder for all left-handers. Cross-laterality is not significant either. However, late development of hand dominance or non-dominance of hand, eye, foot, seems to happen more often in dyslexics. This may not be full ambidexterity.

9. Attention and Emotional Behavioural aspects.

If this is present, is it a primary factor or an outcome of frustration at difficulty in learning?

Emotional behavioural disorder appears to be controllable and intended to annoy.

Attention Deficit Disorder, with or without Hyperactivity, appears to be involuntary, purposeless and puzzling to all concerned. (See Related organisations: ADD/ADHD)

10. Communication/relationship aspects.

This is different from speech and language disorders. Does the testee have difficulty making eye-contact, communicating and making relationships and showing appropriate behaviour? Is there a tendency towards some aspect of autism? (See Related organisations: Autism)

11. Self-esteem.

Literacy is deemed very important in our culture. It is not surprising that those who find it difficult are very frustrated, depressed and have low self-esteem. There is controversy about giving labels, but most dyslexics are very pleased to know that there is a reason for their difference.

12. Intelligence.

There is controversy about the nature of intelligence and how to measure it, but it is a useful concept. It is as wrong to be expecting too much of someone with below average intelligence as it is to be expecting too little of someone with high intelligence.

People of high intelligence who can grasp some things quickly may be very frustrated by their slowness in literacy skills.

People with very low cognitive abilities known as global learning difficulties or mild, moderate or severe learning difficulties may have some dyslexic characteristics but their low intelligence is the primary factor.

Dyslexics usually show a varied pattern of abilities.

13. Diet supplements and drugs.

There is no pill that makes learning to read easy. However, nutritional vulnerability or deficiencies may affect concentration and behaviour. Therefore they affect learning indirectly. Research suggests that some dyslexics lack a natural production of some essential nutritional ingredients. Some people are allergic to food additives. Some drugs control behaviour, but their long term effects are not known. They should only be given on medical advice.

14. Individual styles for learning, working and living.

The assessment should reveal strengths as well as weaknesses. Some dyslexics develop strategies for their own ways of doing things and this should be encouraged.

