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READING PROBLEMS— PREVENTION RATHER THAN CURE

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Obituary notice: Jones, Johnny

Johnny Jones failed to learn to read while a student in one of our local elementary schools. He suffered from a lingering illness apparently caused by a premature introduction of beginning reading, followed by an overdose of dull and, at times, inappropriate instruction, culminating in loss of interest and motivation to read. No special services are planned to mark his passing, nor is it expected that the public will have an opportunity to notice Johnny in the future. He is survived by his disappointed family and friends who stated: "We always thought that Johnny had the potential to do better in school."

As the title suggests, there is concern among many of us that children can experience serious difficulty in learning to read. We expect to see some evidence of confusion and incomplete skill development as our pupils are learning to read. The quandry we face, however, is that some of these children do not grow beyond these stages—they continue to be confused, to not work up to their full potential. Often we have been unable to identify these children from the others in order to provide special instruction early enough to avoid compounding the learning problems that soon arise. In many schools, by the time the parents and teacher realize that the child is having serious difficulty learning to read, often the child has decided that he is stupid—or that school is "dumb"—and we face behavior and motivation problems which compound enormously the task of remediation.

Notice the terms we commonly use to describe corrective reading procedures: symptom; disability; treatment; cure; prescriptive teaching. Such terms, and the title of this article as well, suggest that often we view the instruction of children in much the same way as the doctor views the care of his patients. We would see ourselves as the physician and our pupils as the patients—to be treated with knowledge and concern so that they can live healthy, happy lives.

Ideally, we would like to avoid having the child experience frustration and failure so early in his school career, and so the title of this article "Reading Problems—Prevention Rather Than Cure"—seems reasonable. Yet, it is not. In fact, I believe that this approach to teaching children to read creates more problems than it cures!

A brief examination of a medical setting may help to explain why this is so. In the doctor-patient relationship it is the doctor's task to heal the

patient when he is sick, and to keep him healthy if possible. To do so, the doctor may prescribe a special diet, supplemental aids like vitamins, or a special program of exercise when the patient shows signs of overweight or physical weakness. If the doctor is puzzled by the symptoms he sees, he can call for an examination of the patient by specialists who may use elaborate equipment and techniques to determine the cause of the problem. Since, at times, the symptoms may suggest several possible causes, the doctors may prescribe first one, then a second, then a third type of medication in the belief that one of them will cure the patient and will also suggest post hoc what the problem really was.

In this setting the patient is expected to trust in the doctor's skill and to accept rather unquestioningly his advice and treatment. The patient role is essentially a passive one.

Often our approach to teaching children to read is like the physician's approach to treating sick patients. We presume responsibility for determining the best preparations of basic reading skills for our pupils. We determine the content of the reading program, the rate (dosage) in which it is administered, and the form in which our pupils receive it: direct instruction, workbooks, supplemental activities, tests. We are continually on the watch for signs of weakness or failure in our pupils; when we see evidence that a child is not operating up to his potential (something *we* decide) we diagnose the child's "problem" and prescribe some remedial treatment.

Like the doctor, we expect that each child will listen to our directives and do the work assigned—trusting that we know what's best for his intellectual development (as the doctor does the patient's health). The child who does not accept this type of pupil role—who resists our efforts to prescribe his program—is considered difficult to teach and a problem in our classroom. Despite such problems, we have persisted in our belief that if the method(s) we employ to teach reading are taught thoroughly, systematically, and with determination, most of our children will learn how to read. For the few who resist our efforts, or who have too many problems beyond our influence, failure is an unhappy but not unexpected outcome.

However, there are three fundamental weaknesses inherent in this medical model applied to teaching reading. First, we expect children to find reading difficult. Consequently, there is a tendency in our approaches to teaching reading to look for areas of weakness—of failure—and to overlook areas of strength and achievement. Over time some of our pupils, especially those experiencing difficulty, may infer that little that they do is "right" and, in fact, that they are not even progressing despite the efforts they have made to learn.

Robbed of confidence in their own ability to achieve, many pupils become uninterested, unresponsive, and passive members of our classroom. While many of these pupils may eventually learn the basic decoding skills, they find little enjoyment in reading and little desire to read beyond our directives. So, we've achieved our goal of teaching most of our children to decode—but at what cost!

Second, a medical approach to diagnostic teaching of reading is almost completely one-sided. It is the pupil (patient) who is diagnosed to discover his “problem” — never the teacher (physician). The results of most diagnoses of reading performance involve pupil adaptation to the adopted program — not vice versa. Yet, both Bond and Tinker (1973) and Robert Wilson (1975) state in their texts on corrective and remedial reading procedures that the major reason for reading failure is poor and inappropriate instruction — not pupil inability to learn to read.

Unless our diagnoses are two-sided — to examine our own effectiveness as teachers and the quality of our program, as well as how our pupils are progressing — we may not learn enough to promote acceptable pupil growth in reading.

The third major flaw in using the medical model concerns the teacher-pupil relationship. A good patient accepts completely his treatment as prescribed and avoids self-treatment; a good learner, however, must actively participate in his own education since desire, interest and attention are prerequisites to learning. If we don't seek to involve our pupils in planning at least part of their daily work, and permit them to make choices among a limited range of possible activities, then we can expect our pupils to show little enthusiasm or responsibility (independence) for what they must learn. Without enthusiasm, or at least interest, learning is minimized and often what is learned is not generalized beyond the teacher-school setting. In a sense, we've administered the proper medications, but lost the patient.

Consequently, I'd like to suggest an alternate model which presents a more positive and productive way to view reading instruction. Instead of viewing our reading instruction as an effort to PREVENT FAILURE, why not look upon teaching as BUILDING PROFICIENCY? To do so, let us first agree that children, like each one of us, much prefer to do those activities which they feel they do well, and to avoid doing those things in which they have little confidence.

If we view the child who enters school as an eager, curious individual (who may or may not be ready to sit still, attend carefully, and persist at school tasks) one whom we can direct, not prescribe, into interesting learning situations that they are ready for, then we have rejected our medical model from the start. In this second model the child is recognized as the *learner* (the client), the person responsible for trying to understand, to attend, to think, in order to learn. It is also assumed that he has the *potential* to succeed. The teacher acts as a *consultant*, an adviser, a motivator, and an expeditor attempting to guide the learning process. In order to be effective in this role, the teacher assumes that grade levels are only guides to plotting individual progress, not goals that every child can, or should be expected to reach or to be held back for.

This is not a “love'm and they'll learn” model of instruction. Teachers are still responsible for instructing children and must require a reasonable level of student productivity. However, unlike the medical model of teaching reading, this model acknowledges the fact that learning occurs

within the child and cannot be compelled if the child is passive or uninterested. Since reading, by definition, requires that the child think in order to derive maximum value from the teacher's instruction, it is not reasonable to presume that increased dosages of instruction (like medicines) can ever compensate for the child's inattentiveness or lack of interest.

As the teacher emphasizes what the child can do well, and uses these signs of achievement to signal the introduction of new instruction, the child will recognize that he has succeeded and can continue to do so. The child learns to interact positively and confidently with the teacher to learn new skills and gain more knowledge about the world and his own ability to perform independently. The purposes for the teacher's instruction and the pupil's need to attend and participate become progressively more certain in the child's eyes even as the desire to continue to read grows—because reading is viewed both as important and as enjoyable.

With this orientation, the following approaches to reading ought then to make sense.

From kindergarten, the child should be continually exposed to books through interest centers, story tapes, being read to by the teacher, older students, and their parents, and through brief instruction on the various parts of a book, how books are created, and, as interest develops, how the print represents what we say.

Regardless of the approach you adhere to—be it whole word, phonics (single letter or family), language experience, etc.—your room would include slides, pictures and objects of interest from the community along with the printed words—as labels—which represent those concrete experiences. Most children will absorb, almost unconsciously, a basic sight vocabulary simply by having their attention drawn repeatedly to the words and phrases that represent real events. And as you begin to teach the skills necessary to read fluently and critically, your efforts to help the children understand *WHY* they are doing the various exercises and *HOW* these exercises will give them access to books will be critical to the success of your program.

Instead of surgically dissecting the reading program into tiny, molecular skills to be taught in a rigid sequence for every child, you would struggle to present the particular skills in a coherent fashion related to the act of reading books. In other words, even though you have studied carefully the various skills involved in reading print fluently, you would recognize that it is not so important that the children isolate the skills as it is for them to integrate those skills effectively into their own reading strategies. For we do know this about proficient readers—they seem to integrate, almost unconsciously, the various skills we teach into an effective method of reading while the poor readers seem to learn the skills separately, yet do not integrate them into an effective strategy for processing print.

From first grade, acknowledging the range of reading skills, children should be allowed to read anything they wish during Sustained Silent Reading (SSR). *Everyone*, especially the teacher and possibly the school principal, reads—or looks at pictures—for an appropriate length of time

(two or three times per week) with no obligation to report on what was read in order to stress the importance of reading for enjoyment.

Limit the volume of worksheet exercises and provide more free reading time. When sheets are provided, they should offer some choice and allow the pupil to *practice* skills rather than to always be *tested* on his knowledge of skills.

That is,

- 1) The items should have more than two possible choices so that an inappropriate answer does not, by default, identify the correct choice.
- 2) The students should be free to check their answers—perhaps with the “student checker” of the week—and then, having discovered which items were correctly answered, figure out the answers to those that were wrong.
- 3) The student should have some *choice* of which sheets (on the same skill) he will do, or which eight out of ten items on a page he will do—to develop student responsibility for the work he does.
- 4) There should be a place on most sheets for the student to write his own explanation or examples to show that he understands—i.e., not just recognition, but production ability should be exercised.

Encourage your children to write daily, and to share their writings with others, perhaps by putting them in books to be incorporated into the class library.

Reading corners—attractive, secluded, cozy—would be an essential addition to every classroom. The books would rotate frequently, perhaps with the aid of the public library. In addition to free time, every child would go to the reading corner on a regular basis just to read and look at pictures as part of his reading assignment.

Know your pupils individually—keep interest inventory (cards) on each student (perhaps through interviews) and periodically provide reading materials on that topic as “surprise gifts.”

Utilize a method of plotting progress in skills so that you can effectively plan your practice exercises to fit the special needs of each child by building upon strengths, or weaknesses.

You can do this by

- 1) Using an IRI 2-3 times a year.
- 2) Do oral reading for diagnosis within your reading groups once or twice weekly.
- 3) Use multiple response devices to get high density feedback during skills lessons. (See Gambrell, L. and Wilson, R. *Focusing on the Strengths of Children*, 1972).

Keep fresh yourself.

Attend conferences - ask for professional leave.

Subscribe to journals and other professional magazines, and *read* yourself.

Meet regularly with other teachers and specialists in the district to share ideas (a district newsletter serves this function well).

—Relax (easy to say, hard to do)—individual student progress, *not* meeting grade-related deadlines, is what is important.

Therefore, as one who facilitates the learning of *clients* let's form our program to fit the needs, interests, and talents of our children, *not* force the children to fit the program.

To teach a child to mechanically process print, while destroying his desire to read, serves no purpose. Worse, it may prevent him from discovering the joy of reading later on when the need to read is felt.

I believe that a more realistic and service-oriented view of the teacher-pupil relationship will help us to achieve our elusive long-range goal—to develop readers who *want* to read.

Then, instead of writing the obituary notices for such a significant proportion of our children, the following statement can be written instead:

NEWS DEBUT

Mr. and Mrs. William Franklin, proud parents of Willie Franklin, age 13, are pleased to announce their son's graduation with honors from the local elementary school. Willie has successfully learned to read critically in the content fields as well as narrative materials. In a recent interview Willie stated that learning in school was not too hard and sometimes was fun. He said that his teachers really tried to help him stay interested in things and even let him read what he wanted to read—sometimes.

Willie plans to continue reading books because, said Willie, "Reading books helps you to know more about people and things and because reading books is fun." His parents asked that a special note of praise be given to the elementary school staff who worked so conscientiously to discover their son's interests and to help their son prepare for the future.

Hopefully, at this point you will concur that the title of this article "Reading Problems - Prevention Rather Than Cure" should be changed to read: "Reading - Service Rather Than Surgery." In a similar vein perhaps you will consider a slight alteration in your own job description—from one who *assigns* to one who *assists*.

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