

Specific learning difficulties in healthcare education: the meaning in the nomenclature

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Specific Learning Difficulties (SpLDs) refers to a group of conditions, which encompasses: dyslexia, dyspraxia, dyscalculia, dysgraphia, and Attention Deficit Hyperactivity Disorder (ADHD) (Gibbs et al., 2007). In recent years, however, there has been some debate as to the correct terminology for this diagnostic cluster. This in turn creates uncertainty for the non-specialist healthcare educator. The language and term(s) they choose to adopt may hold unintended implications for their learners. Throughout this short article, we therefore explore the variety of terminology surrounding these conditions. We also discuss the potential inferences behind each of these, to better equip teachers to navigate the increasingly diverse world of healthcare education.

EW is a dyspraxic medical student – she has experience of both living with and researching dyspraxia within medical education. In addition, SS is a junior doctor with dyslexia – he has experience of both living with and researching dyslexia within medical education. It is these experiences, informed by the existing literature, which facilitated the development of this piece.

It is generally acknowledged that the first half of the SpLD acronym stands for ‘Specific Learning’. However, the latter part varies from ‘Disability’ to ‘Difficulties’ and, more recently, ‘Differences’ (Gibbs et al, 2007; Cole and Kraft, 1964; Pollak, 2009). With this variety in nomenclature comes a variety of inferred meaning. The term that is adopted implies the underlying attitudes or beliefs of a given person or organisation (Kapp et al., 2013). Therein lies the importance of understanding the meaning behind this nomenclature.

Calling these conditions Specific Learning *Disabilities* may infer that such individuals are, by definition, less able than others. It implies that their condition has a negative impact on their abilities, and could be perceived as an insurmountable obstacle – especially in trying to access higher education (Pollak, 2009). It may also confer the negative stigma that is associated with being ‘disabled’, which may have wider psychological effects. However, having the clear label of ‘disabled’ may also allow individuals to access support and funding.

Adopting the term Specific Learning *Difficulty* may infer that these individuals will struggle compared to their peers, but do not possess a lack of ability. It implies milder problems than term *disability* – suggesting that issues may be overcome with supportive measures, which can allow them reach their full potential (British Dyslexia Association, 2005; Riddick, 2009).

Furthermore, calling them Specific Learning *Differences* may infer that individuals with SpLDs do not have difficulties at all – but that they simply learn in different, unexpected ways (Pollak, 2009). The British Dyslexia Association first coined the term Specific Learning *Difference* in 2005 (British Dyslexia Association, 2005). Here they explained that, through using the term *difference*, it allows equal focus on both the strengths and weaknesses of individuals. It also places the emphasis on the teacher, to ensure that their lessons are inclusive to all learners (British Dyslexia Association, 2005). However, for those with more severe SpLDs, calling it a *difference* may leave them feeling as though the challenges they face are not acknowledged, or not validated.

This variety in contemporary nomenclature may be misleading to those unfamiliar with this area – such as non-specialists involved in the teaching, support and supervision of healthcare students. In turn, this may impact upon their expectations of individuals with SpLDs, and the supportive measures they may offer them (British Dyslexia Association, 2005; Riddick, 2009).

Exploring the issue from a different angle, we shall now consider how individuals with an SpLD may choose to identify themselves – how they construct their personal identity in relation to their SpLD(s) – for example, using the case of an individual with dyslexia. Should one use the term “I am *dyslexic*” or the term “I *have dyslexia*”? Or, when referring to such individuals, should we as educators say “*a dyslexic student*” or, “*a student with dyslexia*”?

Whilst little research has explored this within SpLDs, there has been much research into the terminology used to describe individuals with autism. The research community have been shown to prefer the term “person with autism” (Kapp et al., 2013; Ortega, 2009). However, studies show that those with autism themselves actually prefer to identify as “autistic” (Kapp et al., 2013; Ortega, 2009). This may stem from a fundamental difference in their understanding of how an individual is affected by their autism. Those that feel that their autism positively contributes to their identity are more likely to use the term “autistic” (Kapp et al., 2013; Ortega, 2009) – recognising it as an integral part of themselves, which helps to define them. This is also advocated by the “neurodiversity movement”, to promote individuals taking ownership of their condition (Kapp et al., 2013; Ortega, 2009). However, those that feel that autism is a “disease” are more likely to separate it from their identity – thereby opting for “person with autism” (Ortega, 2009) – something that may be attached to them, but does not define who they are.

In a similar way, those with dyslexia may choose to embrace this aspect of their identity as “a dyslexic”, or to use the term “person with dyslexia” if they prefer to distance themselves from their condition. Anecdotally, we have encountered similar concerns within our own research into dyslexia and dyspraxia. Journals have specifically asked us to refer to ourselves, or our participants, as “individuals with dyslexia/dyspraxia”. However, is this always appropriate? Does this always reflect the intended ownership of the condition? And could this alter the intended meaning?

Personally, our opinions on this matter are divided. EW prefers the term “dyspraxic medical student”, whereas SS prefers to refer to himself as a “doctor with dyslexia”. SS believes that his preference has developed through years of writing to please journals and the academic community, having previously called himself “dyslexic” in years gone by. Perhaps there is indeed a place for both terms within academic and day-to-day life.

Taking this a stage deeper, one may also ponder the use of the term ‘condition’ to describe an SpLD. This places a medicalised slant on the way we view SpLDs. As members of healthcare professions, such terminology comes naturally to us – it is every day, and has been imprinted on us since we first trained within our respective fields. However, there is increasing interest in stepping away from this mind-set in the world of SpLDs. In order to explore this more fully, we must first introduce the concept of the ‘medical model’ and the ‘social model’ of disability – specifically, how they differ from one another (Shakespeare and Watson, 2001).

Within the medical model of disability, a disability is seen as a problem with the individual in question, where their difficulties prevent them from performing as expected by society. It is seen to reduce their quality of life, and emphasis is placed on “fixing” the individual (Shakespeare and Watson, 2001). In contrast to this, within the social model of disability, it is believed that a disability stems from issues with the attitudes of society, causing environmental, organisational and social barriers, which act to “disable” an individual (Shakespeare and Watson, 2001).

This therefore raises the question of whether or not we should be labelling SpLDs at all. Are those with SpLDs truly disabled? Do they have difficulties? Are they different? Or does society simply need to reframe its constructed beliefs and expectations of those within it? As our culture continues to evolve, our terminology within this field may continue to change accordingly.

“Everybody is a genius. But if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid.” (Unknown, but often attributed to Albert Einstein) (Quote Investigator, 2013).

In summary, there is currently a lack of consensus in the nomenclature surrounding SpLDs and how one should refer to individuals with them. Without this consensus it leaves this important area open to interpretation and potential confusion for everyone involved – particularly non-specialists. It is our opinion and expectation that this will continue to change as societal views of SpLDs evolves over the coming years.

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