THE ADAPTATION OF THE ORTON-GILLINGHAM APPROACH FOR USE IN A PUBLIC SCHOOL SYSTEM*

ARLENE WHITEMAN JONES **

So that our focus is directed toward the same target, let me clarify the title, or at least qualify it. It should be understood that we are here concerned with small groups of children in a preventive or remedial program and not with a regular classroom of students. There are some noteworthy programs where the Orton-Gillingham approach has been adapted to classroom use, but our attention is here turned toward teaching dyslexic children in small group settings.

In this brief session I cannot say as much as I should like to about the relation of the special language teaching to our entire educational picture, but it is important at the outset to stress that concept of the growth and development of the whole child provides its background and sets its tone.

Assuming the goal of human life to be social and personal fulfillment, we will explore here one culturally mandated skill important to the aim—the effective use of symbolic language. For most children this presents no problem; for others it is a devastatingly hazardous requirement.

How does a child in need of special help get into the appropriate program in our schools? In California the classroom teacher and the principal make the referral to the special education department or to the psychologist for a diagnostic evaluation, which will include a physical examination by the child's family doctor, a home visit by the school nurse, and a psychological work-up. All of this information is presented to an admissions committee which is mandated by state law. When the student has been deemed eligible for the Educationally Handicapped Program, he then becomes part of a full-time class of eight to twelve children or a part of a small group of one to eight where he works with the specialist for 30-90 minutes a day and remains in his regular classroom the rest of the time. This program is entirely separate from the programs for the educable mentally retarded, the orthopedically handicapped, the deaf and the blind students.

Once the child has been assigned to a specialist, further diagnosis and techniques of teaching are entirely in her hands. In Claremont, we have found the Orton-Gillingham approach to remediation a most valuable one because of its disciplined structure and its flexibility in combination with the use of other interesting materials.

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** Master Teacher and Consultant, Educationally Handicapped Program, Claremont Unified School District, Claremont, California.
Every person involved in this sequence has a unique and vital role to play. The classroom teacher is cast in the leading part. Whether a child is headed for a program of prevention or remediation, the key person in making the referral is the classroom teacher who has been trained to make discerning observations. She sees the students at work over significant periods of time and has a basis on which to evaluate persistently inadequate performance inappropriate for their school experience. She will not see all of the following discrepancies in each child but probably two or more can be observed:

- rotation and reversals in letters and numbers
- poor visual and auditory memory, discrimination and sequencing
- poor orientation in motor, haptic, spatial and temporal tasks
- confusion in look-alike words
- skipping of little words in reading and substitution of words
- irregular and messy handwriting
- bizarre spelling
- clumsiness and poor coordination of large and small muscles
- difficulty in inhibiting motor and emotional reactions

What about social behavior? Again the developmental and chronological age of the child make a difference, but even early in school experience the student is likely to feel frustration to an agonizing degree; this is hard for him to understand and to manage by himself. As time passes and failures become more and more a part of his daily experience, behavior will worsen. Some dyslexic children are hyperactive and some are not; the hyperactive ones are likely to get attention first. This may or may not be justified, but the survival of the teacher and the parent must be considered! Sooner or later, the problems of the nondisruptive youngsters, also, must be attended to.

What should one expect from a complete diagnostic evaluation? Before starting remediation it is good to have a thorough diagnosis made by an interdisciplinary team. Ideally, this consists of a complete family history, an individual global intelligence test, a Slingerland test, a test of lateral dominance, a perceptual-motor survey, a Bender-Gestalt test, spatial and temporal orientation tests, language achievement tests, social competence tests, and a complete physical examination that includes a neurological and functional description of all sensory modalities. In other words, it is advantageous to know as much about the child as possible, though in many cases this is unrealistic to expect. What is especially helpful is information about his learning patterns; how does this individual learn; which is his reliable sensory modality or combination of modalities; how does he retain the academic kinds of information and what is his uniqueness of association where symbolic language is concerned? Very few evaluations answer even all of these most relevant questions, but we get more of the needed information if we know what we are looking for.

The teacher, and the specialist, if one is available, can generally come