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Language Guide

Guidance for using neuro-affirming language to discuss differences and needs

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Why does language matter?

The language we use both implicitly and explicitly signals the amount of respect and understanding we have for a situation.

Affirming (neuro-affirming) language allows us to discuss pressures and strengths without assigning blame or assuming failure. Using it with a child or young person demonstrates that we see and respect them for who they are and what they value; it shows that we are here to support them in overcoming obstacles that they have identified for themselves as problematic to them achieving their own goals.
An example of affirming language is: It's important to know what learning strategies work best for yourself.

Non-affirming language discusses a child or young person's experience in terms of failures to meet set expectations or standards; it could also be described as being the language of blame – it assigns fault and inflicts consequences. When we use "blame" language, we signal that it is our belief that the young person is 'broken' or is choosing to do things that we deem to be unacceptable. This is harmful to their self-esteem and self-worth. In the case of neurodivergent children, it teaches them that they should be ashamed of there innate way of being.
An example of non-affirming language is: He constantly moves and it distracts everyone around him.

This guide will discuss how to use **affirming language** to talk about and consider **neurodevelopmental differences** and **additional support needs**.

History of disability and difference language

Before we can get into the specifics of where we want to go with language, we need to look at where language has been; this will help us to understand why language matters so very much to the disabled and neurodivergent communities.

Generally speaking, there are two language models that can be used when discussing neurodevelopmental difference/disability: **The Medical Model** and **The Social Model**.

The medical model is the language of diagnoses and pathologies, relying on external observations made by clinicians. It is concerned with identifying disease-states, disorders, and deficits, focusing on finding what is 'wrong' with a person. This model assumes that there is an ideal way of being and that deviations from that ideal are problems to be corrected. In this framework, disabilities and neurodevelopmental differences are described as impairments that need to be fixed through medical or therapeutic means.

In the 1990s, disability rights activists began to push back against the medical model, pushing for the widespread implementation of Person-First Language (PFL). The hope

was that it would make the point to clinicians and society that disabled people are humans, not collections of 'disorders'; they wanted to change the prevailing societal perspective that disability invalidates individual humanity.

Unfortunately, while successful in getting PFL implemented broadly, the intention behind it has mostly been forgotten or disregarded. Rather than emphasizing that disabled people are whole humans entitled to dignity, agency, and autonomy, usage of PFL by people across professions and society leaned into the idea that personhood can only be seen when disability is taken out of the picture — this has lent credence to the perspective that disability is bad and it forcibly separates an individual from society and from achieving their potential. A common refrain from users of PFL, for example, is, "People are not defined by their disability." Sadly, the outcome of the well-intentioned shift to PFL was to further entrench the already dehumanising stigma associated with being disabled.

Person-First Language (Disability as Noun/Thing)	**Identity-First Language** (Disability as Adjective/Characteristic)
Person with disability	Disabled person
Woman who is blind	Blind woman
Child with autism	Autistic child
User of a wheelchair	Wheelchair user

In light of it failing to achieve its purpose, a turn was made away from using PFL and toward promoting the usage of Identity-First Language (IFL). IFL views disability as an inherent part of a person's experience of the world; to consider their disability as separate from them is to deny a part of their personhood. Rather than separating people from their disabilities, IFL makes it clear that truly seeing a person means seeing the totality of their experience. Very literally, IFL incorporates disability into identity, characterizing it as a valuable aspect of self rather than as something bad that needs to be isolated and fixed. It is for this reason that IFL is preferred by the majority of the neurodivergent community.

Not surprisingly, IFL is at the core of the Social Model of disability, which prioritises an individual's internal experience and self-identified needs over the external observations and determinations of clinicians. The social model came about from the frustrations of the disabled community with the belittling rhetoric tied to the medical/deficit model. The community wanted a framework for understanding disability that accurately reflects their personal experiences and that doesn't carry the stigma inherent in describing needs as disorders.

Medical Model	**Social Model**
Clinical	Personal
Pathological	Natural variation
Impairment	Pressure
Deficit	Difference
Disease-state	Identity
Intervention	Support
Diagnoses	Internal experience
Suffers	Experiences
Special Needs	Differing Needs

The social model also highlights the way societal systems and expectations, due to the unspoken assumption that 'ableness' is the default human state of being, erect barriers to day-to-day life for disabled people. This ableism (physical and social discrimination against disabled bodies) is so inherent in the systems and processes of society that most people never notice them until they themselves knowingly experience disability. The unconscious/unspoken expectation that nondisabled, neuronormative bodies are always the majority and the primary demographic lies at the heart of these barriers. Some examples are:

- physical, ex. civic planning that incorporates stairs rather than ramps into the design
- sensory, ex. intensely bright fluorescent lights in stores
- cognitive, ex. access to governmental supports and benefits gatekept by being able complete extensive paperwork

The social model and IFL underpin the Neurodiversity Paradigm. The Neurodiversity Paradigm embraces neurodevelopmental differences as natural variations across the human spectrum; it states that separating people from their disabilities harms them because it creates additional barriers to receiving appropriate support and understanding of needs.

What are neurodevelopmental differences?

The answer to this questions depends on what language model you are using. According to the medical model, neurodevelopmental difference are disorders that need to be treated and/or fixed. Person-First Language would reference 'people with neurodevelopmental disorders' to ensure the person is not forgotten and is seen separately from what makes them different to society.

Our preference is to use affirming language to discuss neurodevelopmental differences. In this framework, neurodevelopmental differences are natural variations in how people's brains develop and function, leading to diverse ways of thinking, learning, and behaving; importantly, every variation is equally valid to the others — no one way is superior to another.

What are additional support needs?

The term "additional support needs" is an example of medical model framing — it describes the needs of neurodivergent people as being additional to neurotypical needs rather than recognizing that they are entirely **different** needs; it assumes that neurotypical needs apply to all people, that they are standard and 'normal,' and any other needs are in addition to those normal ones.

Unfortunately, this term is the one used broadly across education and within legislation in relation to responsibilities to students who require "additional support for learning".

The law states that there is a qualifying additional support need:

"where, for whatever reason, the child or young person is, or is likely to be, unable without the provision of additional support to benefit from school education provided or to be provided for the child or young person."

In this context, additional support for learning is very purposefully given a broad definition with few concrete criteria, which allows for **every child** to be seen and supported as they need **individually**. In this way, the law is recognizing that a child or young person can require additional support for learning in a variety of ways, and that it is common for there to be co-occurrence of multiple factors resulting in additional support for learning.

In practice, additional support ends up coming under three overlapping and inter-dependent categories:

- approaches to learning and teaching
- support from personnel
- provision of resources

Very importantly, this law does not apply only to in-school support.

> *"Section 1(3) of the 2004 Act was amended by the 2009 Act to ensure that additional support is not limited to educational support, but can include multi-agency support from health, social services and voluntary agencies, for example."*

There are many factors that can mean a child or young person requires additional support for learning, either for the long-term or the short-term, which include:

- English as a second language
- Accelerated learning
- Illness
- Being a young carer
- Being/having been a looked after child
- Neurodevelopmental differences
- Bereavement
- Mental health needs
- Experiencing bullying

That is a non-exhaustive list; it demonstrates that "additional support for learning" can apply to any child or young person at any time of their learning journey.

Should people use only Identity-First Language?

Language is living and evolves constantly; terms that were once acceptable can become unacceptable over time — such as how perceptions around Person-First Language have changed. However, there are likely always going to be specific contexts in which each language model has relevance or precedence. Medical model terminology, for example, is appropriate in clinical settings because it is the current language of diagnostic criteria. This means that even though clinical definitions of neurodevelopmental differences (as collections of deficits) are dehumanising, medical model terminology will remain relevant in those settings until the diagnostic criteria themselves are changed. Having the option of differing language models is also important because groups within the disability community have differing preferences, depending on how they view themselves and their specific situation.

Outside of clinical contexts, the most important aspect of language use is ensuring the **autonomy of communities and individuals is recognised and respected**. When speaking with an individual, their preference should always be respected, even if it differs from the majority of the community; when speaking about a community, the preference of that community should be respected, even if it differs from some

individuals within it. For example, the autistic community prefers IFL (autistic) but individuals within it may prefer PFL (with autism).

When we recognise and honour autonomy with our language choices, we demonstrate respect for both the needs and the feelings of the people with whom (or about whom) we are communicating.

Glossary (Terms Used in This Guide)

Source material includes information from:
https://ndconnection.co.uk; https://reframingautism.org.au/service/glossary-terms/

Term	Definition
Ableism	Physical and social discrimination against disabled bodies based on the belief that typical abilities are superior, and that disabled people require "fixing".
ADHD (clinical name/diagnostic term is Attention Deficit Hyperactivity Disorder)	Natural neurodevelopmental variation characterised by an abundance of attention dictated by internal drivers, neural hyperconnectivity, high sensitivity to sensory input, monotropism, an interest-driven dopamine system that needs novelty and variety, and varying processing styles; ADHD distress traits include inattention, impulsivity, hyperactivity (physically and/or mentally), and mood instability.
Additional Support for Learning	When a child/young person requires, for any reason, additional or different support in order to benefit from and engage with learning.
Affirming Language	A way of communicating that uses positive, respectful, and validating framing of an individual's identity and experience.
Autism (clinical name/diagnostic term is Autism Spectrum Condition or Disorder)	Natural neurodevelopmental variation characterised by differences in styles of communication, and cognitive, emotional, and sensory processing, as well as a reliance on predictability to feel safe; autism distress traits include meltdowns, self-injurous repetitive behaviour, and aversion to social interactions.
Autism community	The group of people that includes autistic people, their family members, scientists who research autism, therapists, and anybody for whom autism is a part of their lives are talked about; usually led by non-autistic voices.
Autistic community	The group of people that is made up of and led by exclusively autistic people.
Identity-First Language	Frames disability as an inherent part of a person's experience of the world and acknowledges that truly seeing a person means seeing the totality of their experience; it incorporates disability into identity, characterizing it as a valuable aspect of self rather than as something bad that needs to be isolated and fixed.
Medical Model of Disability	Views disability as an impairment or a deficiency that needs to be fixed, cured, or managed through medical interventions.
Neurodevelopment	A development of the brain's systems and networks, which influences an individual's information processing; this includes how they learn, read, socialise, remember, and pay attention.
Neurodevelopmental differences	The natural variations in how people's brains develop and function, leading to diverse ways of thinking, learning,

	and behaving; importantly, every variation is equally valid to the others — no one way is superior to another.
Neurodivergent	When a person's brain develops and functions in a way that results in them thinking, processing information, and behaving differently to societal expectations. This may be differences in social preferences, ways of learning, ways of communicating and/or ways of perceiving the environment.
Neurodiversity	The concept that all humans have a unique neurological make-up and that this forms an infinite spectrum of human cognition; it is a term for a group of people with mixed neurotypes, which includes neurotypical people.
Neurodiversity Paradigm	The Neurodivergent Paradigm is philosophical basis underpinning the Neurodivergent Movement; it was developed by Nick Walker (2021) working with other Autistic and Neurodivergent academics and activists to give an underpinning to the more activist, rights-based Neurodivergent movement.
Neuronormativity	The societal expectation and belief that neurotypical ways of processing and experiencing the world are superior to other ways of being.
Neurotype	A neurotype refers to the type of neurocognitive make-up of a person; neurotypes are a way of explaining neuro-cognition and embraces the idea of a spectrum of minds. Neurotypes are not always static, and people may move between neurotypes. Neurotypical and Neurodivergent are neurotypes.
Neurotypical	Also known as Predominant Neurotype (PNT) or Neuronormative (NN); when a person thinks, processes information, and behaves in ways that are typical or expected within their culture.
Person-First Language	Frames disability as something to be separated from an individual, emphasising that they are a person first and foremost; this approach is intended to promote respect and dignity for individuals by avoiding language that might define them solely by their disability or condition but tends to result in further stigmatising disability.
Social Model of Disability	Raises awareness of the societal barriers (environments, structures, attitudes) that further disable and restrict the lives of disabled people.

Sources:

disAbility Law Center of Virginia
https://www.dlcv.org/language-blog#:~:text=The%20use%20of%20person%20first,into%20the%20background%20of%20conversation.

Neurodivergent Counselling
https://neurodivergentcounselling.ca/blog/neuro-affirming-diagnostic-criteria-for-autism

Neurodiverse Connection
https://ndconnection.co.uk/resources/p/dictionary-of-neurodivergent-language
https://ndconnection.co.uk/resources/p/nd-affirming-language-guide
https://ndconnection.co.uk/blog/neuro-affirming-definition-of-adhd

Neurodivergent Rebel
https://neurodivergentrebel.com/2020/01/24/the-difference-between-the-autism-community-the-autistic-community/

Reframing Autism
https://reframingautism.org.au/

Scottish Government — Additional Support for Learning: Statutory Guidance 2017
https://www.gov.scot/publications/supporting-childrens-learning-statutory-guidance-education-additional-support-learning-scotland/pages/3/

Therapy Works
https://therapyworks.com/blog/child-development/what-it-means-to-be-neurodiversity-affirming/