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Quick-Start Guide: Neurodivergent Experiences

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Neurodivergent Experiences

Medical Model terminology: Neurodevelopmental Conditions/Disorders
Neuro-affirming terminology: Neurodevelopmental Differences

Every neurodivergent person has a unique neurotype — a one-of-a-kind brain-body system — that shapes the way they take in, process, and express information and interact with the world. To support them, we must understand their unique experience.

However, the standard terminology we have for discussing neurodevelopmental differences isn't concerned with the internal experience; it is focused on describing the external observations made about a person by clinicians and other professionals. Both medical model and neuro-affirming terminology neglects to recognise the human at the centre of those observations. As a result, people within the process can end up being so focused on technical details that they forget what they're really discussing — human experiences. Neurodivergent experiences.

The impact of this on families and young people is a feeling that they are not seen, or heard, or believed, when they try to explain the reality they are living. To help, we are creating this guide. It will use a neuro-affirming perspective to explore 6 neurodivergent experiences:

ADHD (Attention Deficit Hyperactivity Disorder)
Autism (ASC/ASD)
DCD (Developmental Coordination Disorder)
DLD (Developmental Language Disorder)
FASD (Foetal Alcohol Spectrum Disorder)
Learning Disability

Each experience will include a synopsis of 'the basics' you need to know, a list of the terminology you are likely to see used in relation to it, and the details of the current diagnostic criteria. The inclusion of the diagnostic criteria is for reference only; it is not an expression of preference or priority.

When considering the wording of the diagnostic criteria, it's best to remember that the language is reflective of the biases built into a system that's looking for 'problems' as measured against a theoretical ideal. **Those biases assume that neurotypicality is the aim for all people**. They also assume that external observations made by clinicians are the best way of measuring how far from neurotypicality an individual deviates — this is how 'functioning labels' are determined. 'High-functioning' labels are applied to those who are observed to behave closely to neurotypical norms; 'low-functioning' labels are applied to those who are observed to behave in ways significantly different to neurotypical norms. The internal experience of those individuals is not included in the determination of functioning labels.

From the purposes of this guide, all uses of medical model language will be paired with neuro-affirming language to provide context and to emphasise the importance of using a person-centred, experience-based framework when trying to understand and support the needs of neurodivergent people.

General Information

While individual experiences are unique there are certain commonalities across the field of neurodivergence.

Specifically, there are shared differences and experiences related to the areas of development that are considered within the assessment process:

Communication
The part that lets us speak (with and without words) with others

Cognitive
The part that lets us think, plan, and organize; one skill within this area is Executive Function

Sensory
The part that takes in information from all the senses (sight, sound, taste, smell, touch, balance, inside sensations, sense of body in space)

Emotional
The part that lets us know our own feelings, how other people feel, and how to help ourselves feel better

Social
The part that tells us how to act with family, friends, and in different places (like at school)

Motor
The part we need for moving (ex. picking things up, writing, jumping, etc.)

Here are the technical terms to describe some of the commonalities:	
Monotropic thought processing	Direct, straightforward communication
Interoceptive disconnection	Fluctuating capacity
'Spiky profiles'	Transparency
Visual processing and thinking	Deep emotional experiences
Rejection Sensitive Dysphoria	Sensory stimulation required to
Relationship management	Rumination

For individuals, this can look like:	
Focusing intensely on a single task for long periods of time	Not being able to do the same things every day
Body-doubling helps in task completion	Swinging fervently leads to calm
Intense emotional responses	Prefers online friendships and activities
Not recognising hunger signals	Prefers typing to handwriting
Being physically exhausted from social activities	Takes longer than typical to process information coming in and to respond
Being misunderstood all the time	Being confused by reactions from others

This isn't a complete list of commonalities, but it gives a general overview that can be helpful. There is lots more information available on each of the areas of neurodevelopment in these videos.

ADHD

The Basics

ADHD brains produce lower amounts of **dopamine** as compared to neurotypical brains. It was an evolutionary advantage back when surviving required pin-point focus fuelled by dopamine releases in highly stressful situations. But in today's much lower stakes world, where navigating basic day to day life doesn't mean constantly responding to mortal threats and dangers, ADHD brains don't receive enough stimulus to keep them actively engaged the way others want them to be.

Dopamine has two functions in the body: to work as a hormone to raise internal systems to alert status when threatened (survival response); and to work as a neurotransmitter to communicate messages from the brain to the rest of the body via the nervous system.

In this way, dopamine is required for:

Movement	Memory	Emotional regulation	Cognition
Pleasurable reward	Motivation	Directing attention	Mood
Sleep	Arousal	Pain processing	Learning

When dopamine levels are low, then, it means the brain and the rest of the body aren't communicating as well as they can be. And that means the brain can't relax. The brain needs to be able to relax or it burns out.

Our world is designed to support the natural dopamine levels of neurotypical brains. This means that the daily occupations expected of us — like attending school, managing personal hygiene, and relaxing to go to sleep — are significantly easier for neurotypical brains than they are for ADHD brains. When ADHD brains are faced with pressure to meet those neurotypical expectations, they are driven (subconsciously) to find a way to release more dopamine to make it possible. This can look like being drawn to high-danger activities, the kinds of things that are deemed as 'thrill seeking' behaviour; it also drives 'self-medicating' behaviour, like drinking high quantities of caffeine. It's important to remember that an ADHD brain that's doing these things is just trying to meet external demands (to be 'productive') and internal demands (to be able to rest).

The role of ADHD medication is to give the brain the dopamine it needs to contend with neurotypical demands without having to resort to thrill seeking or self-medication. There are numerous brands of ADHD medication (branded and generic) and differing release mechanisms with different active ingredients; they don't all act in the same way. Titration (starting with a low dose and slowly increasing while monitoring the body's reaction) is also a critical part of the process of determining which medication, and how much, works best for that specific ADHD brain.

While a diagnosis of ADHD now includes being given a specific type of presentation — Predominantly Inattentive; Predominantly Hyperactive-Impulsive; or Combined — that is describing what others can see externally, not what the ADHDer is experiencing internally. The reality is that, even when appearing outwardly to be still or 'daydreamy,' on the inside those ADHD brains are experiencing hyperactivity.

The brain is jumping all over, seeking the dopamine it needs to finally feel satisfied enough to relax.

A useful strategy for many ADHDers is **Body Doubling**. Body Doubling offers external motivation in the form of another person providing companionship and gentle accountability while offering up their own executive function as a support. The Body Double doesn't need to be doing the exact same thing, they just need to be physically present, providing the tangible and emotional regulatory support the ADHDer needs to achieve the goals the ADHDer has for themselves.

ADHD children receive 20,000 more negative messages by age 12 than their non-ADHD peers. From a very young age, ADHD children are taught (implicitly and explicitly) to feel shame for their natural way of being, being repeatedly told to 'try harder' and to 'behave better' — corrective direction that there is no physical possibility of them achieving. It is no surprise, then, that they develop a sense of inadequacy and very low self-esteem.

That negative messaging surrounds ADHD children in their day-to-day life. The most common misconceptions about them — that they are purposefully disobedient, that they lack discipline, and that they 'just need to try harder' — are pervasive in society at large. As ADHD children grow into adults, they internalise and carry with them that messaging, resulting in the high levels of depression, Rejection Sensitive Dysphoria, and self-loathing that are present in the ADHD community.

ADHD very commonly co-occurs along with other neurodivergences:

- 50% are dyslexic
- 50% are dyspraxic
- 90% of people who have Tourette Syndrome are also ADHD
- Up to 65% of ADHDers also meet the diagnostic criteria for being autistic

Despite this reality, being given a dual diagnosis of ADHD and Autism was clinically impossible before 2013. The experience of an AuDHDer (someone who is autistic and ADHD) is a completely unique experience in itself.

Related Terminology

Disabled people should choose the language that is used to describe and refer to them, especially when what is being communicated is information about their specific disability. It is never appropriate for non-disabled people to correct disabled people on the language they use to discuss their specific situation. When discussing disability generally, it is encouraged for people to use identity-first language; a specific community's preferences should always be respected. When discussing an individual's situation, their preferences should be respected.

Diagnostic label	ADHD, Predominantly Inattentive; ADHD, Predominantly Hyperactive-Impulsive; ADHD Combined
Community Preference	ADHDer; is ADHD, as in "I am ADHD" Identity-First Language (adjective/characteristic)
Individuals sometimes use	"I have ADHD"

	Person-First Language (noun/separate to self)
Individuals rarely use	'with ADHD'; 'suffers from' Person-First Language & Medical Model-centric
Outdated/offensive terms that should NOT be used	Suffers from; disordered; lazy; naughty; dysfunctional; abnormal; poorly behaved; difficult; disruptive; deliberately defiant; defective; 'morbid manifestation of defect of moral control'

Examples: Neuro-affirming Framing

Phrasing centred around Traits & Internal Experiences — acknowledges strengths

Focused in a crisis	Feels calmer after physical activity	Seeks sensory stimuli	Active learning style
Varying processing styles	Neural hyperconnectivity	Monotropic	Feels emotions deeply
Delights in deep dive research into areas of interest	Motivated by new experiences	Capable of hyperfocus for hours at a time	Uses repetitive motions/stims to self-regulate

Examples: Medical Model Framing

Phrasing centred around Deficits & Symptoms — places fault on the individual

Badly behaved	Excessively restless	Hyperactive	Disorganised
Impaired impulse control	Impaired planning skills	Unwilling to sit still	Distracting to others
Poor time management	Inattentive	Incapable of follow-through	Low tolerance for frustration

Diagnostic Criteria

The language used in the clinical criteria is deficit-based because this is literally the medical model in practice. That does not mean it is more valid, though.

ADHD can be diagnosed in children under the age of five — there is no minimum age required by the diagnostic systems. However, the younger a child is, the more difficult it can be to distinguish ADHD traits from the typical variation of behaviours that occur during the early years of development. This is why caution is recommended when performing assessments of ADHD in younger children.

List of symptoms by presentation type

There are three possible presentations with an ADHD diagnosis: Predominantly Inattentive; Predominantly Hyper Active-Impulsive; or Combined. Receiving a diagnosis of ADHD Combined presentation requires presenting with symptoms from both Inattentive and Hyper Active-Impulsive categories. The wording is set within the Medical Model of deficit-based language and therefore it describes only what is

externally observable, not what is internally experienced. For example, a child may look like they are being 'inattentive' in class to the teacher, but their internal experience is one of significant attention to a topic of interest to them.

Predominantly Inattentive		
Often makes careless mistakes	Has difficulty sustaining attention	Does not seem to listen when spoken to directly
Struggles to follow through on instructions or finish tasks	Has trouble organising tasks and activities	Avoids or dislikes tasks that require sustained mental effort
Often loses things needed for tasks	Is easily distracted by unrelated stimuli	Is forgetful in daily activities

Predominantly Hyper Active-Impulsive		
Restlessness – fidgets with hands or feet or squirms in seat	Leaves seat when staying seated is expected	Talks excessively
Difficulty in quiet activities – is unable to play or engage quietly in activities	Feeling driven by a motor; appears "on the go" all the time	Runs about or climbs in inappropriate situations (or feels restless in teens/adults)
Blurts out answers before questions are completed	Struggles to wait their turn	Interrupts or intrudes on others

DSM-5 Criteria	ICD-11 Criteria
Full DSM-5 is available to purchase	https://icd.who.int/browse/2025-01/mms/en#821852937
Persistent symptoms of inattention and/or hyperactivity-impulsivity present for at least 6 months	Persistent pattern of inattention and/or hyperactivity-impulsivity present for at least 6 months
Symptoms present before age 12	Onset of symptoms before the age of 12
Symptoms occur in 2 or more settings, i.e., school, home, with friends	Symptoms present in 2 or more settings, i.e., school, home, with friends
There is clear evidence of symptoms interfering with or reducing the quality of social, academic, or occupational functioning	Clear evidence that symptoms negatively impact social, academic, or occupational functioning
The symptoms are not better explained by another mental health disorder, and do not occur only during the course of a psychotic disorder	Other conditions must be ruled out as the cause and the symptoms must be outside the normal variation for the age and level of intellectual development
Children (up to age 16) must have 6 symptoms present; Adults (age 17+) must have at least 5	No specified numerical count for symptoms, relying instead on clinical judgment to allow for a more multi-dimensional approach to and greater flexibility in diagnosis

Current Diagnostic Tools — Children	
Conners 4 Questionnaire	Vanderbilt ADHD Diagnostic Rating Scale (VADRS)
Qb Testing — computer-based test	SNAP-IV 26 ADHD Screening (for parents & teachers to complete)
BAARS-IV	ADHD Rating Scale 5 (ADHD-RS-5) for Children & Adolescents
Kiddie-Sads-Present and Lifetime Version (K-SADS-PL)	ADHD Child Evaluation (ACE)
Weiss Functional Impairment Rating Scale — Parent Form	

Current Diagnostic Tools — Adults	
Adult Self-Report Scale (ASRS-5)	ADHD Rating Scale 5 (ADHD-RS-5) for Adults
Adult ADHD Clinical Diagnostic Scale (ACDS) v1.2	Adult ADHD Investigator Rating Scale (AISRS)
Adult Self-Report Screening Scale for DSM-5 (ASRS DSM-5) Screener	Adult ASRS Symptom Checklist v1.1
Barratt Impulsiveness Scale (BIS-11)	Brown Attention-Deficit Disorder Symptom Assessment Scale (BADDS)
Clinical Global Impression (CGI)	Conners' Adult ADHD Rating Scales (CAARS)
Diagnostic Interview for ADHD in Adults (DIVA) 2.0	Wender Utah Rating Scale (WURS)
Childhood Behavior Scale — Parent Report	Current Behavior Scale - Partner Report
Adult ADHD Quality of Life Measure (AAQoL)	Driving Behavior Survey (DBS)
Work Productivity and Activity Impairment Questionnaire General Health V2.0 (WPAI:GH)	Qb Testing — computer-based test

Autism

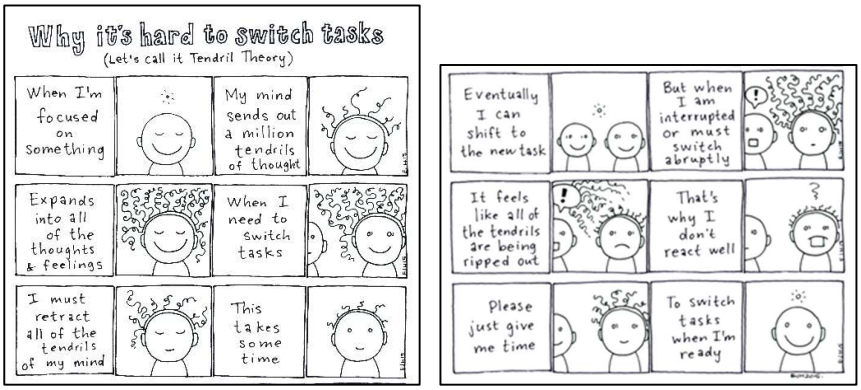
The Basics

Autistic brains are **hyper connective**. What that means is, in certain areas, there are more connections in an autistic brain than in a neurotypical brain. Due to this hyper connectivity, the autistic experience of the world is more intense; by extension, the intensity of the world frequently makes it feel unsafe. As a result, autistic people tend to seek a sense of safety through predictability, routine, and reliable repeatability: the more predictable the world is, the safer they are.

It isn't just any routine that helps an autistic person feel safe, though — it must be ***their*** routine, meeting ***their*** needs. Forcing an external structure on an autistic person and expecting compliance will only increase their sense of being under threat.

When any human feels threatened, the amygdala (the environmental threat assessor in our brain) takes over. This is commonly referred to as the survival response, also known as fight/flight/freeze/fawn. The hyper connectivity of an autistic brain means that the amygdala is always on standby, always perceiving threats. Because of this, autistic people are always primed to fight, flee, or shutdown. It's important to note, though, that those reactions are signs of *distress*, not signs of being autistic.

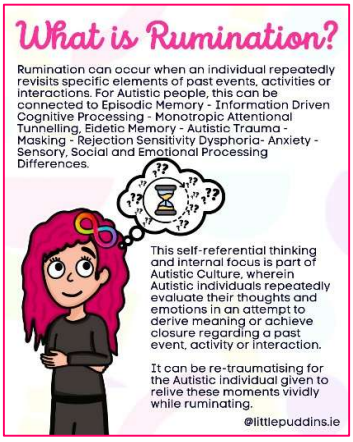
Autistic people are **Monotropic** thinkers; they thrive in being allowed to dig deeply and fully into a topic of interest for as long as they need. It also means that autistic people experience genuine pain when made to change topics/tasks before they are ready to move on. This is one reason that autistic people require supported transitions (between environments, activities, life events, etc). The Tendril Theory cartoon explains this very well.



'Supported transitions' for autistic people doesn't mean simply giving countdowns or setting expectations — it means working with the autistic person to understand their specific need and then implementing a strategy that works to meet that specific need. For some autistic people, that might be giving lots of warnings of an imminent change because it helps them to feel safe to know exactly how much time is left; for others, repeated warnings could equate to repeated and intensifying threats to their safety. There is no one-size-fits-all approach.

Autistic people experience **fluctuating capacity**, which means that being able to do something on one day doesn't mean they will be able to do it on another day.

Rumination (thinking about the same things over and over) is an inherent part of being autistic. Rumination contributes to Rejection Sensitive Dysphoria. Though it can be a difficult aspect of being autistic, there are techniques that can be used to make rumination a more positive experience.



Related Terminology

Disabled people should choose the language that is used to describe and refer to them, especially when what is being communicated is information about their specific disability. It is never appropriate for non-disabled people to correct disabled people on the language they use to discuss their specific situation. When discussing disability generally, it is encouraged for people to use identity-first language; a specific community's preferences should always be respected. When discussing an individual's situation, their preferences should be respected.

Diagnostic label	ASD – Autism Spectrum Disorder or ASC – Autism Spectrum Condition
Community Preference	Autistic Identity-First Language (adjective/characteristic)
Individuals sometimes use	Have autism; with autism Person-First Language (noun/separate to self)
Individuals rarely use	Suffers from autism Person-First Language and Medical Model-centric
Outdated/offensive terms that should NOT be used	(1992-2019) Pervasive Developmental Disorders (PDDs) of Asperger Syndrome, Autism Disorder, Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS); (1900s before 1990) Mental defectives, infantile autism, childhood schizophrenia, autistic psychopath, infantile psychosis, Kanner's Syndrome schizoid; (!800s) Developmental retardation, idiot savant, monomania

Examples: Neuro-affirming Framing

Phrasing centred around Traits & Internal Experiences – acknowledges strengths

Variable Pressures & Strengths	Communicates directly	Feels calmer after swinging a lot	Recharges through alone time

Benefits from co-regulation with a trusted adult	Prefers socialising within familiar parameters	Seeks sensory stimuli	Enjoys rewatching the same show multiple times
Ruminates on certain thoughts	Double Empathy Problem	Intense Emotional Experiences	Situationally Non-Speaking

Examples: Medical Model Framing

Phrasing centred around Deficits & Symptoms – places fault on the individual

Deficient communication	Failure to make meaningful friendships	Refuse to make eye contact
Disordered information processing	Inability to understand and control emotions	Unwilling to sit still and do their work
Lack of empathy	Aggressive & manipulative	Rude in tone and manner

Diagnostic Criteria

The language used in the criteria and the clinical tools is deficit-based because it is literally the medical model in practice. That does not mean it is more valid, though. It is simply the language currently used within the two classification systems: the ICD (International Classification of Diseases); and the DSM (Diagnostic and Statistical Manual of Mental Disorders). The language used, and the diagnostic criteria for autism itself, is not fixed; alterations and updates *are* made to reflect advances in understanding, methodology, and, most importantly, the inclusion of the lived experience of autistic people.

A significant change was made relatively recently, with the DSM-5 (2013) and the ICD-11 (2019), in which the arbitrary divisions used to sort autistic people into different levels (intended to reflect increasing 'severity' of autism) were removed. Many factors* led to those changes, including recognising the methodology and the application of it was biased, inaccurate, and inconsistent. For example, an autistic person's 'severity' level was based upon what clinicians could externally observe and pathologise as 'inappropriate,' not what the individuals expressed as their internal experiences. Importantly, it was acknowledged that the classification systems needed to be revised because there were no clear genetic underpinnings to support the idea of multiple separate diagnoses, nor did multiple diagnoses allow for refined or tailored support pathways. It simply created division within the autistic community with no recognisable benefits to offset that considerable cost. The DSM-5 and ICD-11 were therefore revised so that clinicians would assess for a single, more inclusive, and more person-centred diagnosis of Autism Spectrum Disorder (ASD).

There are still many issues with the current editions of the classification systems, not the least of which is that they continue to be entirely deficit-focused. Another significant failing is that neither classification system specifically calls out a need to examine sensory differences, despite the crucial role sensory stimuli plays in shaping an autistic person's experience of the world. Additionally, the current classification still separates autistic people into different 'levels,' though they now

refer to them as 'levels of need' instead of 'levels of severity.' This vocabulary change reflects only superficial rebranding; the process still determines 'need' by what an external party sees, not by what an individual describes as their experience. As for now, though, these are the classifications we have, so understanding them in detail helps us to explain internal experiences in the words and framing that external observers understand.

A number of formal diagnostic tools have been designed around these criteria, and clinicians are likely to use one (or more) of them to assist in their assessment. The most common of these tools are listed below the criteria. Ideally, a diagnosis should never be based solely on 'results' from any autism-specific diagnostic tool; assessments should involve gathering information from a range of sources and considered in combination with clinical judgement.

+Asperger Syndrome used to be a possible diagnosis but it was removed along with the other 'levels.' AS became a controversial term when people at large began to realise it was named for Hans Asperger, a Nazi doctor who used his own observation-based categorisation method to determine which autistic children (what he called autistic psychopaths) were useful to Nazi Germany. When added to the DSM (1994) and ICD (1992), the criteria for a diagnosis of Asperger Syndrome was based on Asperger's exact research, research that was in support of eugenics, forced sterilisation, and childhood 'euthanasia' for those he determined to not be useful, which included those with complex needs (i.e., non-speaking).

While it was included in the DSM & ICD, the main distinguisher between Asperger Syndrome and Autistic Disorder was early/on-time onset of speech.

DSM-5 Criteria	ICD-11 Criteria
Full DSM-5 is available to purchase	https://icd.who.int/browse/2024-01/mms/en#437815624
A: Persistent deficits in reciprocal social communication and social interaction	Persistent deficits in initiating and sustaining social communication and reciprocal social interactions that are outside the range of typical functioning given the person's age and level of intellectual development
B: Restricted, repetitive patterns of behaviour, interests or activities	Persistent restricted, repetitive and inflexible patterns of behaviour, interests, or activities that are clearly atypical or excessive for the person's age and sociocultural context
C: Symptoms must be present in the early developmental period	The onset of the disorder occurs during the developmental period, typically in early childhood

D: Symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning	Note that characteristics might not fully manifest until later in life due to increased social demands
E: These disturbances are not better explained by intellectual disability or global developmental delay	Characteristics result in significant impairment in personal, family, social, educational, occupational or other important areas

Current Diagnostic Tools – Children	
Autism Diagnostic Interview – Revised (ADI-R)	Developmental, Dimensional, and Diagnostic Interview (3di)
Diagnostic Interview for Social and Communication Disorders (DISCO)	Autism Diagnostic Observation Schedule (ADOS)
Autism Diagnostic Observation Schedule – Second Edition (ADOS-2)	Childhood Autism Rating Scale – Second Edition (CARS-2)

Current Diagnostic Tools – Adults without learning disability	
Adult Asperger* Assessment (AAA) – incl. Autism-Spectrum Quotient (AQ) and Empathy Quotient (EQ)	Autism Diagnostic Interview – Revised (ADI-R)
Autism Diagnostic Observation Schedule – Generic (ADOS-G)	Asperger* Syndrome Diagnostic Interview (ASDI)
Ritvo Autism Asperger* Diagnostic Scale – Revised (RAADS-R)	Diagnostic Interview for Social and Communication Disorders (DISCO)
Developmental, Dimensional, and Diagnostic Interview (3di)	***Note:** 'Asperger' is no longer a diagnosis but the tools were named when it was.

Current Diagnostic Tools – Adults with learning disability
Autism Diagnostic Observation Schedule – Generic (ADOS-G)
Autism Diagnostic Interview – Revised (ADI-R)
Diagnostic Interview for Social and Communication Disorders (DISCO)

DCD (Developmental Coordination Disorder)

The Basics

Also called **Dyspraxia**, DCD is a neurodevelopmental difference that affects a person's ability to plan and coordinate physical movements, making physical tasks and fine motor skills more difficult than their non-DCD peers. People with dyspraxia can also experience issues with language, organisation, and memory, similar to those with dyslexia. It occurs across the range of intellectual abilities, which means that it is a Specific Learning Difficulty (SpLD), *not* a learning disability.

People who have DCD usually benefit from support with:

Motor control skills	Memory	Verbal communication
Organisational skills	Managing time	Finding/using directions

DCD is believed to affect 6-10% of the general population and tends to be identified more frequently in boys, though this does not mean it necessarily occurs more frequently in boys. Dyspraxia also often runs in families.

DCD can exist on its own or it may co-occur with other neurodivergences. Externally observable traits can look like difficulties or differences in:

engaging in physical tasks	doing up buttons	going up/down stairs
hopping, jumping, running	bumping into things/tripping	tying shoelaces
catching or kicking a ball	using scissors, writing, drawing	body posture/bearing

Dyspraxic people often have co-occurring neurodivergences, with research indicating that:

- 50% are also ADHD
- 30-50% are also dyslexic
- 85% of autistic people are also dyspraxic
- there's a high likelihood of dyscalculia
- 55-70% also have depression and/or anxiety

Although DCD is as prevalent as dyslexia, and possibly more so than autism, it is not as well known or understood.

Related Terminology

Disabled people should choose the language that is used to describe and refer to them, especially when what is being communicated is information about their specific disability. It is never appropriate for non-disabled people to correct disabled people on the language they use to discuss their specific situation. When discussing disability generally, it is encouraged for people to use identity-first language; a specific community's preferences should always be respected. When discussing an individual's situation, their preferences should be respected.

Diagnostic label	DCD
Community Preference	Dyspraxic; 'are DCD' (Identity-first language; adjective/characteristic)

Individuals sometimes use	'have DCD'; 'people with DCD' (Person-First Language; noun/separate to self)
Outdated/offensive terms that should NOT be used	Clumsy Child Syndrome; 'struggles with'; 'suffers from'

Examples: Neuro-affirming Framing

Phrasing centred around Traits & Internal Experiences — acknowledges strengths

Big-picture thinkers	Heightened creativity	Deeply Empathetic	Strong problem-solving skills
Impacts spatial awareness	Exceptional long-term memory	Very resourceful	Vibrant imagination

Examples: Medical Model Framing

Phrasing centred around Deficits & Symptoms — places fault on the individual

Clumsy	Disorganised, Untidy	Poor, slow handwriting
Behaviour problems	Poor attention span	Immature behaviour
Unable to perform simple tasks	Poor observational memory of sequencing	Overly sensitive to sensory stimulus

Diagnostic Criteria

The language used in the clinical criteria is deficit-based because this is literally the medical model in practice. That does not mean it's more valid, though.

A DCD evaluation looks at five areas: strength, balance, coordination, visuomotor skills, and fine motor control.

DSM-5 Criteria	ICD-11 Criteria
Full DSM-5 is available to purchase	https://icd.who.int/browse/2024-01/mms/en#437815624
A. Motor performance that is substantially below expected levels, given the person's chronologic age and previous opportunities for skill acquisition.	Developmental motor coordination disorder is characterised by a significant delay in the acquisition of gross and fine motor skills and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness, or inaccuracy of motor performance.
B. The disturbance in Criterion A, without accommodations, significantly and persistently interferes with activities of daily living or academic achievement.	Coordinated motor skills are substantially below that expected given the individual's chronological age and level of intellectual functioning.

C. Onset of symptoms is in the early developmental period.	Onset of coordinated motor skills difficulties occurs during the developmental period and is typically apparent from early childhood.
D. The motor skill deficits are not better explained by intellectual disability (intellectual development disorder) or visual impairment and are not attributable to a neurological condition affecting movement (e.g., cerebral palsy, muscular dystrophy, degenerative disorder).	Coordinated motor skills difficulties cause significant and persistent limitations in functioning (e.g., in activities of daily living, school work, and vocational and leisure activities).
E: The disturbance is not due to a general medical condition (e.g., cerebral palsy, hemiplegia, or muscular dystrophy).	Difficulties with coordinated motor skills are not solely attributable to a Disease of the Nervous System, Disease of the Musculoskeletal System or Connective Tissue, sensory impairment, and not better explained by a Disorder of Intellectual Development.

Current Diagnostic Tools

It is important to note that there is no single test that can definitively diagnose DCD. A diagnosis is typically made based on the results of a comprehensive assessment that includes a combination of tools and methods. This means that while all these tools are available, that won't necessarily all be used.

Children (up to age 21)	Adults (21+)
Movement Assessment Battery for Children (Movement ABC-2)	There is no diagnostic tool for adults; screening tools include:
Movement Assessment Battery for Children Checklist (Movement ABC-2 Checklist)	Adult Developmental Coordination Disorders/Dyspraxia Checklist (ADC)
British Ability Scales (BAS-3)	Wechsler Adult Intelligence Scale (WAIS)
Peabody Developmental Motor Scales	
Bruininks—Oseretsky Test of Motor Proficiency (BOT-2)	
Beery-Buktenica Visual-Motor Integration (Beery VMI)	
Detailed Assessment of Speed Handwriting (DASH-17)	
Wechsler Intelligence Scale for Children Version V (WISC-V)	

DLD (Developmental Language Disorder)

The Basics

DLD (Developmental Language Disorder) is a relatively unknown term used to describe an ongoing difference in using expressive language and/or understanding what other people say. It can sometime impact spoken language (mouth words). It is labelled as a 'spectrum disorder,' meaning it involves several related skills, making each person's experience individual to them.

DLD is a hidden disability, so it isn't externally observable. DLD is very under researched, but we do know that it tends to run in families, so there is a genetic component. It is also a very common condition: it affects 7.5% of the school-aged population and 1 in 14 people in the total population. As with all neurodevelopmental conditions, it is a lifelong disability. It is not very well known, even though it affects so many people: it is nearly 7 times more common than Autism (using the prevalence rates of *identified* autistic people) and 46 times more common than childhood deafness.

DLD commonly co-occurs with ADHD, dyslexia, and reading comprehension difficulties. People with DLD are 4 times more likely to have maths difficulties, 6 times more likely to have reading disabilities, and are 12 times more likely to have all three of these challenges combined. People with DLD also frequently experience mental health difficulties due to being 6 times more likely to experience clinical levels of anxiety. People with DLD are 3 times more likely than their non-DLD peers to experience clinical depression.

Children for whom English is a second language are even more at risk of long-term negative outcomes. They are 50% less likely to be identified as having DLD-related needs than those children who speak English as their only language. There are many contributing factors, but one of the most significant ones is that diagnostic tools are not appropriately normed for children who learn English as an additional languages. Another factor is that many of the professionals who perform the assessments are not multilingual themselves, which confounds their understanding of the needs that are being presented by the young person.

When not identified – due to lack of awareness, inadequate understanding, and unrecognised bias within the assessment process – people with DLD experience poorer educational outcomes, lower rates of both pay and employment, and worse mental health. There is also evidence to support that people with DLD who don't have the correct support will experience poorer life outcomes all around. For example, young people with DCD are 6 times more likely to be imprisoned than young people in the general population; those young people are also twice as likely to re-offend within a year than their non-DLD offending peers. 60% of them had not been identified as having DCD before they were imprisoned.

Receiving a DLD diagnosis is more than just a 'label' – it can relieve people of the burdens of being considered incapable and lazy, and of the internalised belief that they are inferior to their peers. It can also assure them the understanding and support they need to achieve their goals. As a lifelong condition, DLD support

services should be accessible to those who need them, whenever they need them, not just in childhood and adolescence. Taking these learning differences and needs into account can transform lives.

Related Terminology

Disabled people should choose the language that is used to describe and refer to them, especially when what is being communicated is information about their specific disability. It is never appropriate for non-disabled people to correct disabled people on the language they use to discuss their specific situation. When discussing disability generally, it is encouraged for people to use identity-first language; a specific community's preferences should always be respected. When discussing an individual's situation, their preferences should be respected.

Diagnostic label	Developmental Language Disorder (DLD)
Community Preference	People with DLD; 'have DLD' Person First Language (noun/separate to self)
Outdated/offensive terms that should NOT be used	Specific Language Impairment (SLI); Language Disorder; Language Delay; 'suffers from'

Examples: Neuro-affirming Framing

Phrasing centred around Traits & Internal Experiences — acknowledges strengths

Succeeds with multi-sensory learning	Creative thinkers	Adept at practical activities	Compassionate
Adaptable & hard working	Benefits from visual learning strategies	Excel in creative expression	Unique

Examples: Medical Model Framing

Phrasing centred around Deficits & Symptoms — places fault on the individual

Disruptive behaviour	Difficulty with handwriting	Struggles to make friends
Make many errors	Poor attention span	Fails to comply with directions
Difficulty with verbal expression	Poor understanding of information	Trouble answering questions correctly

Diagnostic Criteria

The language used in the clinical criteria is deficit-based because this is literally the medical model in practice. That does not mean it's more valid, though.

Clinical diagnosis is dependent upon a young person's 'severity of problems,' as determined by external observation. In situations where clinicians determine the severity is 'mild,' they may decide that giving a clinical diagnosis is not warranted. This is based in the belief that a diagnosis is only important for identifying specific

problems to be fixed. Clinicians will place priority on problems that interfere with a child's success at school, at home, or in their wider world.

Current Diagnostic Tools

It is important to note that there is no single test that can definitively diagnose DLD. A diagnosis is typically made based on the results of a comprehensive assessment that includes a combination of tools and methods. This means that while all these tools are available, that won't necessarily all be used.

Children (up to age 24)	Adults (24+)
Clinical Assessment of Pragmatics (CAPs)	No diagnostic tool is fully normed for use with adults; many of the tools normed for children/young people can be used informally for adult screening
Clinical Evaluation of Language Fundamentals (CELF-5 Metalinguistics)	
Gray Oral Reading Tests – Fifth edition (GORT-5)	
Nelson-Denny Reading Test	
Test of Integrated Language and Literacy Skills (TILLS)	
Test of Adolescent and Adult Language (TOAL-4)	

FASD (Fetal Alcohol Spectrum Disorder)

The Basics

FASD is a condition that can occur when a foetus is exposed to alcohol in the womb. It can happen at any point of pregnancy and often occurs before the pregnancy is known. Because of this, FASD is very common. Many people who are FASD are unaware of it.

FASD is a lifelong neurodevelopmental condition and, like many neurodivergent conditions, is a hidden disability. It is estimated to affect 3-5% of the general population, which means 1 in 20 people in Scotland are likely to have FASD. Significantly, FASD is experienced by up to 33% of the care experienced population. 75% of children put forward for an adoption medical exam have a history of prenatal alcohol exposure (PAE).

FASD can affect any area of development and can affect almost every single body system. There are more than 400 conditions that can co-occur with FASD. It is very common for individuals with FASD to also have a diagnosis of autism and/or ADHD.

Because of the many variables involved, FASD can impact someone in innumerable ways. While each experience is unique, there are some common externally observable traits, including:

Impulsivity	Sensory system dysregulation	Dysmaturity
Memory problems	Executive functioning troubles	Fluctuating capability
Cognition difficulties	Difficulties with motor skills	Confabulation

Confabulation is a key aspect of FASD and its important to understand what it means so the person with FASD can be appropriately supported. Confabulation is when (particularly in stressful or pressured situations) people with FASD believe they are telling the truth but they aren't – their brains are filling in holes in memory without them realising it, to make sense of the situation in the absence of all the information. These memory holes occur because PAE can impact the development of the prefrontal cortex of the brain, making it difficult for it to access memory. The brain really can't cope with those memory holes, so it spontaneously creates something to fill them in. The person with FASD fully believes that what they're saying is true because the memory gaps are filled very convincingly by a brain needing things to make sense; they won't realise until later, if at all, that this was confabulation.

It is pointless and harmful to push back when a person with FASD is experiencing confabulation. They can't be 'reasoned' with because they aren't consciously choosing to lie. Any insistence on the part of the non-FASD people will only damage communication and trust.

Related Terminology

Disabled people should choose the language that is used to describe and refer to them, especially when what is being communicated is information about their specific disability. It is never appropriate for non-disabled people to correct

disabled people on the language they use to discuss their specific situation. When discussing disability generally, it is encouraged for people to use identity-first language; a specific community's preferences should always be respected. When discussing an individual's situation, their preferences should be respected.

Diagnostic label	Fetal Alcohol Spectrum Disorder with sentinel facial features Fetal Alcohol Spectrum Disorder without sentinel facial features
Community Preference	Person with FASD; Young people with FASD; Adults with FASD; "Affected by FASD" Person-first (noun/separate to self) and non-stigmatising language; emphasis on non-blaming
Individuals will use	Brain-based disability; brain-based disorder; Executive Functioning disorder; Cognitive disorder; Neurodevelopmental disorder, etc.
Outdated/offensive terms that should NOT be used	Fetal Alcohol Syndrome (FAS); Partial Fetal Alcohol Syndrome (pFAS); Alcohol-Related neurological Disorder (ARND); Alcohol-Related Birth Defects (ARBD); Neurobehavioural Disorder-Prenatal Alcohol Exposure (NDPAE). "Suffers from"; "Suffers with"; "a victim of"

Examples: Neuro-affirming Framing

Phrasing centred around Traits & Internal Experiences (acknowledges strengths). With regard to FASD, this is based in using non-stigmatising, non-blaming language.

Disability	Confabulates	Affected differently	Difficulty
Associated difficulties	FASD-affected cognitive processing	Fluctuating capacity	Can't meet those expectations
Dysregulated	Lacks impulse control	Sensory processing differences	Needs FASD-informed strategies

Examples: Medical Model Framing

Phrasing centred around Deficits & Symptoms – places fault on the individual

Brain injured	Impaired	Behavioural Disorder
Disordered	Violent, Abusive	Compensates for memory loss
Condition	Liar	Defiant

Diagnostic Criteria

The language used in the clinical criteria is deficit-based because this is literally the medical model in practice. That does not mean it's more valid, though.

The diagnostic criteria are the same for children, young people and adults. To receive an official diagnosis of FASD, the should be present:

- ❖ Confirmation of alcohol exposure to the foetus during pregnancy
- ❖ Existence of neurodevelopmental challenges
- ❖ Baby pictures that show the face (not smiling)

The baby pictures are intended to show the facial features associated with FASD, which includes: a smooth philtrum (the groove in the upper lip that runs from the lip to the nose); thin upper lip; and small eye openings. These facial features aren't always present in those with FASD; in fact, <10% of people with FASD have the characteristic facial features. As long as there is proof of alcohol exposure to the foetus, a diagnosis is still possible. If there is no proof of an alcohol exposure during pregnancy, an FASD diagnosis is only possible if the facial features are present.

FASD with Sentinel Features	FASD without Sentinel Features
simultaneous presentation of the three sentinel facial features (short palpebral fissures, smooth philtrum and thin upper lip); **AND**	confirmation of prenatal alcohol exposure (PAE); **AND**
prenatal alcohol exposure (PAE) confirmed or unknown; **AND**	evidence of severe impairment in 3 or more of the identified neurodevelopmental areas of assessment
evidence of severe impairment in 3 or more of the identified neurodevelopmental areas of assessment **or**, in infants and young children, presence of microcephaly	consideration given to contribution of genetic factors in all cases and referral may be indicated in atypical cases or where PAE is uncertain
consideration given to contribution of genetic factors in all cases and referral may be indicated in atypical cases or where PAE is uncertain	growth impairment and other birth defects and/or health issues should be documented if present
growth impairment and other birth defects and/or health issues should be documented if present	hereditary, prenatal and postnatal factors that may influence developmental outcome should be recorded
hereditary, prenatal and postnatal factors that may influence developmental outcome should be recorded	

Learning Disability

The Basics

Traditionally, a learning disability has been defined as having an IQ below 70; the global average for IQ being 100 (the average UK IQ is 99.12). It is now uncommon, though, for IQ assessments to be conducted unless their are specific circumstances that seem to make it necessary. As a result, a child may first receive a diagnosis of Global Development Delay (GDD).

A GDD diagnosis indicates that the child is significantly lagging behind their peers in achieving essential developmental milestones across various domains, including physical skills (such as walking and fine motor skills), communication (both speaking and comprehension), and social-emotional competencies.

A substantial number of children with a GDD diagnosis will eventually catch up to their peers. When that does not occur and considerable challenges persist, the child will then be diagnosed with having a learning disability. If the challenges are severe or profound from a young age, the GDD classification is typically bypassed and a diagnosis of Learning Disability is given right away.

The areas in which the presence of significant challenges leads to further investigation include:

- Understanding new or complex information (academically, they may be behind their peers to a mild, moderate, or severe extent)
- A diminished capacity to acquire new skills typical for their age (such as dressing, personal hygiene, and preparing snacks)
- A reduced ability to function independently (which may necessitate additional support in educational or community settings)

30-40% of autistic and/or ADHD children will have also have a learning disability.

Related Terminology

Disabled people should choose the language that is used to describe and refer to them, especially when what is being communicated is information about their specific disability. It is never appropriate for non-disabled people to correct disabled people on the language they use to discuss their specific situation. When discussing disability generally, it is encouraged for people to use identity-first language; a specific community's preferences should always be respected. When discussing an individual's situation, their preferences should be respected.

Diagnostic label	Learning Disability (LD)
Community Preference	Interchangeable use of Learning Disabled and 'person with a learning disability'
Individuals rarely use	Special needs; person with intellectual disability
Outdated/offensive terms that should NOT be used	Mental Handicap, Minimal Brain Dysfunction, Retarded, Idiot, Imbecile; Condescending phrases, ex. 'handi-capable,' 'differently- abled'; suffers from; afflicted by

Examples: Neuro-affirming Framing

Phrasing centred around Traits & Internal Experiences — acknowledges strengths

Communication differences	High support needs	Sleep difficulties	Challenging behaviour
Complex health needs	Coordination difficulties	Non-speaking	Requires support with daily occupations

Examples: Medical Model Framing

Phrasing centred around Deficits & Symptoms — places fault on the individual

Disordered communication	Impaired cognition	Sleep disordered	Aggressive & violent behaviour
Afflicted with illness	Clumsy & wooden	Non-verbal	Incapable of basic daily tasks

Diagnostic Criteria

The language used in the clinical criteria is deficit-based because this is literally the medical model in practice. That does not mean it's more valid, though.

Diagnoses of learning disabilities are usually delivered by a health professional. The time it takes to get a diagnosis will vary depending on the individual child's needs. The criteria generally can be described as:

- Impaired intellectual ability (significantly reduced ability to understand new or complex information and to learn new skills)
- Impaired social/adaptive functioning (reduced ability to cope independently in daily life)
- Onset before adulthood (condition began during the developmental period)

Current Diagnostic Tools

Children (up to age 16)	Adults (age 16+)
Wechsler Intelligence Scale for Children Version V (WISC-V)	Wechsler Adult Intelligence Scale 4th edition (WAIS-IV)
Adaptive Behaviour Assessment System (ABAS-III)	Wechsler Adult Intelligence Scale 5th edition (WAIS-V)
	Adaptive Behaviour Assessment System (ABAS-III)

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