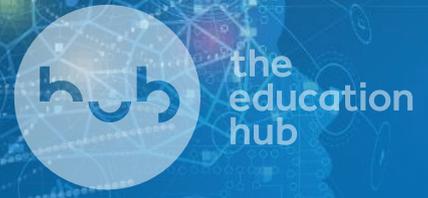


An introduction to neurodiversity and neurodivergence



ECE resources

Neurodiversity is a biological fact: it is a word for the infinite variation in neurocognitive functioning within the human species, analogous to ethnic diversity or gender diversity. Put simply, it means that all humans are wired differently. These differences influence the way an individual thinks and learns, how they process sensory input and perceive the world, and how they interact with others.

An individual is **neurodivergent** if their mind functions differently from the dominant societal standards of normal. An individual is **neurotypical** if their mind conforms to what is constructed as normal in their society. A group of people is **neurodiverse** if it includes more than one neurotype. As the concept of diversity applies to groups of people, an individual cannot be neurodiverse or have neurodiversity.

The **neurodiversity paradigm** is a perspective on neurodiversity that states that no type of mind is inherently more or less valuable or normal than any other. From this perspective, neurocognitive difference is viewed as natural rather than defective, and it is described in terms of **neurotypes** rather than disorders. In acknowledging the role of socially constructed norms when defining neurodivergence and neurotypicality, the neurodiversity paradigm draws attention to the power dynamics and majority privilege that have contributed to the historical framing of minority neurotypes as abnormal or deficient. It should be noted that not all neurodivergent people subscribe to the neurodiversity paradigm.

Where did the concept of neurodiversity come from?

The term neurodiversity was coined by Judy Singer, an Australian autistic sociologist, in the late 1990s, in resistance to the medical model of disability. She wanted to map autism as a societal issue rather than a medical one. This re-mapping represented a radical departure from accepted autism orthodoxies of the era. Under the medical model, autism and other minority neurotypes were and still are considered as neurodevelopmental 'disorders' in a way that emphasises individual deficit and impairment while disregarding societal and environmental factors.

The neurodiversity paradigm, instead, proposes a more nuanced appraisal of neurotypes that encompasses both strengths and impairments. It highlights that context and perspective often determine how a particular trait is experienced: for example, hypersensitivity can enable an individual to find intense delight and joy in flowing water, but it can also disable them when they are in a busy environment.

Picking up Singer's idea, autistic activists and academic theorists have developed the neurodiversity paradigm further, weaving in concepts from the social, relational, and minority models of disability, the disability justice movement, and queer/crip theory. It was through this cross-pollination that the idea of disability as a bilateral mismatch between neurodivergent and neurotypical sensibilities (as opposed to a unilateral deficit) came to the fore. The neurodiversity model was quickly adopted by other disability activists and now embraces a range of neurocognitive differences. In this alignment with other neurominorities, neurodiversity activists focus on shared experiences of marginalisation between groups that are socially constructed as Other, and fight for acceptance of all kinds of human diversity.

Forms of neurodivergence

Neurodivergence can be broadly grouped under the categories of innate and acquired. **Innate neurodivergence** is present from birth and therefore generally experienced as an inseparable part of personhood. Examples of innate neurodivergence include (but are not limited to) autism, ADHD, dyslexia, dyspraxia, dyscalculia, dysgraphia, synaesthesia, auditory and visual processing disorder, Tourette's, intellectual disability, giftedness, Down Syndrome, and FASD.

Acquired neurodivergence can develop at any time of life as part of a health condition, injury, drug use, trauma, stressful life events, or the side effects of medication. As acquired neurodivergence may be episodic or temporary, it is generally not experienced as a part of personhood. Examples of acquired neurodivergence include (but are not limited to) mood disorders, anxiety disorders, Alzheimer's, schizophrenia, and traumatic brain injury.

Variations in terminology

Most of the neurotypes listed above have traditionally been framed in terms of deficit or deviance from the norm, and labeled as disorders and syndromes. This reflects the medical community's focus on assessing a person's difficulties in order to arrive at a diagnosis. While diagnosis is an important first step for accessing services and support, the pathologising terminology used in diagnosis may later be rejected by the person in favour of more affirming and strengths-based language.

This process has been most evident in relation to autism. Identity-first language ('autistic person') is now preferred over person-first language ('person with autism', 'person has autism'), reflecting general language usage where words referring to positive or neutral characteristics are placed before the person (such as 'tall person'), while words referring to negative characteristics are placed behind the person (such as 'person with cancer'). The shift to identity-first language also acknowledges the widespread community perceptions of autism as an integral part of the person, rather than an affliction that can or should be separated from them. Other terms that are often rejected include 'disorder' (using, instead, 'condition'), 'non-verbal' (using, instead, 'non-speaking'), and 'symptoms' (using, instead, 'traits'). The simplistic binary scales of high/low-functioning and mild/severe are also considered problematic, as the level of impairment a person experiences fluctuates according to a multitude of factors within and without the individual, as well as over their life span. This is demonstrated by famous autistic people like Temple Grandin or Stephen Shore, both of whom were labelled low-functioning as children but went on to earn doctorate degrees. If specificity is needed in describing a person, it is preferable to refer to any additional disabilities or circumstances that may impact their ability to 'function' (for example, 'X is autistic, uses a letterboard to communicate, and currently needs assistance with toileting.' 'Y is autistic and able to work full-time when well supported').

Clinical descriptions of neurodivergence often include reference to emotional dysregulation and 'challenging behaviours' as if they were inherent traits of the neurotype. However, these behaviours are less a feature of the person than a consequence of their environment: emotional dysregulation can occur in anyone whose sensory, emotional, social, and cognitive needs are unsupported. Frustration, fatigue, and low self-esteem are also common in neurodivergent people, owing to the mismatch between the enormous effort they tend to put into everyday tasks and the often unsatisfactory outcomes despite this effort. Those who have not been able to access an official diagnosis may be labelled lazy, sloppy, or naughty, adding to their frustration. Accordingly, the 'challenging behaviours' that emotionally dysregulated people engage in may be better described as behaviours suggestive of distress.

It is important to note that these changes in terminology are not applied universally. For example, Attention Deficit Hyperactivity Disorder includes the words 'deficit' and 'disorder', neither of which reflect

the tenets of the neurodiversity paradigm. In community forums, people belonging to this neurotype may describe themselves as 'having ADHD' avoiding the stigmatising words by using the acronym, or 'being an ADHDer', also avoiding the stigmatising grammar by claiming the label in an identity-affirming way. Others may say that they have attention deficits. As everybody has their own preferences, it is crucial to check in with each individual to find out what language they use for themselves.

Myths and misconceptions

There are a number of myths and misunderstandings associated with neurodiversity and neurodivergent children. It is important to acknowledge and consciously reject these misconceptions. For example, there is a perception that neurodivergent children cannot learn. In fact, all children have the potential to learn, and low teacher expectations for neurodivergent children, based on a perceived lack of intelligence, have been linked to underperformance and poor achievement. While some children may require curriculum adaptation and differentiated teaching instruction, this does not mean they are incapable of learning and succeeding.

Another myth is that embracing the neurodiversity paradigm simply means changing how we talk about neurodivergent people. In fact, the neurodiversity paradigm goes beyond language to challenge society's assumptions about what is normal and how difference is framed. Under this model, it is not the characteristics of neurological differences but societies themselves that create barriers to the participation, achievement, and success of neurodivergent individuals. This shifts the onus from the neurodivergent individual to society itself as the locus for change.

There has also been a persistent but misleading belief among some researchers and practitioners in this field that all neurodivergence can be cured. While this is true for some types of acquired neurodivergence, innate neurodivergence is lifelong. Innately neurodivergent people may learn to hide their traits when in public to avoid stigma (called 'masking'), but this does not mean they are cured. In addition, the practice of masking comes at a high cost to the person in terms of energy expenditure and self-worth. It has been linked with burnout and mental health conditions in the research literature.

Using a strengths-based model to support neurodivergent children

While the neurodiversity model acknowledges the challenges a neurodivergent individual may experience, it contextualises these challenges as environmental, societal, and relational instead of casting them as purely individual deficits. Most importantly, it also highlights the strengths a neurodivergent child may bring to the learning environment, increasing awareness and understanding about neurological differences, and reducing social stigma. Indeed, neurodivergent children may have many strengths: these may include creativity, a natural ability to think outside the box, high levels of empathy and self-awareness, straightforward communication, strong problem-solving skills, enhanced perceptual skills, decreased liability to cognitive biases, resilience, and perseverance in the face of adversity. Some of these strengths are intricately linked to their individual 'wiring' and some arise from living as part of a neuro-minority, facing similar bias and exclusion as other minorities. The balanced framing of difference in the neurodiversity model can assist teachers and centres who may be thinking about how to support neurodivergent children to be successful learners.

When a child has an official diagnosis, support can be tailored to meet their individual learning support needs based on the challenges that diagnosis identifies, as well as the child's individual strengths and needs. However, due to gender, racial, and ethnic biases, as well as social inequities in access to screening and assessment, some children may never receive an official diagnosis despite presenting characteristics that align with a specific type of neurodivergence. Support can still be provided to these

children. When a child does not have an official diagnosis and a condition is suspected, it is important to consult with their family before seeking further professional advice.

There are many ways that teachers and centres can support neurodivergent children. This may include fostering a culture that celebrates diversity, providing teachers with professional development on supporting diverse learning needs, and incorporating the child's voice in decision-making processes. Teachers play a key role as both facilitators of and role models for approaches to neurodivergence, although children, leaders, and parents also contribute to the culture of the learning environment.

In terms of learning support, teachers should ensure that learning programmes and the learning environment are designed in ways that engage all children and draw on their known strengths. This strengths-based approach can create opportunities for them to access the curriculum in ways that suit their individual abilities, allowing them to experience success and develop confidence in their abilities but also ensuring that the things they find challenging do not become barriers to their learning. Where additional learning support such as teacher aide support or specialist support like speech language therapy is needed, referrals can be made to the Ministry of Education or relevant authority by contacting a regional service manager. Centres and teachers may support children and their families through this process by making sure they have the information they need and understand the process, and by attending events such as paediatric appointments with children and their families.

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