Toward Neurodiversity-Affirming Language for ADHD

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Abstract

Language shapes how ADHD is understood and how society treats people with ADHD. Conceptualisation as a disorder underpins the deficit-based, medicalised framing of ADHD that dominates clinical, research, and public discourse, contributing to stigma and limiting how people with ADHD can understand their own experiences. Our perspective piece examines power dynamics in language use and the material consequences of harmful terminology. Drawing on the neurodiversity paradigm, we propose a framework to guide language choices that reconceptualise ADHD as a valued part of human neurocognitive variation rather than inherent pathology. Through a neurodiversity framework, we provide researchers, clinicians, and others with reflective questions and examples to guide language that is neurodiversity-affirming, non-pathologising, and better reflects the lived experiences of people with ADHD. We write as an international collective of researchers and professionals, many of whom are neurodivergent and/or disabled, including ADHDers and parents of ADHDers. Learning from autism advocacy and disability studies, we emphasise how participatory research may improve ADHD narratives, thereby influencing knowledge generation. While acknowledging challenges such as institutional constraints, we advocate for coordinated individual and systemic efforts toward language reform. Thoughtful, neurodiversity-informed language may reduce stigma, support epistemic justice, and create a more meaningful understanding of ADHD.

Keywords: neurodiversity; neurodiversity-affirming language; ADHD; epistemic justice; stigma; participatory research; lived-experience expertise; community perspective

Lay Abstract

The words we use to talk about ADHD matter. Currently, ADHD is usually described in medical terms as a 'disorder', meaning it is something wrong that needs fixing. This medical approach dominates how researchers, healthcare professionals, and the public think and talk about ADHD, which can increase stigma and limit how ADHDers understand themselves. This paper examines how language creates power imbalances and real-world harms for people with ADHD. We propose a different approach based on the neurodiversity perspective, which views ADHD as a valuable part of diversity in brain wiring and ways of thinking. We offer practical guidance to help individuals in positions of authority use language that affirms neurodiversity and more accurately reflects the lived experiences of people with ADHD. Our author team includes researchers and professionals from around the world, and many of us are neurodivergent, disabled, have ADHD ourselves, and/or are parents of ADHDers. Learning from autism advocacy and disability studies, we highlight how involving ADHD communities in research can enhance our understanding of and improve our communication about ADHD. We recognise that changing established language can be difficult. For example, using terms like 'disorder' may be necessary to receive appropriate support. However, we believe that both individual choices and changes at higher levels are necessary, such as in the policies of professional organisations and academic journals. Using thoughtful language based on the neurodiversity perspective can reduce stigma, ensure that people with ADHD are heard and believed, and create more meaningful knowledge about ADHD.

Positionality

We are an international collective who understand ADHD through both lived and professional experience. Most of us identify as neurodivergent and/or disabled, and many of us are people with ADHD/ADHDers. Some of us are also parents to children with ADHD/ADHDers. Our group includes researchers focused on ADHD or other neurodivergent/disabled communities, along with an allied health professional working with people with ADHD. A range of perspectives therefore informs our understanding of ADHD, along with the broader experiences of social exclusion that accompany disability and ways of being that fall outside the norm. The mixture of person-first (person with ADHD) and identity-first language (ADHDer) in this piece reflects the mixed preferences within our group, and we recognise that these preferences also vary across the wider ADHD community.

Introduction

Language is the conduit through which we create shared understanding of concepts and communicate meaning. Consequently, language plays a crucial and central role in the social construction of conditions that have traditionally been considered mental disorders. Language can produce, perpetuate, and proliferate stigma (Hoffner, 2022), and its power has been increasingly recognised across medical, psychological, and social fields. Language directly informs how researchers, healthcare professionals, educators, families, the media, and society at large understand and respond to individuals from marginalised communities, including those with mental health and neurodevelopmental conditions. As such, calls have been made to interrogate and modify language choices to mitigate harm (see, e.g., Bottema-Beutel et al., 2021; Granello & Gorby, 2021).

A hallmark of the neurodiversity movement has been the evolution of language used to describe autism. This has resulted in a shift from medicalised, deficit-based language to neuro-affirming, difference-based language (Dwyer et al., 2025) in alignment with the preferences of the autistic community (Bottini et al., 2024). Importantly, these language changes have been rapid. A systematic review of autism research articles reports that neuro-affirming language has become statistically more widespread (Bottini et al., 2024). This effect was apparent despite the review examining only a brief window of less than four years, demonstrating that change can happen quickly with concerted efforts.

In contrast to autism, language use around ADHD has received relatively little attention (French et al., 2025), despite ADHD being widely recognised as a form of neurodivergence. As a diagnosis listed in the Diagnostic and Statistical Manual (American Psychiatric Association, 2013), ADHD is conceptualised and operationalised as a disorder by name and definition. This pathologised, deficit-based framing has dominated the construction of ADHD in the clinical, research, and broader societal consciousness. Until recently, the potential for systemic bias and inaccuracy in this framing has received little scrutiny. However, growing recognition of the neurodiversity paradigm is an opportunity for change and an impetus for thoughtful discussion around how we communicate about the ADHD neurotype.

In this community perspective piece, we first consider power dynamics in the conceptualisation of ADHD and the material consequences of harmful language. To address these issues, we then propose a framework based on the neurodiversity paradigm and self-reflective questions to guide language choices that move away from the deficit-based narrative. This framework is designed to help promote social acceptance of people with ADHD and generate a more balanced understanding of ADHD-related experiences to support epistemic justice. We also take

inspiration from the extensive conversations around language use in autism and disability research. These dialogues demonstrate the benefits of listening to the communities that are impacted by the linguistic choices of researchers and healthcare professionals, highlighting the need for participatory approaches in ADHD research and knowledge construction. Finally, we acknowledge the challenges involved in language reform and offer suggestions for next steps.

Power Dynamics in Language Use

Dominant language can become deeply institutionalised, giving some language users more power than others in controlling narratives about ADHD. Academic and healthcare professionals have considerable power in this regard. For instance, stigmatising language in medical records may encourage clinicians reading those records to adopt negative attitudes (Goddu et al., 2018), illustrating the contagious nature of problematic language when used and accepted without reflection by those in positions of authority. Researchers' constructions of marginalised neurotypes may also permeate the broader social descriptions and narratives regarding these groups (Botha & Cage, 2022) – including those that pervade the media (Goodman, 2014; Yücel, 2023) – and eventually seep into the public consciousness.

In contrast, community members' ability to contest language choices is restricted by systems, institutions, and power dynamics. Contemporary healthcare and disability support systems may force community members to justify their needs in particular terms (e.g., 'deficit', 'impairment', and diagnostic labels that include 'disorder') to access needed supports (including medications) or accommodations. Marginalised individuals or communities can reclaim or repurpose language to combat its detrimental effects (e.g., Strong, 2025). However, pervasive power imbalances limit their ability to affect concrete changes in how their identities and lived experiences are framed. For example, an analysis of young people's social media posts about ADHD illustrated a shared understanding of ADHD that centred on positive attributes (e.g., being energetic); however, posts also captured ongoing frustration with ADHD stereotypes and being misunderstood (Gajaria et al., 2011). Therefore, although community-driven change is essential, community members' advocacy is restricted by power dynamics and remains impeded unless reflected by institutional and professional transformation.

Material Consequences of Harmful Language

The use of harmful language can lead to real, material consequences. Most immediately, harmful language can reinforce stigma and perpetuate negative stereotypes. Negative attitudes towards ADHD and related supports/medications are pervasive across different cultures, and include beliefs that ADHD is over-diagnosed, doubts that ADHD is a legitimate condition, and skepticism

about the usefulness of ADHD medications (Bisset et al., 2022). Stereotypes about ADHD persist, including that individuals with ADHD are more likely to behave in socially unacceptable or dangerous ways and may be less competent (Bisset et al., 2022; Lebowitz, 2016; Visser et al., 2024). Such stereotypes are transmitted through social learning, implicit bias, or social and institutional reinforcement, and the effects on people with ADHD can emerge very early in life. For instance, in an experimental study, children (7–11 year olds) saw vignettes of peers displaying hyperactive/impulsive and inattentive behaviours with or without an ADHD label (Greenway et al., 2023). Children who saw the ADHD label reported more negative attitudes toward the vignette character than children who did not see the ADHD label, illustrating the negative stereotypes invoked by the diagnostic label. Activation of such stereotypes contributes to social exclusion and devaluation of people with ADHD, including differential access to educational, professional, and social opportunities.

In school contexts, teachers' beliefs about ADHD relate to the development of prejudice and discriminatory behaviours against students with ADHD (Metzger & Hamilton, 2021; Vukelić & Vlah, 2024). One study found that when teachers evaluate the performance of students with ADHD, they are more likely to rate them as performing below grade level and less likely to rate them as performing above grade level, irrespective of the abilities shown in subject-specific tests (Metzger & Hamilton, 2021). Therefore, although access to diagnosis (and thus the label) can enable accommodations and support, it may also lead to subconscious discrimination and harmful labeling via activation of stereotypes, which can pose real challenges and stress that neurotypical individuals will not face. For example, young adults with ADHD who were exposed to a stereotype threat performed worse on an academic test than those with ADHD who were not exposed to the threat (Foy, 2018), illustrating the restrictive and diminishing impact of ADHD stereotypes.

In workplace contexts, qualitative reports similarly illustrate that employees with ADHD experience discrimination and prejudice (ADDitude Editors, 2025; Beaton et al., 2022). People with ADHD report responding to such workplace pressures by pushing themselves to work harder or lowering their ambitions (Beaton et al., 2022). In social contexts, research demonstrates widespread reluctance to interact with people who have ADHD (Lebowitz, 2016). The broader community's desire to maintain social distance from ADHDers is evident across different cultures and age groups (Bisset et al., 2022), highlighting the wide-reaching adverse social impacts of the stereotypes activated by the label.

Harmful language also affects individuals' mental health and self-esteem. Indeed, stigma from the public can be internalised when individuals apply harmful stereotypes to themselves (Hoffner, 2022). Studies suggest internalised stigma and anticipated discrimination correlate with

higher ADHD characteristics and psychological distress, along with poorer self-esteem and quality of life (Masuch et al., 2019), underscoring the real-world consequences of stigmatising language. These effects can be especially pronounced and impactful for children and adolescents. A systematic review and narrative synthesis of 11 qualitative studies exploring lived experiences of adolescent ADHDers reported that conflict, bullying, and rejection were commonplace for participants, often with lasting impacts on their self-esteem and identity (Eccleston et al., 2019). Internalisation of harmful language may lead young people to perceive themselves as less capable or less valuable members of society, with potential long-term implications for their health and wellbeing.

It is worthwhile acknowledging the role of intersectionality, which examines how intersecting power relations associated with categories such as ethnicity, gender identity, class, and sexual orientation influence social relations and experiences in everyday life (Collins & Bilge, 2020). Through this lens, we can consider the cumulative effect of discrimination associated with multiple marginalised identities. For example, people from racialised and ethnically marginalised communities and/or Indigenous nations, those from disadvantaged backgrounds (e.g., low socioeconomic status), and women and gender-diverse people experience disadvantage associated with these identities, which increases their vulnerability to harmful attitudes about ADHD. Presentations of ADHD can be misunderstood or dismissed among some of these populations (Paidipati et al., 2017), which can strengthen the harmful impacts of pathologising language. For instance, in a qualitative study, participants described negative and gendered language in reference to women with ADHD (e.g., lazy, ditsy, and clumsy), simultaneously reinforcing both gender and ADHD stereotypes (double marginalisation) (Bradley et al., 2025).

Furthermore, language focusing on ‘disorder’ can unintentionally validate negative stereotypes about characteristics such as non-compliance, aggression, or lack of discipline, which are often wrongly ascribed to people of colour by biased societal narratives. This bias is evident in educational and clinical settings. For instance, youth from some marginalised ethnic or racial groups are less likely to receive an ADHD diagnosis and more likely to receive a disruptive behavior disorder diagnosis compared to their non-Hispanic White counterparts (Fadus et al., 2020). There is also recent evidence that compared to students from other racial groups, Black students with ADHD are more often disciplined by teachers despite teacher ratings of externalising behaviours not differing statistically across groups (Feller-Mende, 2025).

Language also affects self-understanding among people with ADHD. When clinical terminology fails to capture the nuances of lived experience, communities may seek alternatives. For example, the term ‘emotion dysregulation’ is used as a catch-all for the emotional experiences associated with ADHD that are considered ‘atypical’ by researchers and clinicians, yet it does not adequately

represent some of the specific experiences that may be most impactful. This may explain why 'rejection sensitive dysphoria' (RSD) has been widely adopted within the ADHD community to describe a common experience in which criticism or perceived rejection can lead to debilitating dysphoria (Dodson et al., 2024; Rowney-Smith et al., 2024; Sandland, 2025). Despite lacking official clinical recognition as an aspect of ADHD, uptake of this term by the ADHD community exemplifies the desire for language that helps make sense of shared lived experiences (Sandland, 2025). Notably, when neurodivergent people are asked about their rejection sensitive dysphoria, the role of environmental factors becomes apparent, aligning with a neurodiversity framing that emphasises the importance of interactions between the individual and their social context (Sandland, 2025).

Yet when researchers and clinicians prioritise clinical language over community perspectives, they narrow social meanings of ADHD and can limit ADHDers' ability to make sense of their experiences. This prioritisation of clinical language contributes to hermeneutical injustice – where shared language and concepts unfairly limit how the experiences of marginalised groups are understood (Chapman & Carel, 2022). Thus, the dominant language around ADHD not only impacts self-understanding but also undermines ADHDers' capacity to communicate their needs, advocate for themselves, and have their experiences recognised as legitimate. The adverse effects of harmful language consequently extend beyond the individual level and permeate into relationships, communities, and society, restricting participation and diminishing opportunities for pluralistic perspectives and mutual benefit from diversity.

A Language Framework Based on Neurodiversity

Core Principles

The neurodiversity paradigm offers a means of shifting away from deficit-based narratives toward a more affirming and accurate understanding. Directly challenging the medical model of ADHD as a disorder, the neurodiversity paradigm views neurodivergence as an expected and valued part of human neurocognitive variation (Dwyer, 2022; Pellicano & Den Houting, 2022; Sonuga-Barke & Thapar, 2021; Zaneva et al., 2024). Thus, rather than framing ADHD as a 'deficit' or 'disorder' measured against neurotypicality as the ideal, it can be understood more neutrally as a *difference*. Importantly, educating healthcare and education professionals on neurodiversity has been identified as a tool for stigma reduction by young people with ADHD (Visser et al., 2025), suggesting that a neurodiversity approach aligns with the ADHD community's views.

Of course, there are often substantial challenges associated with being different, which the neurodiversity paradigm recognises. Adopting the social model of disability as part of the neurodiversity paradigm allows us to view disabilities associated with neurodivergence as a mismatch between an individual's context and their inherent ways of thinking and being (Dwyer,

2022; Pellicano & Den Houting, 2022; Sonuga-Barke & Thapar, 2021; Zaneva et al., 2024). For ADHD specifically, this notion is supported by empirical findings that social acceptance can buffer against some of the negative outcomes frequently experienced by young people with ADHD, such as lower school grades, co-occurring mental health difficulties, and social challenges (Dvorsky & Langberg, 2016). These findings suggest that contextual factors may interact with an individual's neurodivergence to influence the extent of disabling experiences.

By acknowledging that ADHD can simultaneously be a difference and a disability, neurodiversity approaches may also help to resolve debates over whether ADHD is 'real'. Multiple authors express concerns about how empirically dubious, reductionistic medical framings of ADHD pathologise people in ways that might be harmful, considering the evidence presented earlier that ADHD labels are currently associated with stereotypes and discrimination (e.g., Nilsson Sjöberg, 2021; Te Meerman et al., 2022). However, such arguments risk falling into anti-psychiatry and critical psychiatry traditions. In addition to accepting false and essentialist assumptions (Chapman, 2023), these traditions assume that people must describe themselves as deficient or disordered to receive support. Thus, individuals are left with a stark choice between receiving support and accepting a stereotyped label or missing out on support to avoid the stereotypes and discrimination surrounding the label. In contrast, neurodiversity approaches allow us to recognise disability in neurodivergence while encouraging us to understand neurodivergence in non-pathologising, non-discriminatory ways (Chapman, 2023).

Guiding Questions

Language choices in research and clinical settings are often made automatically based on the most commonly used and understood terms, which may lead to unintentional harm. To avoid this, healthcare professionals, researchers, and others in positions of authority can ask themselves reflective questions to make thoughtful wording decisions that are more likely to support, rather than stigmatise, people with ADHD. Using the neurodiversity paradigm as a foundation, we have developed a list of questions that serve as a framework for making language choices around ADHD (Box 1). Therefore, rather than advocating for specific terms or phrases, we offer these questions as a tool to help readers reflect on language in a way that encourages more inclusive and respectful choices. We also recognise that many readers may prefer concrete and immediately applicable guidance. Accordingly, we list terms that may be preferable to commonly used deficit-based language (Box 2). However, given the dynamic nature of language preferences, our ultimate aim is to encourage readers to critically reflect on language as an active and ongoing practice.

Box 1: Reflective Questions for Researchers

Positionality and process How did I arrive at this term?	● Why am I using this term? What am I intending to communicate or describe? ● In what context am I using this term, and to whom am I communicating it? ● How did I decide to use this term? What information, conventions, discussions, and evidence led me to select it? ● Am I using language that reflects the preferences of people with lived experience? ● Is my language choice unduly influenced by clinical or medical conventions or authority? ● Am I talking about a group that I am part of? Have I engaged with or consulted individuals or communities with relevant lived experiences when making language choices? ● Are there opportunities for me to signal openness to evolving terminology and acknowledging that language preferences may not be fixed or universal? ● If there are perceived limitations to my language choice, can I justify my choice and articulate those limitations transparently?
Biases and framing What assumptions does this term carry?	● Does my language perpetuate deficit-based narratives or challenge them? ● Am I adopting clinical or diagnostic language without considering alternatives? Are there options for inclusive or descriptive terms that would be appropriate in the context of my work? ● Have I considered any historical, cultural, or treatment-related power dynamics embedded in this term? ● What assumptions does this term carry about what is 'normal', 'functional', 'valued', or what 'capacities' and 'skills' people may have? ● Does this language align with how I'd refer to people in other vulnerable or marginalised groups?

Meaning and precision What does this term convey?	● Does this term imply a deficit, disorder, or dysfunction when this is false or questionable? ● Does this language generalise or homogenise ADHD experiences in a way that erases variation? ● Have I explained or contextualised clinical terms that may carry stigma or be misunderstood by non-specialist readers? ● Is there a more inclusive, precise, or strengths-based term I could use instead? ● Can I incorporate more descriptive or functional terms (e.g., 'attention variability' or 'kinetic energy') that better capture lived experiences? ● Do the terms I am using adequately capture the phenomena, or are there relevant aspects of people's realities and experiences that would be ignored or dismissed by these terms?
Consequences and responsibility What impact could this term have?	● Does this language have practical benefits (e.g., facilitating diagnosis or access to support or social perceptions regarding the legitimacy of neurodivergence), and do those benefits outweigh potential harms or stigma? ● Does this language have harmful material or other consequences (e.g., stigma, preventing access to opportunities)? ● Could this term affect how individuals see themselves or how others treat them (e.g., in education, employment, report writing or policy)? ● What might be the unintended consequences of this language for ADHD communities?

Box 1. Reflective questions and prompts to support more intentional and reflexive language choice.

Box 2: Comparison of Neurodiversity-Affirming vs. Deficit-Based Language

Neurodiversity-affirming preference	Deficit-based language to avoid	Rationale for preference
General		
Person with ADHD / ADHDer (based on individual preference)	Suffers from ADHD / Afflicted by ADHD / defined in opposition to 'healthy controls', implying ADHD is unhealthy	Neutral, non-pathologising language that doesn't define the person by perceived deficits; avoids victimisation language; recognises individual choice between person-first and identity-first preferences.
Neurodivergent / Neurocognitive difference / Neurodevelopmental difference / ADHD neurotype	Neurodevelopmental disorder / Abnormal brain	Positions ADHD as an expected part of variation rather than a medical pathology.
Traits and characteristics		
ADHD traits / ADHD characteristics	ADHD symptoms / ADHD behavioural problems	Reframes experiences as inherent traits rather than medical symptoms that need to be 'cured'.
Attention differences / Attention regulation differences / Interest-based attention regulation	Attention deficit / Inattention	Acknowledges differences in attention allocation and sustained attention rather than suggesting cognitive failure.
Emotional sensitivity / Emotion regulation differences	Emotional dysregulation / Deficient emotional self-regulation / Emotion regulation deficits / Emotion	Reflects neurocognitive differences in emotion regulation.

Neurodiversity-affirming preference	Deficit-based language to avoid	Rationale for preference
	regulation problems / Emotional regulation impairment	
Executive functioning differences	Executive dysfunction / Executive function deficits / Executive function problems / Executive function impairments	Neutral description of cognitive differences without implying malfunction.

Box 2. An illustration of specific terms related to ADHD. We present preferred terms informed by the neurodiversity paradigm and contrast them with deficit-based language, along with a brief rationale. We acknowledge that the 'preferred' language is not universal. In selecting these examples, we were guided by existing research (see main text) as well as the lived experiences and preferences amongst ADHDers in our group.

Examples of Neurodiversity-Informed Language Use

Using the core diagnostic trait of 'inattention' as an example, the neurodiversity paradigm offers a framing that is not only more affirming but perhaps more accurate. ADHDers may have an attention regulation style characterised by interest-based (rather than importance-based) attention allocation (Bertilsdotter Rosqvist et al., 2023), and often experience hyperfocus (Ozel-Kizil et al., 2016). A neurodiversity framing would view the patterns of attention allocation among ADHDers as a divergence from neurotypical patterns, which could therefore be described as a *difference in attention regulation*, rather than a deficit. This framing also seems more accurate than 'inattention' or 'attention deficit' given that hyperfocus is common to ADHD and, if anything, reflects a surplus of attention rather than a lack of it. In fact, some ADHDers have indicated their hyperfocus has been beneficial in certain aspects of their lives, such as achieving goals, which contrasts with the connotations of the pathologising term 'attention deficit' (Ramji et al., 2025).

Notably, some research suggests that a neurodiversity framing and consideration of neurotype-associated strengths might be more aligned with the lived experience of ADHD, supporting hermeneutical justice. For example, 'Cognitive Dynamism' emerged as a strengths-based theme in two qualitative studies about ADHDers' perceptions of the strengths associated with ADHD based on their lived experiences (Ramji & Foster, 2023; Sedgwick et al., 2019). This concept captures the highly active and changeable nature of attention and focus in the ADHD mind, encompassing shifts between states such as hyperfocus and mind wandering. It offers a more holistic way of understanding attention regulation in ADHD, supporting a context-dependent interpretation of cognitive experiences, and moves away from terminology that frames attention in ADHD as inherently problematic or disordered.

The neurodiversity approach can also be applied to other ADHD traits to foster an understanding that better reflects their complexities and how they may affect ADHDers. For example, 'hyperactivity' is generally considered a negative attribute. However, research indicates that it may also have benefits for individuals with ADHD, such as supporting executive functioning and self-efficacy (Hoy et al., 2024). A neurodiversity framing invites this more balanced perspective. For example, describing the activity-related aspects of ADHD as a *difference in energy* (Sedgwick et al., 2019) rather than 'hyperactivity' may better encompass both the strengths and challenges that accompany this trait.

Drawing Inspiration from Language Change in Other Areas

We know that language plays a crucial role across various research domains, including biology, the social sciences, and the humanities (Canguilhem, 1952; Keller, 1995; Martin, 1991; Myers, 1990). For example, the biology-focused philosopher Canguilhem explained the importance of

analogies, metaphors, and vocabulary in the construction of scientific knowledge by showing that the very word 'cell' is part of a scientific imaginary (that of the hive), which conditions theory and observation (Canguilhem, 1952). Similarly, it has been argued that monolingualism-based standards and deficit-oriented language in psycholinguistics research perpetuate the marginalisation of some bilingual groups and narrow the scope of inquiry, preventing a thorough understanding of the nuances and complexities of language use (Higby et al., 2023). Thus, researchers should consider how their language choices around ADHD impact the research questions they ask and how these are answered. For example, referring to *differences* in attention regulation (rather than attention deficits) could emphasise how disability experienced by ADHDers is not caused solely by individual characteristics but by a mismatch between an individual's needs and environmental demands. This change in language could encourage expansion of ecological and contextual research, which is currently lacking in the literature, limiting our understanding of lived experiences and perpetuating monolithic conceptualisations of ADHD.

The extensive and ongoing discussion about language related to disability highlights the benefits of engaging in critical discourse around terminology. There has been ongoing debate on whether person-first language (e.g., 'person with a disability' or 'person with ADHD') or identity-first language (e.g., 'disabled person' or 'ADHDer') is more empowering and respectful (Andrews et al., 2022; Dunn & Andrews, 2015; Grech et al., 2024). Empirical research in this area suggests these choices may shape counsellors' attitudes towards their clients (Granello & Gorby, 2021), demonstrating the material consequences of language choice. Studies have also begun to uncover the nuances in language preferences (Grech et al., 2024), including how language preferences might relate to important aspects of an individual's self-concept and social positioning, such as their disability identity (Janiszewski et al., 2025).

Importantly, the active and persistent dialogue regarding disability language preferences has led to significant changes, including at the institutional level. For instance, the most recent guidelines by the American Psychological Association on person-first versus identity-first language have shifted away from recommending only person-first language (unless there is a known preference for identity-first language) to permitting either person- or identity-first, or a mixture of both (American Psychological Association, 2020). Moreover, they suggest that the level of disability identity may indicate preferences of the group being written about. This evolution in recommendations suggests that more discussion and research around ADHD-related language could have the power to effect meaningful change by informing evidence-based language guidelines for clinicians, researchers, and others in positions of authority.

Discourse around language use in autism research, which has historically been the focus of neurodiversity scholarship (Livingstone et al., 2023), may also serve as inspiration for change in the ADHD space. For instance, recommendations for inclusive autism research have integrated the need for scholarly rigour and generalisability (e.g., sample representativeness, contextual and cultural appropriateness) with the need to reflect carefully on language (Dark, 2024). Furthermore, autism advocates have put forth strong arguments for how, in multiple contexts, using medicalised, pathologising, and deficit-focused terms can have detrimental and harmful consequences for those concerned, particularly regarding how they perceive themselves (Dwyer et al., 2022; Milton, 2012). Many of these arguments apply directly to language use around ADHD. Still, it is essential that the views of the ADHD community are adequately explored to ensure their unique preferences are represented.

The autism field has also contended with prominent objections to neurodiversity-affirming terminology. An argument against adopting this terminology is that it may not accurately represent the scientific reality of autism (Singer et al., 2023). However, traditional terminology is often not scientifically justified: for example, it may lack precision or be based on unwarranted assumptions and generalisations (Bottema-Beutel et al., 2021). Frequently, such terminology fails to consider the social construction of disability: that challenges may not reflect simple internal deficits, but rather societal barriers and the interplay of individual and societal factors (Dwyer et al., 2022, 2024). These issues of bias and accuracy also need to be addressed in ADHD research, so that conceptual frameworks and measurement practices more accurately reflect lived experience, avoid pathologising differences, and support the development of research that is both scientifically rigorous and socially responsible. Inclusion of individuals with ADHD across all phases of the research process is crucial for this to occur.

Participatory Research and Language Evolution

Participatory research approaches are essential in the evolution of neurodiversity-affirming language as they centre the voices of individuals who have been marginalised by conventional medical models. Incorporating community members as collaborative partners who share power in the research process underpins participatory research philosophies (Fletcher-Watson et al., 2021). Such approaches are pivotal in facilitating the development of terminology that accurately reflects ADHDers' lived experiences, thereby superseding an exclusively deficit-based clinical interpretation and supporting epistemic justice. An illustrative example can be drawn from autism research: researchers have hypothesised that autism is characterised by a universal deficit in – or even absence of – theory of mind (Gernsbacher & Yergeau, 2019). If researchers accept this deficit framing as fact, then by definition, autistic people lack the cognitive capacity to understand or critique the very theory used to describe them, effectively excluding their voices

from scientific discourse about their own experiences (LaCroix, 2023). This circular logic becomes scientifically and socially harmful, systematically silencing community perspectives despite clear evidence demonstrating theory of mind abilities in autistic people (Gernsbacher & Yergeau, 2019). In other words, deficit-focused language shapes scientific models in potentially misleading ways by excluding the lived experiences of the people being studied. Transforming vocabulary and scientific representations requires elevating the place of lived-experience expertise, making participatory research a vehicle for encouraging more holistic views on neurodivergence and improving the knowledge generation process (Sonuga-Barke et al., 2024).

Participatory approaches may also improve narratives about marginalised communities in meaningful ways by shifting the tone and substance of ideas being communicated. For example, autism researchers who do more to include autistic people in their work have been found to answer questions about autism and autism research in a less ableist manner – that is, with less dehumanisation, objectification, or stigmatisation of autistic people (Botha & Cage, 2022). Moreover, a mixed-methods evaluation of a co-designed mental health education resource for healthcare students and professionals indicated that including lived-experience storytelling encouraged learning *with* people who had lived experience rather than *about* them, and led to substantial changes in learners' attitudes and perceptions (Parnell et al., 2023). Similarly, autism training for university students was more effective when developed in collaboration with autistic university students compared to training developed using a non-participatory approach (Gillespie-Lynch et al., 2022). These examples illustrate how centring lived experience perspectives can meaningfully change the content and focus of communication, and its impact on audiences.

Challenges and Future Steps

There are significant challenges in adopting new language around ADHD. The dominant, deficit-based language that pathologises ADHD is necessary for a diagnosis, and a diagnosis is often necessary to receive support. This maintains the status quo, as even clinicians and individuals with ADHD who reject (or do not prefer) such language feel compelled to use it. Given that the diagnostic definition of ADHD is often framed as an objective description of reality (Chapman, 2023; Gagné-Julien, 2021), discussion of alternatives is restricted. Illustrating this, researchers who use terminology that differs from accepted medical definitions of ADHD can encounter resistance during peer review, as journal and editorial norms often privilege established language. Similarly, the culture in some ADHD research groups may be such that dominant narratives are perpetuated by leadership or suggestions to improve language are dismissed as unnecessary. Change at institutional levels is therefore essential to enable the transformation of language in alignment with lived experience preferences. The discourse around person-first and

identity-first language has shown that this is possible by prompting changes to influential writing style guides, shifting from blanket recommendations to flexible guidelines that recognise diverse preferences across and within communities (Gernsbacher, 2017; Sage Publishing, n.d.).

Another challenge in language reform is the value placed on lived-experience expertise in ADHD research. While the adoption of participatory research is increasing in fields such as autism and intellectual disability, there remain very few examples of participatory ADHD research (Le Cunff et al., 2023; Sonuga-Barke et al., 2024). Valuing, respecting, and centring the voices of ADHDers, and sharing power with them in the knowledge-generation process is essential for reframing ADHD narratives in ways that support and accurately represent their experiences. Continued exclusion of ADHD voices in research processes not only contributes to their ongoing marginalisation, but it also narrows research potential and impedes scientific development. To this end, funding bodies should recognise the need for participatory research practices and account for this in budgeting.

We acknowledge a tension in our argument: we identify how institutional power informs the language choices of individuals, yet we propose that individual researchers and clinicians adopt different terminology. We see this tension as a reflection of the complex reality of structural change. Such changes require systemic shifts, but this is not possible without individual actions. With this in mind, we suggest a pragmatic approach that is responsive to different potential constraints and opportunities. We encourage researchers to adopt inclusive language when they have autonomy, acknowledging that this may prove challenging in certain contexts (e.g., when facing institutional or funder requirements, or when working with mentors or co-authors who disagree, etc.). When feasible, researchers can engage with journal editors and funding bodies about the rationale for language evolution, citing evidence for the benefits of inclusive terminology, such as the arguments we have presented here. We also encourage clinicians, educators, and other professionals working in the ADHD field to adopt inclusive language and proactively seek guidance from individuals with ADHD about their personal preferences. Furthermore, we remind readers that coordinated efforts across research teams or professional organisations empower individual choices. Seek opportunities to educate others in your circle of influence and, if needed, advocate for updated clinical, education, and academic policies on inclusive neurodiversity-informed language.

Conclusion

Language has the power to shape how ADHD is understood and, by extension, how people with ADHD are treated by society. Deficit-based, medicalised terminology has become essential for ADHDers to receive the support they need, but it simultaneously contributes to stigma and

negatively impacts self-understanding of ADHD experiences. The neurodiversity paradigm offers a path to relieve this tension by conceptualising ADHD as simply part of human neurocognitive variation, without undermining the fact that ADHDers face real challenges navigating a world that is not designed for them. Using a neurodiversity framing may help reconceptualise ADHD in a more affirming way and also enhance accuracy by more comprehensively capturing the lived experiences of people with ADHD. Concerted efforts to change the way ADHD is spoken about – by individual professionals and at institutional levels – are key to language reform. Most importantly, these efforts should be informed by listening to those in the ADHD community and learning from them through participatory research.

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EF: Conceptualisation, Project administration, Writing - original draft, Writing - review & editing; LS: Writing - original draft, Writing - review & editing; LB: Writing - original draft, Writing - review & editing; AK: Conceptualisation, Writing - original draft, Writing - review & editing; AM: Conceptualisation, Writing - original draft, Writing - review & editing; AVR: Writing - review & editing; PD: Writing - original draft, Writing - review & editing; MZ: Conceptualisation, Writing - original draft, Writing - review & editing.

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