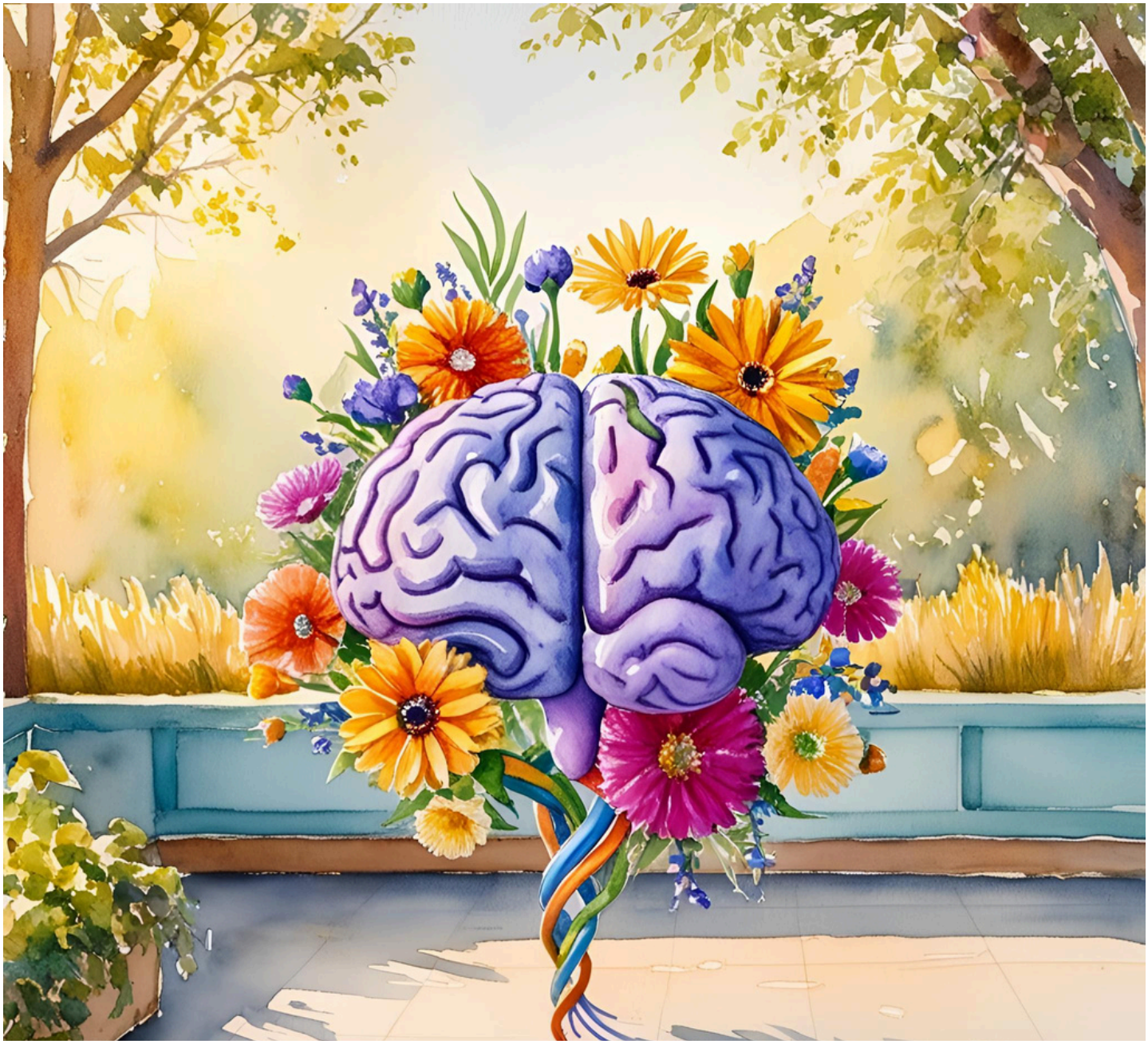
SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience



SPRING-SUMMER 2025| ISSUE 4

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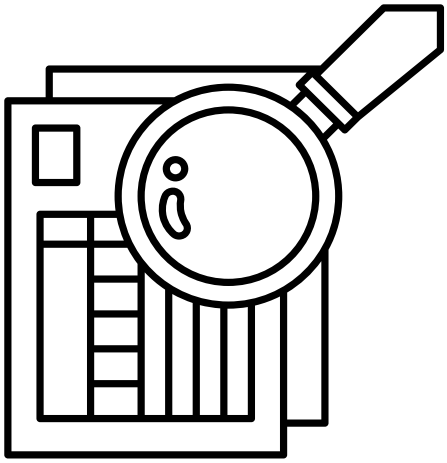

IN THIS ISSUE

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SPRING-SUMMER 2025 | ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

EDITOR'S WELCOME

FOURTH ISSUE !

by Sana Fatima

Welcome to Our Fourth Issue!

I can hardly believe it's been over a year since we first launched this newsletter. As a self proclaimed 'small-win enthusiast' reaching this milestone fills me with great pleasure and humility, and a huge, mounting sense of responsibility. I have to admit that carving out a tiny space for this publication in the broader literary world of medicine, mental health and neurodevelopmental psychiatry continues to be a journey mixed with challenges and growth, learning and reflection, and indeed joy and gratification.

Working on this newsletter has been a deeply enriching experience-one that has not only expanded my own understanding in a range of areas, neurodevelopmental psychiatry and beyond, and has challenged me to see these through new lenses.

From the very beginning, one of our key missions has been to bring important conversations about neurodevelopmental psychiatry to the forefront, to explore the complexities, the nuances, the evolving narratives and shifting viewpoints, that shape this field. At its heart, this newsletter has always been about fostering dialogue, exchanging ideas, and celebrating the richness of diverse identities, ideas, perspectives, presentations and experiences.

This special issue, **"Beyond Labels: Identity, Diagnosis, and Lived Experience,**" dives deep into the intricate interplay between clinical diagnosis and personal identity. This issue also has a focus on trainees and their journeys navigating neurodivergence and post graduate training. Themes which will resonate with many of our readers. Keeping with the spirit of creativity, diversity and inclusivity, we have expanded our scope to include art, literature and poetry, recognising that expression takes many forms. I hope these additions stimulate discussions and provide new avenues and perspectives to our understanding of neurodevelopmental psychiatry.

We begin with a thought-provoking piece by RCPsych's autism champion Conor Davidson**, *What's the Harm in a Diagnosis?***—a critical exploration of diagnostic labels and their double-edged impact, offering clarity while also raising essential questions in this ever-evolving conversation.

In this deeply reflective piece, ***Neurodiversity: Reflections of a Medical Director***, David Sims draws upon his experiences as a Child and Adolescent Psychiatrist and Medical Director to explore the evolving narrative of neurodiversity within medical education. With insight and nuance, he traces how perspectives have shifted over the years, offering a compelling meditation on inclusion, understanding, and progress in the field.

Bhathika Perera shares insights from a research project that examines the unique ***struggles and strengths of Doctors with Mental Health Difficulties and ADHD*,** shedding light on neurodiversity within the medical profession.

Dheeraj Chaudhary shifts the focus to another, often-overlooked demographic as he shares his work on ***ADHD in Older Adults***, addressing the increasing recognition of late-life diagnoses and their far-reaching implications.

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SPRING-SUMMER 2025 | ISSUE 4

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Helen Spencer shares a deeply poignant piece, ***Psychiatry—The Worst Specialty for a Dyslexic Doctor?,*** reflecting on her journey from school to medical training and into Psychiatry—an article that will undoubtedly resonate with many, especially talking about the lesser-talked-about neurodevelopmental condition i.e Dyslexia.

In our Expressions in Verse section, Shevonne Matheiken shares ***Trainee in Difficulty,*** a moving reflection on the challenges faced by neurodivergent trainees in medicine.

For those drawn to the intersection of psychiatry and creativity, our Perspectives in Palette showcases ***Where is My Mind,*** a striking piece of art by Dr. Virna Teixeira, offering a unique artistic insight on the lived experience of neurodivergence.

In Frames of Mind, Dr. Deepak Moyal presents ***ADHD History,*** a fascinating retrospective on how our understanding of ADHD has evolved over time. A topic that continues to be both facinating and thought-provoking.

Our **Media Spotlight** section offers a curated selection of podcasts and talk shows featuring discussions with Neurodevelopmental Psychiatry and subject matter experts, providing an engaging way to stay connected with the latest in neurodevelopmental psychiatry beyond the written page. In the section '**between the lines'** we talk about books that have touched us, this time I speak about 3 books I have recently read, and share what I took home. Lastly, find a brief reflection on our cover image in our section **Visual Expressions**.

I hope this issue sparks discussion, fosters new insights, and encourages reflection on the intricate relationship between diagnosis, identity, lived experiences and beyond.As always, I welcome your thoughts, contributions, and feedback - I am learning everyday and your feedback is a huge part of this learning !

Dr. Sana Fatima is a Consultant Psychiatrist in the Early Intervention Psychiatry. She has a keen interest in Neurodevelopmental Psychiatry and Health Education. She also often finds herself at the intersection of diversity—a perspective that has fueled her fascination and passion for neurodiversity and diversity in all its forms.
In 2021, she led a regional project in Yorkshire and Humber, developing a professional support and well-being program for resident doctors and dentists . She also played a key role in a national project on *neurodiversity in medical education*, leading the faculty development stream. Through this work, she advocated for a greater understanding of neurodiversity in resident doctors/dentists and highlighted the urgent need for environmental and attitudinal reforms within medical education.
Committed to promoting inclusivity in mental health, medicine and medical education, Dr. Fatima strives to create spaces where diverse experiences and perspectives are not only recognised but deeply valued.

SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

THE AUTISM CHAMPION BLOG

WHAT'S THE HARM IN A DIAGNOSIS?

By Conor Davidson

I've spent pretty much my whole career trying to persuade colleagues in general adult psychiatry to take autism seriously. So the idea that autism could be over-diagnosed causes me some cognitive dissonance to say the least. Yet the question of possible overdiagnosis has become impossible to ignore as the demand for autism assessment continues to steadily increase. This week there was another flurry of newspaper articles on the subject, prompted by the release of Suzanne O'Sullivan's new book, The Age of Diagnosis: sickness, health and why medicine has gone too far. In it, O'Sullivan argues that everyday variation in human experience is being over-medicalised and inappropriately given diagnostic labels like autism and ADHD.

Over the last few years, I've spoken about this to many colleagues who work in the field. They hold a range of views, all sincerely held in good faith. Many argue that the rise in diagnosis is unequivocally a good thing, correcting past decades of widespread under-diagnosis (and indeed, misdiagnosis). Some, however, express concern over the direction of travel: are we heading the same way as the USA, where 1 in 36 children now have an autism diagnosis? There is no question that autism diagnosis is on the increase. There was an exponential 787% rise in recorded autism diagnoses in the UK between 1998 and 2018. The latest (still unpublished) NHS England data shows 5.9% of boys and over 2% of girls aged between 10-13 years old have autism. This is much higher that the oft-quoted national prevalence figure of 1.1%.Of course, autism prevalence is much more complicated than these headline figures suggest.

Autism is massively under-recognised in older people. In psychiatric settings it is commonly missed, perhaps due to overshadowing by co-occurring mental illness. And there is widespread consensus within the clinical community that historically we have tended to under-diagnose autism in girls and women.

Even if O'Sullivan is right, and 'milder' forms of human social difficulty are now given the label of autism, is this necessarily a bad thing? I thought about this recently when, in the adult autism clinic where I work, we were considering whether a patient met the diagnostic criteria. It was a scenario no doubt familiar to many of you: the patient described a number of autistic traits, but the developmental history was not particularly suggestive and the ADOS score was in the 'autism spectrum' range. The MDT were debating whether all the DSM-5 criteria were met, and to what extent 'masking' was a factor explaining the lower-than-expected ADOS score. My registrar was there, in her first week in post, and asked us: 'what's the harm in just giving a diagnosis?'.

It was a great question. The patient, like many we see in clinic, was already invested in an autistic identity and saw it as an explanation for their struggles with social anxiety and workplace difficulties. When diagnosed with autism, most people are relieved and grateful. At follow-up they usually describe a psychological benefit in terms of self-understanding and self-acceptance. A diagnosis can unlock reasonable adjustments in the workplace. It allows access to autism-specific charities and support groups. It also provides a sense of identity and connection to the wider autistic community. On the other hand, if a diagnosis of autism is not made, it's not unusual nowadays for patients to be upset, challenge the decision and even to make formal complaints.

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THE AUTISM CHAMPION BLOG

WHAT'S THE HARM IN A DIAGNOSIS?

By Conor Davidson

It would be surprising if these factors did not exert an unconscious pressure on clinicians, when faced with ambiguous cases, to err towards making a diagnosis. However, I think it is important for us as a clinical community to also reflect honestly on the potential downsides of an autism diagnosis. There is not much research evidence to guide us in this. Qualitative studies suggest that for some people the emotional and psychological impact of a diagnosis can be negative, at least in the early stages, triggering feelings of confusion, shock or regret.Disclosure of diagnosis can be tricky to navigate – some people report being disbelieved by family members or not taken seriously by employers. There can also be implications for insurance, travel visas to certain countries, and career options (for example, joining the military). As a psychiatrist, a particular concern for me is whether a diagnosis can, in some cases, actually lead to worse rather than improved functional and mental health outcomes.

O'Sullivan reports that in interviews with people diagnosed with autism and ADHD, she noticed: 'all perceived their lives to be better off thanks to a diagnosis. Every person welcomed the diagnosis into their lives. But almost all had left their job, dropped out of education and lost many old friends. Several were housebound…I saw a worrying gap between the perceived benefit of being diagnosed and any actual improvements in quality of life.' Leaving aside the fact that this is anecdotal rather than research evidence, an alternative interpretation could be that these people had adjusted their lifestyle to better fit their neurodivergent identity, and to take them at their word that their quality of life is better. That said, given what we know about the long-term mental health impacts of unemployment and social isolation, it would be concerning if autism diagnosis was associated with such outcomes. It is at least theoretically possible that an autism diagnosis may lead to greater avoidance of social activities and thus worsen levels of social anxiety in the long run.
My own clinical experience is that the sort of negative functional outcomes that O'Sullivan describes are rare. However, I don't think we can simply dismiss concerns like these. Our clinical practice must be guided by evidence. Further research is required to systematically investigate the medium and long-term impact of autism diagnosis on quality of life.

Ultimately, the question of whether autism is being overdiagnosed—and the potential harms or benefits—is complex and nuanced. While diagnosis can offer validation, support, and access to resources, it is crucial that we remain mindful of possible unintended consequences. A well-intentioned diagnosis should empower individuals, not inadvertently limit their opportunities. As clinicians, researchers, and advocates, our responsibility is to ensure that diagnostic practices are rooted in robust evidence, ethical integrity, and a genuine commitment to improving lives. This is why ongoing research is essential—so that we can better understand the real-world impact of diagnosis and continue to refine our approach in the best interests of those we seek to help.

Dr Conor Davidson is a consultant psychiatrist in general adult psychiatry, and clinical lead of the Leeds Autism Diagnostic Service. He was appointed Autism Champion for the Royal College of Psychiatrists in May 2021. The focus of this work is on improving autism awareness and autism training for psychiatrists. He chairs the College cross-faculty autism group and sits on the NHS England national autism strategy steering group

SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

REFLECTIONS & HORIZONS

NEURODIVERSITY: REFLECTIONS OF A MEDICAL DIRECTOR

By Dr. David Sims

I trained in child and adolescent psychiatry at the time when the diagnosis of ADHD and Autism was being embedded in practice. I had the privilege of receiving training in the diagnostic instrument from Lorna Wing and one of my first roles as consultant was in developing assessment clinics. This also set me on a track for developing as a medical manager and clinical leader.

As we developed services in Child and Adolescent Mental Health we were supported by young people and their parents and carers. I was involved in the development of the Cygnet programme which supports parents and carers develop an understanding of the autistic spectrum. This work helped me focus on the lived experience in families of neurodiversity and to put that experience at the core of my practice. I have taken that in to everything in my medical leadership roles.

Over the last few years as medical director I have had a patient mentor who has autism. He helps keep me focused on the needs of our population and the way the health care we offer has to be adapted to support all those we work with. I have been part of our local staff network for disability and hear the ways in which our staff teams also find it difficult at times to bring their best selves to work as we can make their neurodiversity a problem.

Some of the more encouraging developments have been to see all psychiatrists adding understanding especially ADHD and autism to their PDPs. It is no longer seen just as an area for CAMHS and that somehow adults have grown out of it. I think this means we can have conversations about what this means for services. And how we can improve the experience of all.

We recognise that we see more people in our inpatient services with neurodiversity and that they stay longer than they should. We have a responsibility in mental health to support the recognition of comorbidity and complexity in the presentations of the people with whom we work both in community and more acute services so that we can bring better outcomes including reducing time in hospital. In addition we can support our colleagues in employment and housing to see better futures for all.

As I look forward I hope that we all continue to learn from those with neurodiversity. Their stories of how we have not met their expectations and their leading in our service design will be key. As my patient mentor keeps reminding me I have achieved only a little but together there is more to get sorted. It’s his story and those of the individuals and families with whom I work that keep us all pushing towards improvements. It’s really good to see lived experience at the heart of Oliver McGowan training so that in the next generation they will look back to those individuals as well as to Lorna Wing and others who spoke on their behalf in the past.

Dr. David Sims is a child and adolescent psychiatrist and for the last 6 years medical director in Bradford District Care NHS Foundation trust. He trained in autism assessments nearly 30 years ago and was part of the earliest assessments for autism, ADHD and tic disorders amongst others in Bradford. He continues to do clinical work currently in a local school for communication and interaction.

CONNECTING THE DOTS

DOCTORS WITH MENTAL HEALTH DIFFICULTIES AND ADHD

By Bhathika Perera

A study was carried out to explore relationship between ADHD and mental health difficulties among doctors. Electronic records from 2877 doctors seeking mental health care through the National Health Service Practitioner Health service were analysed using demographic data, psychopathology scales for depression, anxiety, psychological well-being and ADHD Self-Report Scale (ASRS). Analyses were conducted to explore associations between ADHD screening, demographic variables and co-existing mental health disorders.

Research findings:
1.Out of 2877 doctors accessing NHS Practitioner Health with mental health problems, 35% screened positive for ADHD.
2.ADHD screening positivity reduced with age, with the highest rates in 20-29 year olds.
3.No difference in screening rates was found between ethnic groups.
4.38% of male doctors screened positive for ADHD compared to 33% of female doctors.
5.Those who screened positive for ADHD exhibited high levels of inattention-related symptoms.
6.45% of those who screened positive for ADHD also had high levels of anxiety, depression and low psychological well-being.

Key points:
1.Mental health problems in the NHS workforce are increasing, leading to higher sickness absence rates and impacting patient care.
2.Identifying the factors contributing to poor mental health in staff is crucial for developing effective strategies to improve workforce well-being and retention.
3.While the impact of ADHD is well understood in the general population, its interaction with mental health challenges among doctors has not been previously studied
4.This study showed that over one in three doctors with mental health difficulties screened positive for ADHD.
5.High rates of low mood, anxiety and reduced overall psychological well-being were observed in doctors screening positive for ADHD.
6.Existing research already demonstrates symptom overlap between depressive disorders, anxiety disorders and ADHD which can lead to diagnostic challenges.
7.Existing support systems for healthcare staff do not clearly and consistently provide pathways for assessing ADHD or offering necessary workplace adjustments.
8.Therefore, it can be challenging for employers to understand how to best support employees with such difficulties, while those affected may struggle to articulate their needs and access appropriate workplace adjustments and support.

Link to the full paper : https://doi.org/10.1093/occmed/kqae139

Bhathika Perera PhD, FRCPsych, MBBS, MMedSci, MSt, PGDip
Dr Bhathika Perera is a psychiatrist specialising in intellectual disability and neurodevelopmental disorders. He is an Associate Professor at University College London and an Honorary Consultant Psychiatrist at North East London NHS Foundation Trust.

SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

IN FOCUS

ADHD IN OLDER ADULTS

By Dheeraj Chaudhary

Attention Deficit Hyperactivity Disorder (ADHD) is often perceived as only a childhood condition, yet it persists into adulthood, significantly impacting daily functioning and overall health. The prevalence of ADHD in children is approximately 5%, with up to two-thirds of cases continuing into adulthood. Among adults, prevalence estimates range from 4–7%, depending on study methodology and population demographics.

O'Nions et al. (2025) found that adults with diagnosed ADHD experience a notable reduction in life expectancy compared to the general population—6.78 years for males and 8.64 years for females. This highlights ADHD as a critical public health concern, given its role as an independent risk factor for multiple physical and mental health disorders.
As life expectancy increases and the global population ages, ADHD in older adults is likely to emerge as a significant yet overlooked public health issue. Identifying and addressing ADHD in this demographic is essential to improving their quality of life and overall health outcomes.

Dobrosavljevic et al. (2020) conducted a meta-analysis including over 20 million participants, revealing an ADHD prevalence of 2.18% among individuals aged 65 and older when assessed using community-based screening tools. However, this rate dropped drastically to 0.23% when based on clinical diagnoses documented in medical records, indicating a substantial underdiagnosis of ADHD in older adults.
Challenges in Diagnosis

The symptoms of ADHD in older adults such as inattention, memory difficulties and executive dysfunction are often misattributed to normal aging or early-stage dementia. This misclassification can lead to a failure to provide appropriate and effective treatment. When cognitive deficits are automatically ascribed to age-related decline or mild cognitive impairment (MCI), individuals with ADHD may be denied interventions that could significantly improve their quality of life.

Compounding this issue, older adults frequently present with multiple comorbid mental or physical health conditions, further complicating the identification of ADHD symptoms. The longstanding perception of ADHD as a childhood disorder contributes to a lack of awareness regarding its persistence into later life.
Goodman et al. (2024) highlighted key barriers to recognition and treatment in older adults, including clinical blindness, clinical prejudice, clinical inexperience, and clinical complexity.

While the core symptoms of ADHD remain consistent across the lifespan, their manifestation and intensity may differ in older adults. Difficulties with relationships, increased social isolation, and the cumulative impact of lifelong executive dysfunction often become more pronounced with age.
Despite the growing recognition of ADHD in adulthood, specific training on ADHD remains insufficiently integrated into higher training programmes for Old Age Psychiatry. Additionally, there is a notable lack of refined assessment tools designed specifically for diagnosing ADHD in older adults, further contributing to its underdiagnosis and undertreatment.

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Dr Dheeraj Chaudhary is a Consultant Forensic Psychiatrist working for Priory Healthcare. He has a longstanding interest in Neurodevelopmental disorders. He runs a private Neurodevelopmental Psychiatry clinic. He is dedicated to raising awareness about Neurodevelopmental disorders among the general public and health professionals. He achieves this through presentations, talks, and leveraging social media as a platform to reach wider audiences.

SPRING-SUMMER 2025| ISSUE 4
NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER
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By Dr. Dheeraj Chaudhary

Challenges in Treatment

Treatment rates remain disproportionately low. Research (Dobrosavljevic 2020) indicates that only 0.09% of older adults receive ADHD treatment, with fewer than 40% of those clinically diagnosed ultimately accessing appropriate pharmacological interventions. This discrepancy can be attributed to treatment hesitancy, systemic biases against elderly patients, and a general reluctance to initiate stimulant therapy in later life.

Pharmacological research on ADHD in individuals over 60 remains limited, but available evidence—alongside clinical experience—suggests that older adults respond to treatment with similar efficacy and adverse effect profiles as younger populations.

Concerns regarding the prescription of stimulant medications in older adults are often rooted in clinical bias rather than empirical evidence. A study by Ermer et al. (2013) assessed the safety of lisdexamfetamine in adults aged 55–84 and found no significant trends in pulse or blood pressure variations associated with age, reinforcing the need to challenge unfounded reservations about stimulant use in this demographic.

Conclusion

ADHD must be recognised as a lifespan disorder that extends well beyond childhood and adolescence. Despite increasing awareness of adult ADHD, its presence in older adults remains significantly underdiagnosed and undertreated. The growing body of research highlights its impact on physical health, mental well-being, and overall quality of life.

Misattributing ADHD symptoms to normal aging or cognitive decline denies individuals access to appropriate treatment, contributing to poorer health outcomes and reduced life expectancy.

Addressing these gaps requires a concerted effort in research, psychiatric training, policy development and service provision. By integrating ADHD into the broader framework of psychogeriatrics, we can ensure that older adults receive the recognition, diagnosis, and support they need.

ADHD in older age is not just an emerging clinical challenge—it is a public health priority that demands immediate attention.

Recommendation

ADHD in older adults remains an underexplored area, presenting significant opportunities for much-needed research, guideline development, policy refinement, and service enhancement.

-Urge further recognition and training of ADHD in older adults.
-Develop age-appropriate diagnostic criteria and refined assessment tools.
-Increase awareness among old age psychiatrists to reduce misdiagnosis and underdiagnosis.
-Conduct long-term studies on the safety and efficacy of ADHD medications in older populations.
-Establish services and guidelines for the assessment and treatment of ADHD in older adults.

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SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

BEYOND THE SURFACE - STORIES, EXPERIENCES AND LIVED PRESPECTIEVES

PSYCHIATRY – THE WORST SPECIALTY FOR A DYSLEXIC DOCTOR?

By Helen Spencer

Although I find it very amusing, it is also very frustrating that I struggle to spell the name of the speciality I have chosen - why so many random consonants smashed together in no logical order?! But perhaps I chose it because I haven't always been dyslexic, I was only diagnosed when I was 37. Although I know that this is not technically true, and that I have always been dyslexic, it did feel like everything changed once I knew. Lots of things became clearer and easier, but there was also a psychological struggle and battle with stigma that I hadn't anticipated. I think most people would still see dyslexia as a negative thing that, given the choice, they would prefer not to have. It is seen as a weakness; it is classed as a 'learning disability' and carries strong associations with lower than average intelligence. It is not surprising, therefore, that if you consistently do well academically then it's harder to spot or even believe that it is present.

Throughout my early years I met all my developmental milestones; my verbal language skills were excellent, and my written skills were above average. I was consistently at the top of the class in primary school and when I went to secondary school was in the top set for all subjects. In hindsight, I suppose this was when I started to feel different to everyone else, but I had no frame of reference and certainly dyslexia in those days was something you couldn't even be assessed for unless you weren't in the bottom set. So, I trudged through secondary school doing well, but never as well as predicted. When I was predicted an A* I'd get an A, when I thought I'd be top of the class, I was 5th. And getting an A instead of and A* is not something you want to complain about! My reports always said the same thing 'Helen is exceptionally bright, but she needs to apply herself more.' I was called 'lazy', 'messy', 'disorganised', 'a daydreamer'.

In reality, I was working twice as hard and for longer than everyone else to achieve the same goal. Unsurprisingly, in subjects like music and drama, where the majority of the assessment was practical, I excelled. Science and maths were also strong subjects because I didn't have write long sentences in order to demonstrate my understanding. I went on work experience in a psychiatric hospital when I was 16 and instantly knew it was what I wanted to do. Everything about it fascinated me and I became passionate about understanding mental health and making a difference to those who struggle with it. Unfortunately, by this point I had completely lost confidence in my academic ability and felt I wasn't 'clever' enough to go to medical school.

I went to university and studied drama but kept my interest in medicine by working in a local GP practice as an HCA and receptionist. After completing my degree (and getting a 2:1 instead of my predicted 1st) I set up and ran a successful international theatre company. Although I was loving my work in drama, psychiatry was still calling me, and I decided to apply for a pre-med course. I was convinced I would fail it and then I could say, 'well, I've tried, but I couldn't do it'. To my surprise I got a distinction in pre-med and earned a scholarship into Manchester University to study Medicine. Every year of my medical training I thought 'this is the year that I will fail, and they will kick me out for being a fraud'. I know that imposter syndrome is common for all medics, but when you have dyslexia its on a whole other level!

In medical school there were more clues that I was dyslexic, but the penny never dropped – I was always the top of the year for OSCEs and bottom of the year in my written papers. I excelled on placements but sat shaking with fear at the back of lecture halls. I scraped through my finals and then had no problems during foundation years. My feedback was always excellent – diligent, hardworking, organised, excellent practical and communication skills.

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SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

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PSYCHIATRY – THE WORST SPECIALTY FOR A DYSLEXIC DOCTOR?

By Helen Spencer

Finally, I was starting to feel competent! I got into psychiatry training and my dream was finally coming true. Cue RCPsych exams. I think to my peers I was seen as very capable and when we all set off to take Paper A there was no doubt in people's minds that I would pass. But I didn't pass, I failed by some margin. The shock and disbelief on other people's faces was so embarrassing to witness. It was always followed by people trying to explain it away, 'you've been so busy', 'you've got young kids', 'you'll smash it next time' etc. But I didn't smash it next time, I failed it again. I failed paper A three times and Paper B twice. I watched as my peers finished core training and I had multiple extensions to training. I was sat in the doctor's office one afternoon talking to an FY2 about having failed another attempt. She nonchalantly asked if I have ever had a reading test and said that she had been diagnosed with dyslexia in medical school when she was struggling to finish the exams in time. Long story short, that simple questions changed my life. I was tested, diagnosed, given extra time and adjustments for my exams and passed them all first time.

It was at this point that my real journey with dyslexia began. So many things about my life to this point started to make sense. I think the most profound thing I learnt, was that dyslexia are not just about reading and writing. Dyslexia effects your perception of the world, the way your problem solve, your concentration, your sensory processing, and so much more. I suddenly knew why I can't make a decision in supermarkets, but I'm very decisive in an emergency. Dyslexic thinking is completely different to those without it and although it has some challenges it also comes with enormous strengths. At first, I felt ashamed to tell people I was dyslexic, perhaps they would think I wasn't a safe doctor? But I decided that it was important to understand what it meant and then to help other people to understand not only me, but what dyslexia is for others as well.

I started looking into dyslexia and found a whole world of people who are so incredibly successful, pioneering and at the top of their fields. It was so inspirational to see and feel a part of a community of innovators and creatives. Although sad, that every single one of them had a story like mine, of feeling misunderstood, not good enough and tired of working twice as hard in an education system and working environment that is designed for non-dyslexics. As with theories around ADHD, it is felt that the incidence of dyslexia in the general population has not changed over time because we play an important role in a functional society. We need people who are strong communicators, who explore and innovate, who make connections between things and use reasoning to solve problems. This is the power of dyslexic thinking, and this is what makes me a good psychiatrist and an effective medical educator.

80% of dyslexics leave school unidentified and most of them will be high achievers who have spent years learning how to cope and compensate. It's not a surprise that I was drawn to a specialty that allows me to use my dyslexic thinking to the full. But it has been a battle to get here and to get the support I needed from both the educational and working systems I have been a part of. We need to widen our understanding of the strengths that dyslexics bring because if we only focus on the weaknesses we will never benefit from their unique gifts.
I am proud to tell people I am dyslexic and very grateful for all the strengths is has given me – it may not have always been easy, but I wouldn't change it for the world. I am now determined to make that journey easier for other people by raising awareness and talking about my own experience with pride.

To learn more about dyslexia and dyslexic thinking visit www.madebydyslexia.org.

Dr Helen Spencer is a Consultant in Old Age Psychiatry based in York. Although born and bred in Yorkshire, she completed both a Drama and Medical degree in Manchester, before returning to the Dales for her Psychiatry training. In 2017 she won an award for innovation in medical education for work developing communication and emotional intelligence training for doctors using applied drama techniques. She continues to balance her love of theatre and mental health and is often found on stage in York and Leeds. As a dyslexic educator she is a proud advocate for dyslexic thinking and stives to improve understanding around this and other forms of neurodiversity.

SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

EXPRESSIONS IN VERSE

TRAINEE IN DIFFICULTY"

By Shevonne Matheiken

This poem is about three fictional doctors who have ADHD, autism and AuDHD respectively. Based on real experiences of a community of neurodivergent medical students and doctors in the UK. This was recited by the author at the RCPsych Annual Medical Education conference 2024 as part of a talk on neurodiversity in the workplace.

He had multiple exam failures, despite being a competent doctor in practice.
Time management had always been difficult. Unable to progress to higher training, he was promptly given "the label".
A neurodiversity screening followed which opened the doors to answers.
Is there any medication to help? he asked.
Yes - excellent medication, but it is out of stock nationally.
Can I have reasonable adjustments in my exam? Yes - the Equality Act says so, but first a 5 year waiting list for formal assessment.

She never understood why life itself felt so overwhelming.
A high performing doctor who crashed with exhaustion on the weekends.
Occasional feedback about being "too blunt", "inflexible" and "unable to see others perspectives".
Complimented often for her "attention to detail" and diligence.
Often found sat alone in a dark quiet room when not working.

There was a constant battle inside their head. One side that enjoyed the routine and 1:1 work in anesthesiology.
The other chaotic side that got bored and understimulated easily.
This exhausting internal battle lit the flame of burnout.
When sleep deprivation of parenthood entered the picture, the plates started dropping, and the flame turned into a raging fire.

What is wrong with me?
The autism masked the ADHD, and vice versa The conclusion was - you're fine, here is a leaflet. But I'm not fine, can I have more support?
No, You're not causing anyone any trouble at work.
You've never failed exams.
You're not suicidal (yet)
You're NOT a trainee in difficulty.

Dr Shevonne Matheiken is an international medical graduate from India, currently ST6 in Old age psychiatry in East of England.She has a keen interest in neurodiversity, inclusive leadership, digital innovation, doctors wellbeing and reducing inequalities in health care.
She won 1st prize at an international competition at World Congress of Psychiatry in 2022, talking about co-production as the bridge between medical and social models of ADHD. Her paper titled 'Adult ADHD: time for a re-think' published in BJPsych Advances was awarded Editors Choice 2024 at RCPsych publication awards. She is working on a digital innovation addressing the adult ADHD crisis as part of Cohort 8 of the NHS Clinical Entrepreneur Programme.
She was also nominated and highlighted as 1 of the '25 women in psychiatry ' during a special campaign of the RCPsych women in mental health special-interest group during the pandemic. She was part of the first cohort of RCPsych Leadership and Management Fellowship Scheme. During her role as psychiatric trainees committee (PTC) vice-chair, she was the project lead for the RCPsych podcast series relating to doctors well-being called 'You are not alone'.
Shevonne was awarded the Japanese Society of psychiatry and neurology (JSPN) fellowship in 2020, and the World psychiatric Association fellowship (WPA) in 2022.

SPRING-SUMMER 2025| ISSUE 4

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Beyond Labels: Identity, Diagnosis, and Lived Experience

PERSPECTIVES IN PALETTE

WHERE IS MY MIND

By Dr. Virna Teixeira

"Where is my mind?" is a digital mixed media artwork combining collage and painting. I've used a sagittal midline of the brain as a frame to create functional creative depictions of its areas. I am a SAS doctor working in psychiatry but I trained and worked previously for years as a neurologist in Brazil, and I have MSc degree in Medical Humanities. I am currently a Junguian analyst in training in London. I am bringing this background because it might be interesting to explain some images I've used in the artwork.

Being a visual thinker, I've mixed images of a labyrinth in the parietal area due to its complex integration of sensory perception and spatial orientation; funky unconventional glasses in the occipital area (which contrast with bars in the ocular region), and fairy tales' imagery in the frontal lobe. Fairy tales are often used by Junguian analysts to understand unconscious processes and emotions. The limbic system is represented by Artemis, the goddess of hunt and wilderness.

The title of the artwork is a reference to Pixies' song 'Where is My Mind?', which evokes some dissociation between mind and body. I've had a late diagnosis of ADHD while working in a prison (followed by an autism diagnosis, which runs in my family), where I learned a lot about neurodevelopmental disorders. By the time I did this artwork I was reflecting on this tension between the potentially creative, unique way of seeing things but also the contention of the impulsivity for instance and other hindrances neurodivergent people face, creating a contrast with it. Hence the bars in the eyes, the distraught ventriloquist trying to express herself, the dress with a long zipper in the cervical area, the mask-like image covering part of the face.

An artwork can be open to many interpretations but my reflection here is how to amalgamate these separate contradictions. I enjoyed the aesthetic aspect while doing it, like a kind of meditation.

Virna Teixeira graduated in medicine in Brazil, where she trained and worked as a neurologist consultant. She moved to the UK ten years ago and now works as a SAS doctor in psychiatry. She is a poet, writer, translator and visual artist. Due to her creative interests, she did a MSc in Medical Humanities at King's College London. Virna has had collections of poetry published in South America, Portugal and the UK and wrote a book of short stories. She runs an indie Latin press, Carnaval Press (www.carnavalpress.com). As an artist, she works with printing techniques, digital art and mixed media.

SPRING-SUMMER 2025| ISSUE 4
NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER
Beyond Labels: Identity, Diagnosis, and Lived Experience

FRAMES OF MIND

ADHD: A BRIEF HISTORY

By Dr. Deepak Moyal

Although the frequency of the diagnosis of ADHD has certainly increased rapidly in the second half of the twentieth century, the discovery of ADHD is not recent. Excessively hyperactive, inattentive, and impulsive children have been described in the medical literature since the late nineteenth century. In the early years of the twentieth century, the syndrome was clearly described, along with its various cardinal manifestations, such as soft neurological signs, minor congenital anomalies, and inattentiveness, and labelled a 'defect in moral control (1).

According to the prevailing social Darwinian theory, moral control was the latest and greatest achievement of evolution, and, as a consequence, was considered particularly susceptible to loss as a result of various brain insults (2). Only persons with a genetic predisposition to ADHD were thought to develop the disorder. The adverse environmental and social circumstances that were characteristic of the situations of many affected persons were considered consequences rather than causes of the disorder.

According to Barkley (3), George Still (1) and Alfred Tredgold (4) were the first authors to focus scientific attention on the behavioural condition in children that most closely approximates what is today known as ADHD. In a series of three published lectures, in 1902 Still (1) described 43 children in his clinical practice who were often aggressive, defiant, resistant to discipline, excessively emotional, and who showed little inhibitory volition. Most were also quite overactive. Still believed these children displayed a major deficit in moral control in their behaviour that was relatively chronic in most cases. Much as today, a greater proportion of males than females existed in Still's cases (3:1) and their disorder appeared to arise in most cases before eight years of age and frequently in early childhood (two to six years of age). Still proposed a biological predisposition to this behavioural condition that was probably hereditary in some children, while the result of prenatal or postnatal injury in others.

Still hypothesised that the deficits in inhibitory volition, moral control, and sustained attention were causally related to each other, and to the same underlying neurological deficiency. He speculated on the possibility of either a decreased threshold for inhibition of responding to stimuli or a cortical disconnection syndrome where intellect was dissociated from will, which may be due to neuronal cell modification or brain damage.

Later Tredgold also subscribed to this theory of early, mild and undetected brain damage to account for the disorder (4). Temporary improvements in conduct might be achieved by alterations in the environment or by medications, both Still and Tredgold found, but they stressed the relative permanence of the defect even in these cases. The need for special educational environments for these children was strongly emphasised.

Some mention is also required of the Post Encephalitic syndrome described in early 20th century which manifested as a behavioural syndrome similar to current ADHD but felt out of repute soon after wards (5).

The nosological systems recognised ADHD not before the advent of DSM II as "Hyperkinetic Reaction of Childhood". The formal name of ADHD was eventually adopted by the DSM III R in 1987.

References
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2.Wright R. The moral animal: Why we are, the way we are: The new science of evolutionary psychology. Vintage; 2010 Nov 3.
3.Barkley RA. A theory of ADHD. Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment. 2006:297-334.
4.Tredgold, A. F. (1917). Moral imbecility. Practitioner, July, 43–56.
5.Eisenberg L. Commentary with a historical perspective by a child psychiatrist: when "ADHD" was the "brain-damaged child". Journal of child and adolescent psychopharmacology. 2007 Jun 1;17(3):279-83.

Dr. Deepak Moyal is a Higher Trainee in General Adult Psychiatry with a special interest in addictions and neurodevelopmental disorders. He has been in psychiatry for more than 14 years and is working closely with the College in various roles in addition to being a Trainee.

MEDIA SPOTLIGHT

NEURODEVELOPMENTAL PSYCHIATRY BEYOND THE WRITTEN WORD

BBC Radio 4 - Archive on 4, Trouble Staying Still: ADHD's Identity Crisis :
https://www.bbc.co.uk/programmes/m0028997

Presentation to Global ADHD Conference https://www.youtube.com/watch?v=cmXQ2OrBwW4**
**BBC Radio 5 Live interview responding to growing demand for ADHD services
https://t.co/KIbOTRq1bF (2hrs 47mins in)**

**Today Programme Interview responding to ADHD waiting list investigation
https://www.bbc.co.uk/sounds/play/m0021bcp (2hrs 37mins in)**

**Inflammation links neurodivergence to chronic fatigue in BMJ Open
https://bmjopen.bmj.com/content/14/7/e084203?rss=1**

**Royal Society paper A model linking emotional dysregulation in neurodivergent people to the proprioceptive impact of joint hypermobility
https://royalsocietypublishing.org/doi/10.1098/rstb.2023.0247**

Hypermobility and Long COVID paper https://bmjpublichealth.bmj.com/content/2/1/e000478

** Channel 4 ADHD documentary https://www.channel4.com/programmes/sam-thompson-is-this-adhd**

** Anna Richardson podcast https://itcantjustbeme.co.uk/episode/13-do-i-have-adhd-with-shaparak-khorsandi **

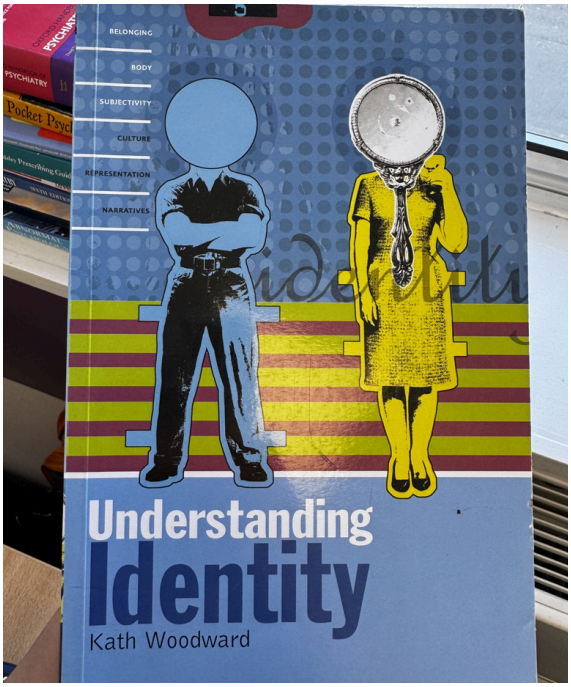
** BBC Radio 4 Inside Health Interview https://www.bbc.co.uk/sounds/play/m00199ym (10mins in) for videos and plain English summary see here https://bit.ly/3oiDQuT **

** Evidence session for the autism act parliamentary committee – Watch it on parliamentary TV here: https://committees.parliament.uk/event/23471/formal-meeting-oral-evidence-session/

BETWEEN THE LINES

SO FAR IN 2025: WHAT I'VE READ, LOVED, AND LEARNED FROM

by Sana Fatima



1. Understanding Identity - Kath Woodward

I've always been fascinated by the concept of identity and continuously look for ways to deepen my understanding of this intricate subject. This engaging read offered a broader and more nuanced perspective, helping me to see identity as a multidimensional construct shaped by a wide array of personal, social, and cultural influences.

What struck me most was the notion that identity is both internally experienced, and socially constructed. From a psychiatric and neurodevelopmental viewpoint, I inferred that Woodward's ideas closely echo the principles of the biopsychosocial model. Her focus on how identity develops through early life experiences, social interactions, and self-reflection provides valuable insights into how we can approach mental health more holistically in clinical settings.

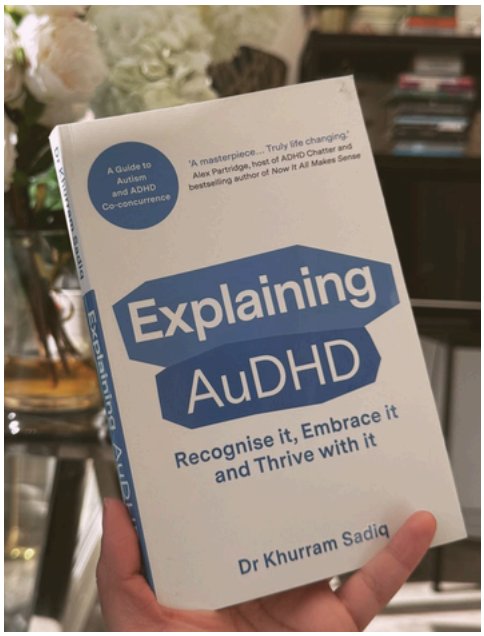
This pleasant read has deepened my appreciation for the need to consider the complexity of identity when assessing and supporting individuals in a mental health context.

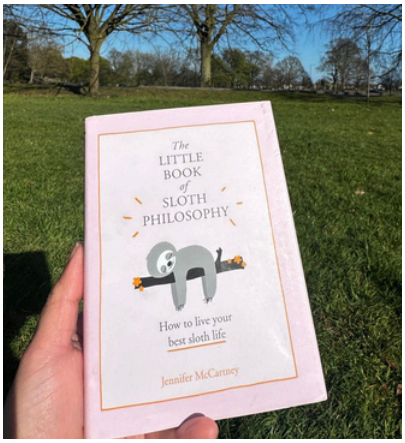
2. Explaining AuDHD - Dr. Khurram Sadiq

This thoughtfully written book offers a profound exploration of the complex overlap between Autism and ADHD, delivering a clinically informed yet deeply compassionate perspective on these co-occurring neurodevelopmental conditions. Among its many insights, it enhanced my understanding of the challenges inherent in dual diagnosis and shed light on the limitations of rigid diagnostic frameworks.

In clinical practice, it has reinforced the value of holistic assessments, contextual awareness, and the need to tailor care to reflect the nuanced and overlapping nature of neurodivergent experiences.

As an international medical graduate, I found Dr. Sadiq's personal and professional journey to be an especially meaningful aspect of the book. His story was both moving and empowering, offering a strong sense of connection, representation, and reassurance that deeply resonated with my own experiences of navigating a career in medicine, across diverse cultures and healthcare systems.





3. The Sloth Philosophy - Jennifer McCartney

Lastly, this light-hearted yet thought-provoking read served as a powerful reminder of the importance of rest, reflection, and resisting the constant pull of urgency. It offered a refreshing perspective amid the often fast-paced and high-pressure nature of healthcare. I've found myself increasingly advocating for a more mindful approach—embracing pacing, presence, and sustainable wellbeing not only for myself, but also for my colleagues and those I support.

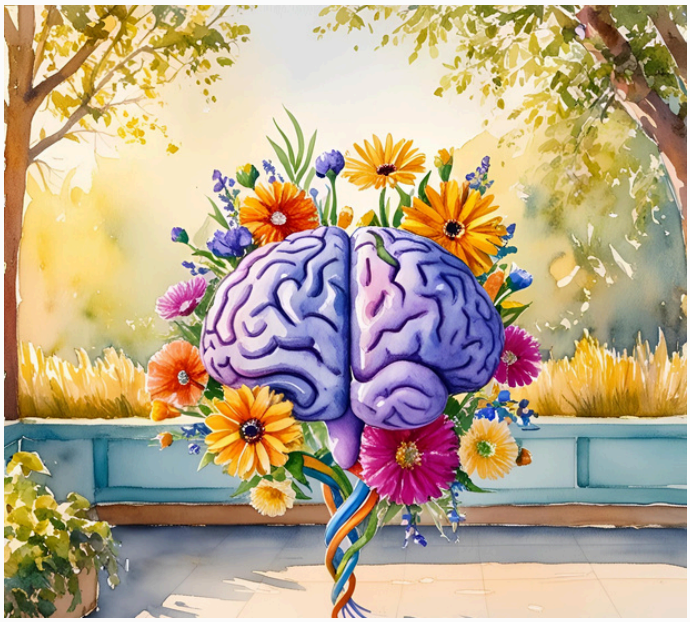
NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Neurodiversity Awareness Month

VISUAL EXPRESSIONS

ON THE IMAGE

by Sana Fatima



I developed this image (having a play with AI), and felt it subtly aligned with our theme "Beyond Labels: Identity, Diagnosis, and Lived Experience."

The brain in this depiction signifies the medical lens through which neurodevelopmental conditions are often viewed, including aspects like cognition, intellect, diagnosis, and biological frameworks. While, the flowers blossoming from it illustrate growth, individuality, and the rich personal experiences. And just as flowers take root and bloom uniquely, neurodevelopmental conditions manifest differently in each individual.

While no image can do justice to the complexity of this notion, I hope that this depiction resonates with our theme and the articles in this issue—whether exploring the impact of diagnosis (What's the Harm in a Diagnosis?), the intersection of professional identity and neurodivergence (Doctors with Mental Health Difficulties and ADHD), the challenges faced by older adults with ADHD, the importance of profound and poignant lived experiences - (the experiences of dyslexic doctors in psychiatry), or the evolution of our understanding of ADHD and shifting narratives in this realm.

More broadly, I hope this serves as a reminder that understanding neurodevelopmental conditions is rarely straightforward—it spans social considerations and medical manifestations, requiring a delicate balance between clinical frameworks, diagnostic criteria, evolving perspectives, research, anecdotal insights and lived experience (to name a few). While debates continue on which approach holds precedence, what remains crucial is recognising these multi-faceted, multi-dimentional prespectives in informing our approaches. And as ever, valuing the importance of critical thinking, shared learning, open discourse, and advocacy.

Lastly, I hope you enjoyed reading this edition.
We'd love to hear from you—please feel free to contribute, comment, suggest, or share feedback with us at:

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OUR CURRENT EXECUTIVE COMMITTEE COMPRISES:

Jessica Eccles – Chair
Peter Carpenter - Immediate past chair
Raja Mukherjee - Finance Officer - ID Faculty rep
Conor Davidson - Autism Champion
Ulrich Müller-Sedgwick - ADHD Champion
Sam Tromans - Academic secretary
Bhathika Perera - ID in ADHD CoP lead
Jenny Bryden - Chair of Autism CoP
Sana Fatima –Communications lead

National reps:
Premal Shah - Scottish rep
Helen Matthews - Wales (in transition, retiring)
Saleen Tareen - Northern Ireland rep
Marie Boilson – Scotland 2nd rep and Ireland links

Faculty reps:
Jenny Parker - CAP Rep
Tim Alnuamaani - GA rep
Ken Courtenay - Forensic rep
Quinton Deeley - Neuropsychiatry rep

Individual Coopted:
Marios Adamou - ADHD & Autism interests
Terry Brugha - Academic interest
Dheeraj Chadhary - private forensic Neurodiversity
Ashok Roy - DHSS and HEE link
Mike Smith - ADHD interest
Mark Lovell - child interest
Alison Lennox – Autism
Anna Sri – Autistic doctor with ADHD, member of WHSIG
Dietmar Hank - ADHD interest