Psychreg Journal of Psychology OPEN ACCESS

Volume 10, Issue 1, June 2026 ISSN 2515-138X | pjp.psychreg.org

THEORETICAL ARTICLE

Shared language, shared care: Rethinking learning disability terminology

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Cite as: Gott, A. (2026). Shared language, shared care: Rethinking learning disability terminology. *Psychreg Journal of Psychology*, *10*(1), 14 to 25. https://doi.org/rmhs

ABSTRACT

Effective care for people with learning disabilities depends on collaboration across psychiatry, psychology, speech and language therapy, education, and social care. Yet a shared professional vocabulary is often absent. Drawing on historical, sociological, and psychological perspectives, this article argues that inconsistent terminology fragments services and introduces clinical and ethical risks. When professionals working with the same individual use different language to describe the same behaviours, the consequences can be concrete: compromised assessment accuracy, weakened therapeutic engagement, diagnostic overshadowing, and unequal access to interventions. This article situates these concerns within a broader analysis of how language functions as a mechanism of power and professional identity in multidisciplinary settings. It then proposes practical strategies to address terminological fragmentation, including interprofessional education, co-produced glossaries, shared referral tools, and discourse-focused reflective practice. Greater linguistic consistency, the article concludes, can strengthen collaboration, reduce inequity, and promote more coherent, person-centred care for people with learning disabilities

Keywords: interprofessional collaboration; learning disabilities; psychological practice; shared language; terminology standardisation

Language has long shaped how people with learning disabilities are diagnosed, supported, and understood (Sotonwa, 2024). Over the past half-century, terminology has shifted, with terms such as *mental handicap* and *mental retardation* historically used in clinical, educational, and policy contexts before being gradually replaced by *learning disability, global developmental delay,* and *intellectual disability* (Tassé & Mehling, 2018). These shifts reflect sociopolitical changes, advocacy by people with lived experience, and rights-based reforms (Barton, 2013; National Council on Disability, 1994; Walmsley, 2005).

However, research suggests that these terminological shifts have also created fragmentation across disciplines and services (Hancock et al., 2023). This article examines how inconsistent professional terminology across disciplines can impact multidisciplinary collaboration, ethics and clinical outcomes. It proposes practical steps to build a shared professional language.

The National Institute for Health and Care Excellence (NICE) defines a learning disability as a significantly reduced intellectual ability and impaired adaptive functioning, with onset in childhood (NICE, 2015). Despite this framework, interpretations of learning disabilities and related terminology can vary considerably across multidisciplinary professional disciplines and service settings (Büttner & Hasselhorn, 2011). For example, terms such as Language Disorder, Developmental Language Disorder, Language-based learning disabilities, Specific Learning Disorder, and Specific Learning Disability are commonly used to describe children struggling to learn at school, but their application differs depending on the professional context (Archibald, 2024).

This variation matters because inconsistent terminology can shape how needs are identified, assessed, and addressed. Such inconsistency may affect diagnostic decisions by changing thresholds for recognition. It can also influence service eligibility by determining who qualifies for support, as well as shaping intervention design by guiding which approaches are prioritised (Hancock et al., 2023; Haydon-Laurelut & Nunkoosing, 2016; Silverman, 2013). These inconsistencies also risk diagnostic overshadowing and fragmented care, creating confusion for families and challenges for

Received: 16 October 2025 | Accepted: 15 December 2025 | Published: 01 June 2026
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professionals, as they complicate communication across disciplines and make it harder to coordinate consistent support (Peña-Salazar et al., 2020).

Much of the existing research has explored how professionals communicate with people with learning disabilities (Hancock et al., 2023; Metcalf & Colgate, 2019; Sotonwa, 2024). However, far less attention has been paid to how professionals communicate with one another about learning disabilities across different disciplines and service contexts (Gabriel & Lester, 2012; Hancock et al., 2023; Oulton et al., 2022). This gap highlights how shared terminology is essential not only for accurate assessment but also for cohesive, collaborative care. (Gabriel & Lester, 2012; Hancock et al., 2023).

To address these concerns, this article situates current debates in their historical context, examines conceptual and clinical tensions, and outlines ethical and practical consequences of misaligned language. It also proposes strategies for creating shared professional vocabulary, reflecting the needs and perspectives of people with learning disabilities and their families. The aim is to promote shared approaches to language, supporting professionals in maintaining communication that is consistent, inclusive, and effective.

Historical development of terminology

The terminology surrounding learning disabilities has evolved over time through a complex interaction of science, policy, and culture. Early descriptions such as *idiocy*, *feeblemindedness*, *mental deficiency*, and *mental retardation* dominated professional and legal discourses until the late twentieth century (Tassé & Mehling, 2018). These deficit-based labels not only reflected prevailing medical views but also justified institutionalisation and segregation by framing people with learning disabilities as inherently dependent and incapable of participation in mainstream society (Walmsley, 2005).

From the 1970s onward, language began to reflect wider social and political change. The move towards *learning disability* and *intellectual disability* coincided with deinstitutionalisation and the rise of community-based services (Mansell & Ericsson, 1996). This linguistic shift reframed people as citizens with rights rather than patients to be managed (Barton, 2013). It also broadened professional responsibility from containment to participation, expanding opportunities for inclusive education and community living (National Council on Disability, 1994). These developments marked a clear shift in both professional identity and access to support.

By the 1990s, disability rights movements and inclusive education policies reinforced the idea that terminology carries moral and political weight (Salvador-Carulla & Bertelli, 2007). Central to this evolution was the adoption of *people-first language*, which refers to phrasing such as “person with a disability” rather than disabled. This is now widely recognised as the most respectful and rights-based form of communication (Żuchowska-Skiba, 2023). Language no longer served only to describe; it became a tool for recognising personhood and agency (Cluley, 2018). As this phrasing entered professional guidelines and policy documents, practitioners began to emphasise collaboration, transparency, and individual planning. Terminological reform thus translated into more participatory and ethically grounded approaches to assessment and care, linking everyday professional communication to values of dignity, autonomy, and inclusion (National Council on Disability, 1994; Winter, 2015).

International frameworks further shaped this evolution (Kearns et al., 2025; Wylie et al., 2013). The World Health Organization’s *International Classification of Functioning, Disability and Health* (ICF; World Health Organization [WHO], 2001) reframed disability using a biopsychosocial model, shifting attention from impairment to participation and environment. This reframing encouraged clinicians to view barriers not solely as individual deficits but as interactional and systemic, leading to broader assessment approaches and new intervention priorities (Coenen et al., 2022). For example, a clinician using the *International Classification of Functioning, Disability and Health* framework might describe a young person’s learning disability not just by cognitive scores, but also by how classroom noise, inaccessible materials, or communication impact engagement (Coenen et al., 2022; WHO, 2001).

Similarly, the *United Nations Convention on the Rights of Persons with Disabilities* (United Nations General Assembly, 2006) redefined disability as a human rights issue, obligating governments to ensure equal access to education, health care, and social participation, and to remove structural barriers to inclusion. This extended the influence of language beyond clinical contexts, shaping

policy, funding priorities, and international accountability (Kanter, 2023). Together, these frameworks consolidated a global shift towards rights-based terminology and encouraged professionals to collaborate across disciplines (Coenen et al., 2022; Kanter, 2023). However, differences in terminology between the WHO model and national systems meant that true alignment remained elusive (Wylie et al., 2013).

Related subfields illustrate similar patterns of terminological evolution and instability (Bishop, 2014; Gibbs & Elliott, 2020). For example, the term "dyslexia", coined in the late nineteenth century by Rudolf Berlin to describe reading difficulties in adults with "normal intelligence", later came to be understood as a language-based disorder affecting reading and spelling and gained widespread use in education and clinical practice (Gibbs & Elliott, 2020; Wagner, 1973). Successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have also reshaped the boundaries and terminology of learning and communication disorders, reflected evolving scientific knowledge and shifted professional priorities (Katchergin, 2016). These advancements meant that more individuals qualified for targeted interventions and accommodations in schools, university and workplaces (Hancock et al., 2023; National Council on Disability, 1994; Wylie et al., 2013). Despite this progress, debates over diagnostic validity, overgeneralisation, and distinct profiles have persisted (Gibbs & Elliott, 2020). Bishop (2014) identified over 130 terms for unexplained language difficulties, many of which were too broad for clinical utility, illustrating how linguistic expansion can inadvertently create confusion as well as opportunity.

Nevertheless, research has argued that the adoption and usage of these terms has been inconsistent across disciplines and countries, with varying rates of uptake between psychology, psychiatry, education, and social care, limiting its practical impact (Büttner & Hasselhorn, 2011; Cluley, 2018).

This historical trajectory shows that linguistic shifts both reflect and drive changes in power, policy, and care. Each new term re-articulates progress towards greater inclusion and rights-based practice. Yet translating this shared understanding into consistent multidisciplinary practice remains an ongoing challenge (Bishop, 2014; Gibbs & Elliott, 2020).

Divergent frameworks across professions

Multidisciplinary teams now underpin most learning disability services (Hancock et al., 2023). However, differences in professional training and theory can create varied interpretations of the same behaviours (Hancock et al., 2023). Research indicates that speech and language therapists and mental health clinicians often share relatively aligned clinical language around communication and emotional needs, using terms such as *dysregulation* and *distressed behaviours* (Hancock et al., 2023; Relojo-Howell, 2021). In contrast, educational and residential staff typically adopt more behaviour-led or operational terminology, often without access to developmental or diagnostic language, including terms like *disruptive* or *challenging behaviour* (Hancock et al., 2023). Conceptually, these differences make it difficult to understand the function and meaning of behaviour.

Evidence suggests that in hospital settings, professionals often use terms such as *learning disability*, *developmental delay*, and *special needs* interchangeably when referring to children with learning disabilities (Oulton et al., 2022). A critical discourse analysis of referral texts to UK Community Learning Disability Teams found that referrer documents, often authored by educational or social care staff, tended to portray "challenging behaviour" as residing within the individual, implying that it stemmed from the child's inherent traits or deficits. Conversely, service responses, typically from clinical professionals, reframed these behaviours as products of environmental or systemic factors (Haydon-Laurelut & Nunkoosing, 2016).

Such discrepancies also occur within single professions. Gabriel and Lester (2012) found that teacher educators may hold conflicting metaphors when trying to define learning disabilities. In practice, this might look like one teacher describing a pupil as a 'puzzle to solve' focusing on identifying and addressing what the student struggles with, while another sees the pupil as a 'unique journey' focusing on supporting the student's strengths and individual way of learning. [Added practical clarity for non-academic background]. This demonstrates that professionals may share terminology but not meaning, producing what has been called "false consensus" (Ross et al., 1977). When this happens, multidisciplinary collaboration risks breaking down, as team members unknowingly work from

incomputable conceptual maps (Gabriel & Lester, 2012; Ross et al., 1977). Families and colleagues may potentially receive inconsistent information about a child's needs, which may delay intervention or reduce its efficacy (van Eck et al., 2024).

International variation

Cross-nationally, the UK commonly uses the term *learning disability*, while North America and parts of Europe prefer *intellectual disability*. DSM-5-TR uses *intellectual disability (American Psychiatric Association [APA], 2022)*, whereas ICD-11 (World Health Organization [WHO], 2018) uses *intellectual developmental disorder*. Within the UK, some services now adopt *intellectual disability*, creating further tension between medical classification frameworks and social policy discourse (Cluley, 2018; McCarthy & Manji Daffi, 2024).

This terminological variability can complicate international research comparisons, collaborative practice, and communication across professional disciplines (Martin et al., 2022). The coexistence of multiple terms within the UK and internationally may lead to conceptual confusion and practical inconsistency, as professionals may attach different scopes, criteria, or connotations to each label (Cluley, 2018; Martin et al., 2022). In research, this variability makes it difficult to aggregate findings, conduct systematic reviews, or perform meta-analyses, since studies may operationalise similar phenomena under different terms (Bach-Mortensen & Verboom, 2020; Wallace et al., 2012). In professional practice, they risk undermining consistent standards of care across European and global contexts, potentially leading to divergent assessment approaches, intervention strategies, or eligibility decisions (Wylie et al., 2013).

Theoretical perspectives

These variations are not only practical obstacles to communication and care; they can also reflect deeper issues of power, legitimacy, and professional identity. To understand why terminology matters so significantly, it is useful to draw on sociological theories of language. Bourdieu (1991) described language as a form of *symbolic capital*, a resource that gives professionals influence and credibility. In practice, those who control the terms used in reports or meetings often shape how needs are defined and whose expertise is prioritised. Foucault (1972) similarly argued that professional language decides what counts as legitimate knowledge and whose views carry weight. In multidisciplinary settings, this means some professions' ways of speaking are automatically treated as more authoritative than others.

In clinical teams, when one's profession's vocabulary dominates, such as psychiatry's medical terms or education's behavioural labels, it can marginalise alternative perspectives (Haydon-Laurelut & Nunkoosing, 2016). Certain vocabularies can carry more institutional legitimacy than others, meaning that language can not only convey meaning but also positions professionals, and the individuals they describe, within hierarchies of knowledge and authority (Fealy et al., 2018). Medical terms like *disorder* or *symptom* frame behaviour as pathology, while educational terms like *non- compliance* emphasise control and performance (Cluley, 2018). Both can overlook social or communicative factors that may be central to understanding need.

These dynamics can be seen in everyday clinical discussions. In a multidisciplinary meeting about a child with a learning disability who displays self-injurious behaviour, a psychiatrist might describe it as 'impulsive behaviour linked to attention-deficit/ hyperactivity disorder (ADHD)', whereas a psychologist might frame it as 'distress communication in response to environmental or sensory triggers'. When the medical framing dominates, medication may be prioritised over behavioural interventions. Such moments highlight the need for reflective practice, encouraging professionals to consider how their language and professional knowledge shapes understanding and access to support (Calvert et al., 2016; Haydon-Laurelut & Nunkoosing, 2016; Metcalf & Colgate, 2019).

Psychological theories further illustrate these dynamics. Goffman's stigma theory illustrates how labels create "spoiled identities", influencing how people with learning disabilities are perceived socially and clinically (Goffman, 2009). Similarly, attribution theory demonstrates that the language professionals use to explain behaviour, whether biomedical or behavioural, shapes both expectations and emotional responses (Heider, 2013). To illustrate, a behaviour labelled *oppositional* may be seen as defiant, whereas framing the same behaviour as *communicative intent* invites interventions which provide alternative ways to communicate or engage (Haydon-Laurelut & Nunkoosing, 2016; Royal

College of Speech and Language Therapists; Truesdale et al., 2019). For psychologists, this highlights how diagnostic labels not only communicate clinical categories but also shape how professionals and the people they support understand behaviour, influencing therapeutic alliances, self-perceptions, and identity formation within clinical and educational contexts (Tandos & Stukas, 2010).

However, such differences reflect not only varied terminology but also distinct professional understandings (Metcalf & Colgate, 2019). When professionals' language and interpretations are aligned, communication is clearer, interventions are better coordinated, and outcomes for children and young people are improved. This highlights the importance of all professionals, at every level and across all roles, having access to, and using, precise, respectful, and shared terminology, supported by training and reflective practice (Hancock et al., 2023; Oulton et al., 2022). In this way, language both reflects and constructs professional boundaries and organisational structures, directly shaping the kinds of support and care that individuals with learning disabilities receive (Unhjem et al., 2019).

Importantly, diversity in conceptualisation is not inherently problematic (Christensen et al., 2021). Different perspectives can enrich professional debate, broaden understanding, and lead to more holistic care (Christensen et al., 2021). Educational staff may focus on learning environments, clinicians on developmental profiles, and together these insights generate more nuanced interventions (Bronstein, 2003; D'Amour & Oandasan, 2005). These differences are beneficial when they are recognised, communicated, and coordinated across teams. Conversely, differences that go unacknowledged or miscommunicated can hinder care, raising ethical concerns around consistency, transparency, and equity (Hancock et al., 2023).

Clinical and ethical consequences

Inconsistent terminology across disciplines is not merely a theoretical concern, it can have direct clinical and ethical implications (Gabriel & Lester, 2012; Hancock et al., 2023). When professionals interpret the same behaviour differently, communication breaks down, and individuals' risk being misdiagnosed or inadequately supported (Peña-Salazar et al., 2020).

A common example arises in referrals to Learning Disability CAMHS services. A teacher might describe a child as "constantly moving around" and a clinician might interpret this as hyperactivity, leading to a referral for the ADHD pathway. In contrast, an occupational therapist might interpret the same behaviour as "constantly sensory seeking", prompting consideration of autism or sensory integration difficulties. Although both professionals are observing the same child, their differing professional frameworks lead them to use different language. This in turn channels the referral into different diagnostic and service pathways, with potentially divergent outcomes for care and support.

These divergent perspectives can result in reductive labelling, whereby complex behaviours are oversimplified, and increase the risk of diagnostic overshadowing (Peña-Salazar et al., 2020). Diagnostic overshadowing occurs when a person's learning disability masks co-occurring conditions such as mental health difficulties or communication needs, resulting in those additional difficulties going unrecognised (Peña-Salazar et al., 2020). In practice, this might look like a person expressing pain through agitation, withdrawal, or self-injurious behaviour being described simply as "displaying challenging behaviour", as if such responses are an inherent part of their learning disability. Therefore, misaligned terminology can also undermine continuity of care (Haydon-Laurelut & Nunkoosing, 2016; Silverman, 2013).

The therapeutic alliance can also suffer. In therapy contexts, talking-based approaches like cognitive behavioural therapy often assume verbal reasoning and introspective language, yet these approaches may be delivered without sufficient adaptation for children with speech, language, and communication needs (Silverman, 2013). When the language used in therapy or assessment does not match the child's communicative capacity, the process becomes inaccessible and risks reinforcing stigma rather than alleviating it (Hancock et al., 2023).

Research further shows that diagnostic labels can also influence professional perception (Gifford & Knott, 2016; Kashikar et al., 2025). Gifford and Knott (2016) found that the specific diagnostic label assigned to an individual, such as autism, learning disability, or Down syndrome, significantly influenced how staff understood and emotionally responded to challenging behaviour. When

labelled as autistic or having Down syndrome, behaviours were more often viewed through biomedical explanations, eliciting more positive staff reactions. In contrast, the label *learning disability* was associated with attributions to learned behaviour and more negative emotional responses. Similarly, Kashikar et al. (2025) found that teachers given a label for learning difficulties, either *learning disability* or *special learning needs*, reported lower academic expectations and made more recommendations for special school placement, reflecting stereotype-informed judgments. These findings reveal how language subtly guides empathy, expectations, and the perceived legitimacy of needs.

Ethically, terminology is therefore a mechanism of power and inclusion (Bourdieu, 1991; Foucault, 1972). When language frames individuals as challenging or difficult, it can legitimise unequal treatment (Goffman, 2009; Haydon-Laurelut & Nunkoosing, 2016). Conversely, language that acknowledges systemic and communicative factors supports fairness, participation, and person-centred practice (Hancock et al., 2023; Metcalf & Colgate, 2019; Royal College of Speech and Language Therapists, 2017). Psychologists, operating at the intersection of diagnostic and relational work, hold responsibility to model reflective and inclusive terminology (D'Angelo et al., 2023).

Beyond individual ethics, the consequences extend to structural and policy levels. Funding allocations, commissioning decisions, and service eligibility criteria are often tied to diagnostic categories (Whitfield et al., 2023). Terms such as *learning disability, intellectual disability,* and *global developmental delay* are used across different contexts and age groups, but not always interchangeably (Büttner & Hasselhorn, 2011; Cluley, 2018). These variations can affect how data are recorded, how eligibility is determined, and which services qualify for support (WHO, 2018).

For example, services often have criteria for who they can accept, often based on whether an individual is described as having a mild, moderate, or severe learning disability. However, when terminology is used inconsistently, it can be difficult to determine whether someone meets the threshold for specialist input, leading to uncertainty or variation between areas (Cluley, 2018; NICE, 2015; Oulton et al., 2022;). At the policy level, language influences how need is recognised and resourced, affecting the distribution of public funds and shaping the priorities of research and education (Bach-Mortensen & Verboom, 2020). Thus, inconsistent terminology perpetuates inequity not only between individuals but between systems. Addressing this requires coordinated policy leadership to clarify and align the use of these terms across health, education, and social care sectors, ensuring that linguistic variation does not obscure eligibility or delay access to support (NHS England, 2023).

In summary, linguistic inconsistency shapes not only communication but also the ethical landscape of practice. For clinical psychologists, terminology is more than descriptive, it structures how need is recognised, whose perspective is legitimised, and how care is delivered (Cluley, 2018; van Eck et al., 2024). Attending to language is therefore an act of professional accountability: through reflective and shared use of terminology, psychologists can help ensure that diagnostic clarity supports dignity, equitable access, and meaningful participation in care.

Recommendations

Research

Future research should examine how language operates in practice, particularly within multidisciplinary decision-making. Ethnographic studies of clinical team meetings could illuminate how terminology influences assessment, referral, and intervention (Borgstrom et al., 2021). There is a notable gap in longitudinal data examining how labels impact educational, social, and psychological outcomes across the lifespan. Most existing studies are either qualitative or short-term, leaving unanswered questions about the long-term effects of early diagnostic terminology on wellbeing or particular diagnostic labels (Goldberg et al., 2003).

International comparative research is limited. Studies that investigate how different terminological frameworks influence equity and inclusion, especially in multilingual European contexts with varied policy environments, would provide valuable insights (Mouboua et al., 2024). Crucially, co-produced research with individuals with learning disabilities and their families is essential to ensure that future frameworks reflect lived experiences rather than top-down professional categorisations (Sutton, 2020).

Psychological practice

Interprofessional learning initiatives show considerable promise in addressing terminological fragmentation. Metcalf and Colgate (2019) describe a reflective training model in which healthcare students, including psychology, nursing, and speech and language therapy trainees, collaborated on communication tasks with people with intellectual disabilities. These sessions encouraged participants to translate discipline-specific terminology into plain language and discuss how wording influenced their assumptions about behaviour. Evaluations showed improved confidence, empathy, and interprofessional communication.

Similarly, Calvert et al. (2016) highlight the value of *dialogical reflexivity* in clinical supervision, where practitioners explore how language shapes their perceptions of clients and colleagues. This process encourages professionals to recognise the ethical and relational implications of terminology. Supervisors can model this by reflecting on their use of terminology in reports and therapy sessions (Calvert et al., 2016).

Embedding speech and language therapists within multidisciplinary training can further bridge conceptual gaps, ensuring that communication needs are consistently considered across clinical, educational, and social care contexts (Royal College of Speech and Language Therapists, 2017). It is important to acknowledge that implementation may be constrained by funding limitations, staffing shortages, and challenges in recruiting specialist professionals. Focused and well-designed initiatives can help to address and alleviate such barriers.

In applied settings, brief multidisciplinary workshops can replicate these approaches within NHS and educational services. For example, teams might review anonymised case notes together, comparing how different professional languages frame the same situation. Such exercises make visible the influence of discourse on decision-making and strengthen shared understanding.

Developing shared conceptual tools is critical. Co-created glossaries and shared reflection activities, as outlined by Vienni-Baptista et al. (2023), can further standardise understanding across teams while preserving disciplinary nuance. Frameworks such as Universal Design for Learning offer a model for aligning educational and health approaches (Boucher et al., 2025). Practical innovations, including co-developed referral templates and shared health record fields for communication profiles, could provide mechanisms to reduce fragmentation (Solvang et al., 2025). In several UK NHS trusts, standardised electronic health record entries allow clinicians, speech and language therapists, and social care professionals to build a comprehensive, collective understanding of a person's communication style. This reduces reliance on discipline-specific jargon and enhances continuity of care (NHS Digital, 2022). More broadly, developing shared conceptual frameworks supports not only professional consistency but also mutual understanding, both between disciplines and between professionals and the people they support (Hancock et al., 2023; Oulton et al., 2022).

Policy

Policy guidance from bodies such as NICE and NHS England could explicitly embed shared terminology within referral and assessment standards (NICE, 2021; NHS England, 2023). Integrated care systems and regulatory frameworks might monitor linguistic alignment as part of quality assurance processes, ensuring that consistent language underpins service delivery and decision-making. Psychology professional bodies, including the British Psychological Society and the APA, have a central role to play in promoting standardisation (Winter, 2015). They can issue guidance on inclusive terminology, develop best-practice frameworks for assessment and therapy, and provide continuing professional development to foster linguistic reflexivity across the profession (APA, 2023; British Psychological Society [BPS], 2025).

To operationalise this, a national working group could be convened, including representatives from psychology, education, social care, speech and language therapy, and service-user organisations. Its remit would be to produce an interprofessional terminology charter, updated every five years, aligned with international standards and lived-experience input. Government and research-funding bodies should also recognise terminology as a structural equity issue. Funding streams could prioritise projects that evaluate the impact of shared language frameworks on outcomes, ensuring that linguistic coherence becomes a measurable aspect of service quality..

Practical barriers to implementation include long-standing institutional habits and existing

professional silos (Mahomed-Asmail et al., 2024). These could be mitigated through targeted funding for interprofessional training initiatives, pilot programmes demonstrating the value of standardised terminology, policy incentives for co-produced care frameworks, and shared documentation standards (Boucher et al., 2025; Metcalf & Colgate, 2019; Winter, 2015). Clinical psychology, as a discipline operating across both research and practice domains, has a unique role to play in influencing such policy development and ensuring that linguistic frameworks support inclusion, coherence, and equity (Winter, 2015).

CONCLUSION

Terminology in learning disability services has changed considerably over the past half-century, but change has not produced consistency. Different disciplines continue to use different language to describe the same people and the same behaviours, with practical consequences for assessment, referral, and care. This article has argued that these inconsistencies are not simply a matter of professional habit. They reflect deeper differences in training, theoretical frameworks, and institutional power. When one profession's vocabulary dominates a clinical setting, other perspectives can be marginalised, and the individuals being discussed may be reduced to the terms most convenient to the system rather than most accurate to their experience. At the same time, terminological diversity is not inherently a problem. Different professional lenses can produce richer, more complete pictures of need. The difficulty arises when those differences go unacknowledged or uncommunicated. Shared language is not about flattening professional knowledge into a single framework; it is about creating enough common ground for collaboration to function and for care to remain coherent. Practical steps exist. Interprofessional training, co-produced glossaries, reflective supervision, and shared documentation standards can all reduce fragmentation without requiring uniformity. What is needed alongside these tools is a wider recognition, at policy and institutional level, that language is a structural issue in learning disability services, not a peripheral one.

Acknowledgements: None declared
Conflict of interests: None declared
Ethical approval: Not applicable
Funding: None declared

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