
About APD

This page contains many of the genuine questions that I am regularly asked about Auditory Processing Disorder APD. Some are answered in more depth in other documents on the APD Support UK website, where listed.

1. What are the indications that a child might have APD? [Here are some of them, but only full testing can tell you for certain. They don't need to have them all.](#)
 - a. A child with APD might appear not to hear when you speak to them, especially if it is noisy, unless you get their attention first. APD is not an attentional problem, they just need to know you are speaking to them or lipread.
 - b. They might be suspected of having hearing loss, only to have perfect hearing (although APD can exist in people with hearing loss).
 - c. Even in a quiet room, they might not understand what you say or ask them to do.
 - d. They might have difficulty with more than one instruction or carry out a list of instructions in the wrong order.
 - e. They might have problems with knowing who to listen to in a group of people: the direction of the speaker.
 - f. They might muddle up similar sounds or words.
 - g. There might be misunderstanding, miscommunication, tears and frustration because they don't understand or can't express themselves due to word retrieval issues.
 - h. They might have a problem with using the phone, understanding fast speech or people with unfamiliar accents.
 - i. Sometimes they might hear the start, middle or end of a sentence, all of it or none of it. On other occasions it might be different.
 - j. The effects are random and intermittent, worse when tired, ill or stressed. There will be good days and bad days.

- k. It will be more obvious once they go to school or in a group of people. They might struggle to understand what is going on in the classroom, work slowly, seek reassurance from teachers and peers that what they are doing is correct, or they might not know that they have misunderstood and constantly get things wrong.
 - l. They might struggle to make and keep friends due to miscommunication or poor social skills. It is not their fault.
- 2. Why do health professionals not believe me about APD, saying it's rare and my daughter can't have it, or I can't have it? This is purely down to lack of awareness about APD. Recent international research has indicated that APD is thought to be present in 5% to 7% of children (some sources say up to 10% or 1 in 10) and in over 20% of adults. The amount increases steeply in children who have learning difficulties, with up to 40% of those children also having auditory processing deficits. By comparison, according to WHO in 2019, Autism/ASD is thought to affect only 1 in 160 children worldwide (with an estimated 1.1% in the UK). Please share information on APD with medical and education professionals. Share this website <https://apdsupportuk.yolasite.com/>
- 3. What causes APD? APD is thought to be caused by neurological damage to the brain. It might be present from birth or develop after an illness or head injury, ear infections and glue ear; there are many suspected causes. But cause doesn't affect the type of difficulties a person experiences, may never be known, and really doesn't matter.
- 4. How would you explain APD in layman's terms? APD affects the way the brain processes sound and speech. It is a problem with the brain not the ears. APD affects understanding what you hear. It can affect people randomly and intermittently, unlike hearing loss which is always present.
- 5. How can I explain APD in simple terms to my APD child and their siblings? APD means that they might not always understand what is said to them or follow instructions properly.

6. How can people with APD explain their particular type of difficulties effectively to those who don't understand? And how can they best advocate for themselves? This comes from knowledge of how it affects them. Each individual will have a different combination of difficulties and different needs. They need to learn them and explain it simply; parents can help children understand once they understand. E.g., if they know that they can't understand speech when it's noisy, they can ask to be spoken to without the TV on, or somewhere quiet. If they prefer information to be repeated, rephrased or written down, they can ask for that. If they have a problem with a list of instructions, they can ask for one at a time, or for them to be written. The same applies to adults. Self-advocacy takes practice and should be started as early as possible. Parents must advocate for their child until they have learned to do so effectively.
7. Is APD a lifelong condition? Yes, it is normally permanent if present at birth or in early childhood. Although there can be some slight improvement until the age of 12/13, it never goes away. But development of coping strategies tailored support and self-advocacy skills can help and this is why accurate diagnosis is vital in knowing what support is needed. Late-onset/acquired APD might go away or be improved as the illness or injury which caused it heals. Coping strategies/self-advocacy are essential in all cases, at all ages.
8. Should we go to our GP to refer? GPs can refer for NHS testing, but also certain other professionals such as paediatricians, educational psychologists and speech and language therapists. Different testing centres have their own process, criteria and exclusions. For full referral, testing centres, criteria and testing details, please see the "APD testing centres" document and criteria sheets [here](#) (if they have been provided to us). <https://apdsupportuk.yolasite.com/diagnosis.php>
9. How do I explain APD to my GP and seek a referral? Many GPs and other professionals have still not heard about APD or the referral and testing process.

You can give them a copy of this document and other information from this website <https://apdsupportuk.yolasite.com/diagnosis.php> also the information on APD testing centres as above. Explain how you think your child is affected, give them a list of your observations and provide a copy of a report containing suspicion of APD by an appropriate professional, plus copies of diagnosis reports listed in the testing centre criteria. School observations are also useful. Your child will need a basic hearing test in the 3 months before referral to rule out glue ear and hearing loss and your GP can arrange this. Once you have those results and copies of all other required information, you can seek a referral. See the “APD Testing centres” document for full details here. <https://apdsupportuk.yolasite.com/diagnosis.php>

10. What are the benefits of an official APD diagnosis for children and adults? APD affects everyone uniquely and only full diagnosis can tell you the particular combination of difficulties experienced and their severity. Without this knowledge, you cannot hope to gain appropriate or adequate support and reasonable adjustments at school and at work. This is because you won't know which difficulties are present or the tailored support that is needed. Diagnosis also brings validation and demonstrates that the sufferer is not alone or to blame for their struggles, and that there is a valid, medical reason for it. It can come as a relief to adults to know why they have struggled all their lives, whether at school, socially and later at work. Diagnosis can provide access to reasonable adjustments under the Education Act 2011 and Equality Act 2010.
11. At what age can APD be tested in children? The age of testing can vary between testing centres, but it is usually from the age of 8 on the NHS or 6/7 privately. Please check with your chosen centre that your child meets their age and other criteria.
12. How can an adult be diagnosed? Please read the section for adults in the APD testing centres document here, <https://apdsupportuk.yolasite.com/diagnosis.php>

13. What to do if the GP/hospital refuses to refer? Under NHS Patient Choice in England, you are entitled to a referral to a hospital and consultant of your choice. If you are refused, make a complaint to your local Clinical Commissioning Group, details here. Wales does not have this option and there is currently no full testing in Scotland or NI.
14. How does APD vary in every child in a family? APD does run in some families but there is no currently-known pattern regarding how it is passed down. Everyone with APD is affected uniquely even within families, so siblings will vary in its effects. Even in twins, one might have APD and one might not, or there will be different effects. APD can also be acquired from glue ear and many other causes. Each child will need unique support.
15. Can you explain how APD may not exist alone? APD can (and normally does) exist alongside any number or variety of other unrelated conditions, disabilities or difficulties, including mental health issues. There is often added stress and anxiety which can develop as a result of coping with it all (especially when undiagnosed or not fully supported). This will also adversely affect processing, as can coping with any and all other issues. Each condition must be identified, diagnosed and fully supported. There can be overlapping symptoms which makes this harder. Misdiagnosis can also occur where there are similar symptoms, so it is even more important that accurate diagnosis is carried out by the appropriate, trained professionals for the purpose.
16. If you have a diagnosis of ASD, can you still be assessed for APD? It is now generally assumed that all children with ASD will also have APD (although not all children with APD will have ASD). This assumption can lead to children with ASD being refused APD testing at some centres, as testing is not felt to be needed. However, only by knowing how a child is uniquely affected by APD can tailored support be put in place. There are centres which will test for APD with a diagnosis of ASD so long as there is evidence provided that the child is “high functioning”, able to maintain attention and respond appropriately to the lengthy testing (although some private centres will split it up over 2 or 3 days). Some children might find this too much or even distressing; parents know their child

best and should make the decision whether/where to seek a referral based on that knowledge. (Testing centres have their own criteria and it is best to read them where available before deciding where to seek a referral).

17. How does APD change as a child ages? APD will not improve much or worsen.

As a child gets older and they develop effective coping strategies and (hopefully) support is put in place, this makes it easier to deal with. Children without support will not experience an improvement past maturation of the auditory processing system at 12/13. A child with APD will struggle greatly when they move to secondary school, with an increase in workload and in the difficulty of work, with more people and new voice patterns to get used to etc. Stress and other conditions will add to the adverse effects, making it seem as if the APD has worsened. This is why school support is vital. They also need to learn self-advocacy skills as early as possible, in order to ask for help when needed, and knowing what they need as an individual will help with that. APD remains into adulthood, so support in further education and at work is also essential. Each child with APD will become an adult with APD and they need preparation for that.

18. How does APD affect teenagers? Teenage years can be particularly difficult for

those with APD. The effects of hormones can make processing more difficult (as they can in pregnancy and during the menopause). Isolation is common in children and teenagers with APD who might have few in-person friends due to communication difficulties or who avoid social situations where they feel they fail. Peer pressure is high, making it more important for the teenager with APD to not appear different from others, leading to possible refusal of school support. Those with APD are vulnerable to bullies and can be impressionable. They often have low self-esteem and poor confidence. There are many dangers for all teenagers such as addictive habits and reckless behaviour etc. Those with APD are very vulnerable to such temptations, maybe as escapism, or as a way to try and take back control when they feel they have none, or seen as a means to help them fit in. It is common for children and young people with APD to suffer from anxiety. Those who are undiagnosed or unsupported are more at risk, at any age. Behaviour issues are also a cry for help. Parents are advised to watch

out for signs of stress, anxiety and depression and changes in behaviour and seek mental health support where appropriate.

19. Can you suggest any APD strategies and techniques? Coping strategies are unique to each individual. They can be a matter of trial and error and can take time to develop. Some might be automatic, like lipreading. What works for one person might not help another. But generally speaking, avoiding situations with a lot of noise, stress and verbal input can help. An individual with APD needs people to face them when speaking so that they can read lips and body language. Use their name and get their attention first and speak clearly. Keep language simple and sentences short and allow time for processing of information and replies. Ask THEM what will help them best to understand. Information should be presented in the way that they need it, to aid understanding. Personal coping strategies can depend on preferred learning style. Some people prefer verbal information to be repeated or rephrased. For others, as vision is the primary sense, information/questions should be written or given via diagrams. Showing someone rather than explaining, as well as providing written instructions, provides the multi-sensory format preferred by many. Parents should help their child learn and use them in a variety of settings, as well as teaching them develop self-advocacy skills. They will need to know what help they prefer and how to ask for it.

20. Will GPs and other professionals be able to support us? GPs and other professionals are not trained to provide support for APD at school, at work or in everyday life. APD Support UK provides a website, Facebook groups and a variety of support and information for all ages. We are currently the only voluntary organisation in the UK and Europe providing specific support for families and individuals affected by APD.

21. Does APD cause a stutter? This is not a recognised symptom of APD but APD can co-exist with anything and everything. It might be a side effect, in that a stutter or stammer could occur if a child with APD was unsure what they wanted to say or how to say it; it might even be a way of masking word retrieval

difficulties, like a coping strategy. A stutter/stammer can also be caused by stress and children with APD are under daily prolonged stress.

22. How does APD affect communication and the understanding of the English language? APD affects how the brain processes and understands speech (receptive language). It does this in several ways with varying severity. APD makes it hard to understand what is said. Misprocessed information can be incorrect or incomplete, making it hard to understand a question or respond appropriately to instructions. Poor auditory memory will affect what is remembered from what is heard. Added background noise makes processing harder. APD therefore poses a barrier to learning because there will be gaps in knowledge. APD can lead to miscommunication and misunderstanding in all areas of life, which can affect all relationships. Work will also be affected as they get older. This is why coping strategies and continued support are so important.

23. How much information can they miss? This will also vary from one person to another, depending on the individual difficulties and their severity. It can also vary day to day and even hour to hour. They might process all, some or none of any sentence that they hear. It is not like hearing loss; the effects are random. This is why it is unwise to just tell people that it is hearing loss, because they will wonder why a person with APD might understand perfectly at one time and not another; they can even be accused of “making it up”. It will differ on good days and bad days and be affected by illness, tiredness, stress and even dehydration.

24. Can APD affect expressive language APD can have effects on expressive language in some children. Due to not being able to process speech sounds effectively, they might not be able to remember them or reproduce them accurately as a result. A child with APD and this deficit might intermittently hear **p** as **b** or **t**, or **ch** as **ch** at times, and other times as **sh**. This can happen with any number of sounds, randomly and intermittently, so there is no way for that child to consistently remember, learn them, or reproduce them when speaking. (There are also other causes of expressive language difficulties, including glue

ear and language impairment as well as other physical causes). If APD is present when learning to speak, this can have a huge effect on speech acquisition in some children. APD does not cause a speech problem in all children. But APD can also affect written expression in some children due to word retrieval issues.

25. Does having APD affect learning to read? It can, in some children. As described above, APD can affect the way some children learn the sounds of speech/phonemes in order to speak. Children will also need to recognise and remember them consistently in order to learn to read/spell. They will need to be able to relate these sounds/phonemes to the written format, words/graphemes. Inability to do so can cause reading and spelling difficulties. This problem with reading/spelling is known as auditory dyslexia, one of the 2 main causes of dyslexia (the other is visual dyslexia caused by scotopic sensitivity /Irlen's Syndrome and other types of Visual Processing Disorder/VPD). But not all children with APD will have a problem with reading or spelling/dyslexia.

26. What is the best way to teach someone with APD to read/spell? Phonics is the usual way to teach reading/spelling, and is normally the best for those without APD affecting their ability to learn speech sounds/phonemes. However, phonics is **not** the way to teach or remediate a child with APD who has this problem, because a child with APD has a neurological deficit preventing them learning phonics and to pursue this approach is cruel and pointless. These children will need whole word and multi-sensory methods of teaching which do not involve phonics.

27. What are the links between APD, dyslexia and Irlen's syndrome? APD and Irlen's Syndrome are not linked; they can simply co-exist in some children. Irlen's Syndrome/scotopic sensitivity is just one aspect of VPD. A child with reading/spelling difficulties (the original definition of dyslexia) might have either APD, VPD or both as a cause. A child might also have either or both and have no reading/spelling difficulties.

28. What should I be pushing for in terms of education support for APD? This will depend on your child's unique set of APD difficulties plus what they will need to support all other diagnosed conditions and difficulties. (The same applies to an adult at work or in further education). The document "APD in the classroom" can help as a rough guide. <https://apdsupportuk.yolasite.com/parents.php> But only a full diagnosis can tell you what your child needs and generic support is not specific enough for a child with APD. These are children with very complex needs and must be supported as such: a one-size-fits-all approach will not work. Your child might not need the same support as another child already receiving support for APD at your school. Although there might be some similarities and cross-overs of support might occur, your child will have different difficulties, severity and co-existing issues to address. You need to find out what they have and what will work. Ask your child what they struggle with and what they think would help. Work with the school to put in place what was recommended on their diagnosis report and help them to come up with a plan.
29. Will every child with APD always need an EHC assessment? An Education, Health and Care Plan/ EHCP or Statement is based on need, not diagnosis. If you feel your child is making adequate progress, this usually means they are receiving adequate support. If you feel your child is not making adequate progress and you believe school is not able to provide the support which is needed, you can request an EHC assessment. In England, you can seek impartial advice from IPSEA and SOSSEN. In Wales, you should request a statutory assessment for a Statement of Educational Needs or request the equivalent in Scotland or NI.
30. What can I do if my child's school will not accept the APD diagnosis or provide support? You should complain to the school and follow their complaints process. If not satisfied, complain to the Local Authority using the letter template on the "Promoting APD" page.
<https://apdsupportuk.yolasite.com/promoting-apd.php>
31. How do I know how much support is needed? It is always best to have support in place in school and at home which deals with the worst-case scenario.

Always assume that any child with APD might not correctly or completely process anything that they hear at any given time. There will also be times when they think that they have processed and understood what is said, only to find that they have misprocessed some of it, or all of it. They will never know for sure if what they think they heard is accurate and will be unaware when this happens. Any notes that they make at school will be likely to be incomplete or incorrect and these are what they work from and learn from. This is why it is vital that they all receive pre-printed handouts and subject-specific vocabulary sheets with meanings beforehand, as pre-teaching as well as written instructions, as early as they are able to read them. They should not make their own notes, then nothing can be missed. This is a reasonable adjustment, a legal obligation for schools allowing children access to an appropriate education, according to the Education Act 2010 and the Equality Act 2011. Similar support will be needed in further education and at work.

32. Is APD a disability? APD meets the criteria of a disability in the UK in that it is a physical impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities. It does depend on severity but APD is long-term (lifelong) and it affects communication, which is a vital daily activity. Also, the effects of APD are compounded by the other co-existing conditions that the person will have, plus the stress of coping with it. They might also meet the criteria of a disability.

33. What does having APD sound like? APD can be difficult to describe as it is different for everyone, depending on their individual difficulties and the severity of each one. It could be described as being like a badly tuned-in radio signal. It has also been described like hearing underwater: others might perceive it differently. At times, a person might effectively process nothing. The effects are also intermittent and variable throughout the day, worse when tired, ill or stressed, even when dehydrated. Effects can also be compounded by the effects of other conditions. There are videos available online which try to demonstrate this, but they are subjective and what each individual with APD experiences will be different. Ask them to describe it, if they can.

34. Why is a child with APD tired from school? Homework just makes it worse.

Having APD is exhausting; they try harder than neurotypical children to even get through the school day. Having to implement coping strategies also takes up energy. They might be more tired when ill, or stressed (and school can be extremely stressful, even on a good day). By the time they come home, they can be in sensory overload and unable to take in any more information, like a saturated sponge can take in no more water. The brain can effectively switch off, so nothing more might be processed or learned. They might appear to 'zone out' at school or at home when this happens. (If unable to rouse a child when zoning out, you might want to see your GP to rule out absence seizures). Exhaustion and sensory overload are why homework should be disapplied, or at least fully differentiated, if essential, and kept to a minimum. Children with APD will need regular sensory breaks during the day in a quiet space to prevent sensory overload. It also helps to make sure they remain hydrated throughout the day. It is common for parents to ask their child about their day and find that they don't remember until much later on, or will relate events days later. This also applies to adults at work. At home they need rest and relaxation to allow for delayed processing which can occur hours or more later.

35. Intervention outside of the classroom - what are the benefits and drawbacks?

A child with APD might need intervention by e.g., a SALT for additional language issues, or other professionals; if so, it is essential that they receive it. Mental health support is also vital, where needed. Some parents choose to employ a home tutor if their child is not receiving support at school, to make sure that their child does not fall behind. The same situation applies as with homework: they need to rest. Emotionally, it can imply to that child that they are failing at school. Children with APD are very aware of failure. They can blame themselves, adding to feelings of worthlessness, adding pressure to achieve when they should be relaxing. Instead, parents must push for the support they need at school.

36. Does a child with APD qualify for DLA/PIP? Yes, but a successful application will depend on the effects on daily living, not just education. It depends on the type and severity of APD difficulties and co-existing conditions including anxiety

etc. and the amount of support that the child needs each day on a regular basis. the document here explains the process. Various agencies such as Citizens' Advice, Cerebra, Disabilityrightsuk, and Advicenow can help.

37. Is a specialist school better for a child with APD? That would depend on the child, and the type of support they need for their APD and other difficulties, also the school and the support that the school is willing to provide. An EHCP/statement can help guarantee support, although a specific school can only be requested (not guaranteed). There are no specific schools just for APD.

38. What are the myths around APD? Here is the truth about APD:

- a. A child or adult with suspected APD does not need to have all the difficulties. You only need 2 of qualifying severity for a full diagnosis of APD (or one difficulty or more of lesser severity for a diagnosis of auditory processing difficulties). Children have been refused referral over this myth.
- b. Auditory processing difficulties, or even one difficulty alone can be debilitating and still needs support.
- c. Each person with APD is affected uniquely: it isn't like other conditions whether you have it or not. Only a specialist diagnosis can tell you how you are affected so that you can seek tailored support.
- d. There is testing available for APD in the UK and it has been available since 2004.
- e. APD can co-exist with any number of conditions: it doesn't have to be either APD or something else.
- f. APD is not itself a learning difficulty (it is a medical condition, which needs a medical diagnosis and cannot be diagnosed by an education professional). But it can affect learning in a lot of children and adults and might co-exist with learning difficulties.
- g. You cannot usually "grow out of" APD but coping strategies and appropriate support can make it easier to manage.
- h. APD does not get worse as you get older. It's just that coping strategies can start to fail as hearing and eyesight are affected by age, making it harder to deal with. Illness and stress make it harder to cope, at any age.

- i. An FM system will not improve or cure APD (and neither will hearing aids, or medication, or anything else). It is just a tool to improve clarity and volume of speech, not the processing itself, but clear speech without background noise can give the person with APD a better chance to process and understand speech in certain circumstances. However, assistive technology should not be the only provision and never used instead of developing coping strategies and self-advocacy skills.
- j. APD does not affect hearing; it affects the way the brain processes what it hears. It can occur in someone with perfect hearing or someone with hearing loss. APD affects what is heard. But it should be considered as a hearing condition because the brain is affected and the brain plays a vital role in the hearing process. Without it, what we hear is just unintelligible noise: speech has to be processed effectively by the brain for it to make sense. This is why APD must be diagnosed by a consultant in audiovestibular medicine. Local authority sensory teams should therefore support APD as a sensory need.
- k. APD does not affect intelligence.

39. How can I help someone with APD? Talk to the person with APD that you are seeking to support. Encourage them to learn about how they are affected and work out what they need to help them as an individual. Help them to develop coping strategies and learn to explain it to others. That is the best way to help anyone with APD.

FURTHER INFORMATION

More information is provided on the APD Support UK website.
<https://apdsupportuk.yolasite.com>

Please email me if you have a different question to ask about APD in children, teenagers or adults.: apd.support.uk@aol.co.uk and share this information to spread awareness and accurate information about APD and its effects.

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