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Stability and accuracy of specific learning disability diagnoses from childhood to young adulthood

Allyson G. Harrison , Nathaniel Davin  and Emma Jamieson 

Regional Assessment and Resource Centre, Queen's University, Kingston, Ontario, Canada

ABSTRACT

Objective: Specific learning disorder (SLD) diagnoses made in childhood are often assumed to be stable across development; however, diagnostic stability has frequently been conflated with diagnostic validity. This study examined (a) the accuracy of childhood SLD diagnoses at the time they were made, relative to objective academic impairment and (b) the stability of SLD diagnoses from childhood to young adulthood.

Method: Archival data were analyzed from 325 postsecondary students who underwent comprehensive adult psychoeducational assessment and for whom childhood assessment documentation was available. Childhood reports were coded for assessment content, diagnostic clarity, and evidence of objective academic impairment. Diagnostic stability was evaluated by comparing childhood and adult SLD diagnoses across reading, written expression, and mathematics.

Results: Most childhood assessments included standardized measures of cognitive, academic, and behavioral functioning; however, fewer than half included measures of phonological processing, and only 52.3% contained a clear diagnostic statement. Across domains, 82–89% of childhood SLD diagnoses were supported by objective academic impairment at the time of assessment. Despite this, diagnostic stability from childhood to adulthood was moderate, with approximately 59% of childhood diagnoses retained across reading, writing, and mathematics, and roughly 40% not confirmed at adult reassessment.

Conclusions: Findings indicate that while many childhood SLD diagnoses are supported by contemporaneous academic impairment, that impairment does not always persist into adulthood. These results underscore the importance of distinguishing diagnostic accuracy from diagnostic stability and highlight the need for careful reassessment of learning difficulties in postsecondary contexts rather than reliance on childhood diagnoses alone.

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Introduction

Specific learning disabilities (LDs), referred to as Specific Learning Disorders (SLDs) in the Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5; American Psychiatric Association [APA], American Psychiatric Association, 2013; APA, 2022), are neurodevelopmental disorders characterized by persistent difficulties in reading, written expression, and/or mathematics that are substantially below expectations for age and educational exposure. Prevalence estimates suggest that between 5% and 15% of school-aged children meet criteria for a SLD, with impairments in reading representing the most common presentation (APA, 2022). Although SLDs are widely conceptualized as life-long conditions, there remains considerable variability in how they are defined, identified, and documented across developmental periods and educational systems.

The term “LD” is a broad, umbrella term used by both the educational and legal systems in Canada, while

“SLD” is a specific medical term used for a clinical diagnosis (APA, 2022). As clinician preference or the position of those diagnosing/identifying differs, most childhood documentation used the term LD while other reports used SLD. For the purpose of this paper, both terms are interpreted and used interchangeably.

Historically, definitions of LDs have varied substantially, contributing to ongoing ambiguity regarding diagnostic boundaries. Early conceptualizations emphasized deficits in psychological processes affecting language and academic learning (e.g., Kirk, 1963; Shah et al., 2019), whereas later frameworks, including the DSM-5, emphasized persistent academic impairment relative to age-matched peers, with onset during the school years (APA, 2013; 2022). Despite these refinements, there remains no universally applied operational standard for diagnosing SLDs, particularly in applied educational and clinical contexts (Hajovsky et al., 2025; Harrison & Holmes, 2012; Maki & Adams, 2020; Miciak et al., 2014). This lack of consensus has

important implications for diagnostic accuracy, comparability across settings, and the long-term stability of diagnoses.

SLDs are most commonly first identified in childhood, often within school systems where the primary goal is educational support rather than diagnostic precision. Advocacy organizations and professional bodies frequently assert that SLDs represent lifelong conditions that warrant ongoing academic accommodations into adulthood, even when early interventions have been provided (e.g., Baker, 2023; Bonner, 2024; Canadian Psychological Association, 2015; Learning Disabilities Association of Canada, 2024). At the same time, adult and postsecondary diagnostic contexts impose different expectations, including the need for current documentation of functional impairment, standardized test data, and adherence to accepted diagnostic nomenclature (Gerber, 2011; Gregg et al., 2006; Harrison & Holmes, 2012). These differing expectations raise critical questions about whether childhood diagnoses reflect enduring neurodevelopmental disorders or whether they instead capture developmentally limited or context-dependent academic difficulties.

Central to this issue is the distinction between *diagnostic stability* and *diagnostic accuracy*. Stability refers to whether a diagnostic label remains the same over time, whereas accuracy concerns whether the original diagnosis was supported by objective evidence of impairment and consistent with accepted diagnostic criteria at the time it was made. A diagnosis may be stable yet inaccurate if it is repeatedly reaffirmed without adequate evidentiary support, or unstable yet accurate if early academic difficulties resolve or change as development and educational demands evolve. Failure to distinguish between these constructs has contributed to conceptual confusion in the SLD literature.

Empirical research examining the long-term stability of SLD diagnoses remains limited. Available evidence suggests that early-identified academic difficulties, particularly in reading, do not always persist. Longitudinal studies have demonstrated that a substantial proportion of children identified with reading difficulties in early grades no longer meet diagnostic criteria several years later (Badian, 1999; Shaywitz et al., 1992; Torppa et al., 2015). Torppa et al. (2015), for example, documented both late-emerging and resolving dyslexia across development, highlighting heterogeneity in learning trajectories. These findings challenge assumptions that early identification necessarily reflects permanent impairment.

Research further suggests that the apparent stability of SLD diagnoses may be strongly influenced by the quality of the initial assessment. Rosenblum et al. (2010) demonstrated that less comprehensive childhood

assessment reports were significantly associated with changes in diagnosis upon reevaluation, whereas more comprehensive assessments were associated with greater diagnostic consistency. Importantly, this work also identified widespread departures from recommended assessment practices, including the absence of clear diagnostic statements and failure to assess key cognitive processes.

Concerns regarding diagnostic accuracy are reinforced by a broader literature documenting frequent departures from accepted diagnostic criteria in both childhood and adult assessments. Clinicians have been shown to rely on nonspecific labels, IQ-achievement discrepancy models, or subjective indicators of difficulty while failing to document objective academic impairment (Dombrowski et al., 2004; Fletcher & Miciak, 2017; Harrison, 2017; Harrison et al., 2021; Sparks & Lovett, 2009). As a result, many individuals labeled as having a SLD do not demonstrate performance below normative thresholds on standardized achievement measures (Harrison et al., 2021; Sparks & Lovett, 2009; Weis et al., 2016). Additionally, childhood reports frequently include diagnostic labels that do not correspond to any recognized nomenclature (e.g., learning disabilities in processing speed or working memory; Rosenblum et al., 2010).

These issues take on particular importance at the postsecondary level, where institutions are increasingly asked to rely on childhood documentation to justify academic accommodations. When diagnoses are vague, unsupported, or outdated, accommodations may be granted in the absence of current functional impairment, raising concerns about construct validity, fairness, and the appropriate allocation of resources. Conversely, individuals with genuine but previously undocumented impairments may be under-identified if early assessments were incomplete or poorly conducted.

Understanding the stability and accuracy of SLD diagnoses from childhood into young adulthood is therefore essential for multiple reasons. First, it informs whether reassessment should be considered routine at key developmental transitions. Second, it clarifies the extent to which childhood diagnoses can be assumed to reflect enduring neurodevelopmental disorders rather than transient academic difficulties or context-dependent learning problems. Third, it provides empirical grounding for policies governing eligibility for accommodations in adult educational or high-stakes test settings, including whether childhood diagnoses alone should be considered sufficient or whether reassessment and current evidence of impairment are warranted.

The primary objective of the present study was to examine the stability and accuracy of SLD diagnoses from childhood into young adulthood in a large, clinically referred postsecondary sample. Specifically, the study evaluated whether childhood diagnoses conformed to accepted diagnostic criteria, whether objective evidence of academic impairment was documented, and whether the same impairments were evident upon adult reassessment. Secondary objectives included examining domain-specific patterns of stability (reading, written expression, mathematics), evaluating the role of assessment comprehensiveness in diagnostic outcomes, and characterizing the prevalence of nonspecific and nonstandard diagnostic labels in childhood documentation.

Method

Participants

This study employed archival data from consecutively assessed postsecondary students who were referred to a university-based regional psychological assessment center for a comprehensive psychoeducational or neuropsychological evaluation between 2016 and 2025. All individuals were seeking either confirmation of a previously identified learning disability or updated documentation to support academic accommodations for their LD. Any students who agreed to have their anonymous data used for subsequent research were included in the archival database employed in the present study, and ethics approval was provided by the General Research and Ethics Board at Queen's University. Cases eligible for inclusion were those in which the client had undergone at least one prior psychological, psychoeducational, or neuropsychological assessment during childhood or adolescence and for which a copy of the earlier assessment report was available for review in the archived file. Cases were excluded if no copy of the prior assessment report was available in the case file or if the childhood report was incomplete to the extent that diagnostic conclusions could not be evaluated (e.g., missing the diagnostic page and all test data). One additional case was excluded because the study design required that the most recent pre-adult assessment document a diagnosis of SLD in order to evaluate diagnostic stability from childhood into adulthood. In this instance, while the initial (early childhood) school-based assessment "identified" a learning disability, the most recent prior assessment (at age 14) did not diagnose SLD/LD, nor was SLD subsequently confirmed in the adult reassessment conducted at the regional assessment center.

The final sample consisted of 325 students who were assessed in childhood or adolescence and referred for a postsecondary reassessment and were documented as having a SLD diagnosis or school-board identification in their most recent childhood assessment or in the adult-aged assessment they completed at a university-based regional assessment center. Inclusion required documentation indicating that a LD or SLD diagnosis had been assigned in childhood, regardless of assessment comprehensiveness.

Participants were enrolled in either university (institutions that focus on academic and theoretical education, offering undergraduate (typically 3–4 years) and graduate degrees) ($n = 149$) or community college (institutions that emphasize practical, career-oriented training and typically offer certificates (1 year), diplomas (2–3 years), and occasionally, applied degrees (2–3 years)) ($n = 176$) programs at the time of their adult reassessment. Demographic variables coded included gender, age at time of childhood assessment, age at follow-up assessment, and educational setting at follow-up. In cases where multiple childhood assessments had been completed, information from the most recent assessment conducted prior to the adult reassessment was used for primary analyses, as this report would have been the one most likely relied upon for educational decision-making and accommodation provision pending updated documentation.

Measures and coding framework

Because this study was archival in nature and involved heterogeneous assessment batteries administered over multiple decades by different practitioners, no single standardized test battery was required for inclusion. Instead, assessment reports were coded according to test domains and diagnostic features relevant to accepted diagnostic criteria for SLD as outlined in the DSM-IV (APA, 1994), DSM-5 (APA, 2013) and DSM-5-TR (APA, 2022). Coding included the following:

Cognitive, Academic, and Behavioral Measures

For both childhood and adult assessments, the presence of standardized measures of cognitive functioning, academic achievement, and personality, behavior, or emotional functioning were coded. Measures of cognitive functioning were subdivided into the following classification categories: Intellectual functioning, speed of information processing, and auditory-verbal measures of phonological processing.

Intellectual functioning was defined as the administration of a standardized measure of general

cognitive ability (e.g., Wechsler scales or comparable instruments). Tests of auditory-verbal phonological processing skills were defined as specialized tests measuring elision and sound manipulation skills (e.g., the Comprehensive Test of Phonological Processing, Wagner et al., 1999). Phonological processing was considered separately due to its well-established theoretical and empirical role in reading development and dyslexia (e.g., reading disability research). It was not subsumed under a broader “academic achievement” construct to preserve conceptual specificity. Additionally, subtests that simply measured pseudo-word decoding as part of an omnibus achievement test battery were not deemed specific tests of phonological processing. These were included in the academic achievement-reading domain as decoding pseudo-words is often impaired in individuals with reading disorders (Nielsen et al., 2016).

Information processing tests were coded based on standardized indices or subtests explicitly identified as measures of processing speed within the test manual (e.g., Processing Speed Index or timed symbol-based tasks on measures like the Wechsler Intelligence Scale for Children, Fourth Edition, Wechsler, 2003). Academic achievement measures were coded as present if the assessment included any standardized tests of reading, written expression, spelling, and/or mathematics (e.g., Wechsler Individual Achievement Test, Third Edition, Wechsler, 2009).

For childhood assessments, measures of personality, behavior, or emotional functioning included student, parent and/or teacher questionnaires that evaluate general personality, behavior, and/or emotional functioning (e.g., the Behavior Assessment System for Children, Reynolds & Kamphaus, 1992), projective personality methods (e.g., the Rorschach), or measures that address specific behavioral concerns (e.g., the Behavior Rating Inventory of Executive Function, Gioia et al., 2000). For adult assessments, we coded whether the assessment included self-report measures of these same constructs (e.g., the Personality Assessment Inventory, Morey, 1991).

When multiple indices of intellectual functioning were reported (e.g., Full Scale IQ and General Ability Index on the Wechsler Intelligence Scale for Children (Wechsler, 2003, 2014), clinical interpretation followed standard practice: overall intellectual functioning was considered broadly average if either the Full Scale IQ or General Ability Index fell within the statistical average range or higher (e.g., above the 16th percentile).

Diagnostic classification

Diagnoses from childhood reports were coded verbatim and then classified into one of four categories: (a) DSM-

consistent SLD diagnoses specifying an academic domain (reading, written expression, mathematics, alone or in combination), (b) non-specific or vague LD diagnoses (e.g., “learning disability” without specification), and (c) nonstandard or non-recognized diagnoses not included in accepted diagnostic nomenclature (e.g., “learning disability in working memory,” “learning disability in processing speed”). For cases in which the diagnosis consisted solely of a school-board identification (e.g., “meets criteria for identification as having a communication exceptionality-learning disability”) without a formal psychological diagnosis provided in the report, these were coded separately (i.e., a fourth category) and not treated as diagnostic determinations.

Adult follow-up diagnoses were coded using the same framework, allowing for direct comparison of diagnostic stability across time. Follow-up diagnoses were all made using the DSM-5 (2013) criteria for SLD. Additionally, follow-up diagnoses were made exclusively by licensed clinical, educational, or neuropsychologists, as opposed to the variability found in the previous childhood assessments.

Impairment thresholds

To ensure consistent classification across tests and eras, objective cutoffs were applied uniformly. Based on impairment criteria codified in DSM-5 and DSM-5-TR, scores were coded as indicative of impairment if they fell at or below the 16th percentile (standard score ≤ 85 or scaled score ≤ 7). Scores at or above the 17th percentile (standard score ≥ 86 or scaled score ≥ 8) were coded as within normal limits. These thresholds reflect standard psychometric conventions for defining impaired performance and were selected to prioritize reproducibility and consistency across examiners, rather than reliance on clinical judgment alone. When reports described performance qualitatively (e.g., “average”) without reporting exact scores, these data were coded as non-impaired but flagged as imprecise.

Procedure

All eligible files were identified through the center’s archival database, after which we retained only those cases in which previous assessments had been undertaken and the documentation provided at reassessment.

Each case was independently reviewed by three members of the research team trained in psychoeducational assessment and diagnostic criteria for SLD. Coding focused on the presence or absence of key assessment components (cognitive, academic and behavioral measures), diagnostic statements, and objective evidence of impairment (i.e., achievement test scores

below the 17th percentile). Discrepancies in coding were resolved through consensus discussion.

The comprehensiveness of childhood assessments was coded using criteria adapted from Rosenblum et al. (2010). Specifically, reports were coded for whether they included standardized measures of cognitive functioning, academic achievement, and personality, behavior, or emotional functioning, as well as whether a clear diagnostic statement consistent with accepted nomenclature was provided and whether the assessment was completed by a qualified professional. Psychological or emotional measures used to evaluate exclusionary factors were also noted when present, as was the administration of performance and/or symptom validity tests.

For adult reassessments, similar variables were coded, including date of assessment, age at assessment, educational setting, test domains assessed, and diagnostic outcome. Performance and symptom validity testing was also noted when reported ($n = 324$), consistent with standard practice at the assessment center.

Data integrity and missing information

In some childhood reports, tests were listed without accompanying scores or were described only qualitatively. In such cases, impairment status could not be definitively established and was coded as missing for that variable. Reports with missing pages were retained if sufficient information was available to determine test domains assessed and diagnostic conclusions; otherwise, the case was excluded. All coding decisions were documented to allow for transparency and replication.

Analytic plan

Analyses were designed to evaluate both the *stability* and the *accuracy* of SLD diagnoses from childhood to young adulthood.

Diagnostic stability

Diagnostic stability was examined by comparing childhood and adult diagnostic outcomes at both the global and domain-specific levels. At the global level, diagnoses were classified as stable if a LD or SLD diagnosis was present at both time points, regardless of domain. At the domain-specific level, stability was evaluated separately for reading, written expression, and/or mathematics by examining whether the same domain(s) of impairment were identified in both childhood and adult assessments.

Patterns of diagnostic change were coded into the following categories: (a) stable diagnosis (same

diagnostic status across assessments), (b) resolution (most recent childhood diagnosis not supported in adulthood), (c) late identification (no childhood diagnosis but diagnosis supported in adulthood), and (d) diagnostic shift (change in identified academic domain). Frequencies of each pattern were calculated to characterize developmental trajectories.

Diagnostic accuracy

Accuracy of childhood diagnoses was evaluated by determining whether the diagnostic label provided was supported by objective evidence of impairment at the time of the childhood assessment. A diagnosis was considered accurate if the report documented standardized achievement scores at or below the 16th percentile in the relevant academic domain and if the diagnostic label conformed to accepted nomenclature. Diagnoses that lacked objective evidence of impairment, relied solely on nonspecific labels, or used non-recognized diagnostic terminology were coded as inaccurate/unsupported.

Role of assessment comprehensiveness

To evaluate whether assessment quality was associated with diagnostic stability, childhood reports were classified according to their level of comprehensiveness, based on the presence of standardized measures of cognitive functioning, academic achievement, and behavioral measures, as well as a clear diagnostic statement. Rates of diagnostic stability and accuracy were compared across levels of assessment comprehensiveness.

Descriptive and inferential analyses

Descriptive statistics were used to summarize sample characteristics, diagnostic categories, and assessment features. Where appropriate, chi-square analyses were conducted to examine associations between assessment comprehensiveness, diagnostic accuracy, and diagnostic stability. Effect sizes were reported to facilitate interpretation. All analyses were conducted using standard statistical software, with alpha set at .05.

Results

Characteristics of childhood assessment documentation

Mean age at childhood assessment was 10.58 years ($SD = 2.99$; median = 10 years). Mean age at adult assessment was 19.55 years (median age = 19 years). The sample included 147 males, 173 females, and 6 non-binary/other. Consistent with the study aims, analyses examined diagnostic accuracy (i.e., whether childhood diagnoses were supported by contemporaneous

objective evidence of academic impairment) separately from diagnostic stability (i.e., retention of diagnosis across time). Descriptive analyses indicated that most childhood assessment reports contained core structural components typically expected of psychoeducational evaluations. However, the presence of these structural elements did not consistently translate into clear or diagnostically specific conclusions (see below). As shown in Table 1, a referral question was documented in 96.9% of reports, and background history information was included in 92.3%, with multiple sources of background information provided in 87.4% of cases. Behavioral observations (93.2%), a summary or conclusion section (96.6%), and recommendations (97.5%) were also commonly present. While most initial diagnostic assessments were completed or supervised by a licensed psychologist (91.4%), a small proportion were completed by a medical doctor (1.2%) or by non-regulated individuals (7.4%) who were not authorized to provide formal SLD diagnoses within their jurisdiction.

Standardized testing was reported in the vast majority of childhood assessments. Nearly all reports included measures of intellectual functioning (98.5%), academic achievement (96.9%), and information processing (98.8%). However, tests of phonological processing were included in fewer than half of reports (39.4%), and measures of personality, behavior, or emotional functioning were included in approximately two-thirds of cases (66.5%). Performance validity tests (PVTs) were rarely administered in childhood (7.7%), whereas symptom validity measures were reported in 45.4% of assessments and were limited to parent- or teacher-completed instruments. Notably, despite SLD being defined by impaired academic achievement, 10 of 325 childhood assessments (3.1%) were assigned a SLD diagnosis without administration of any standardized measures of academic achievement. All such cases were completed

by either a medical doctor ($n = 3$) or an unregulated assessor ($n = 7$).

Despite the frequent inclusion of testing, only 52.3% of childhood reports contained a clear diagnostic statement in which the examiner explicitly specified a SLD in reading, writing, and/or mathematics. The remaining reports used vague or nonstandard diagnostic labels or classified students as meeting school board criteria for identification as having a “communications exceptionality – learning disability.” This highlights substantial ambiguity in diagnostic communication. Most students demonstrated broadly average intellectual functioning, with 84.6% scoring in the average range or above on measures of general cognitive ability. One student diagnosed with a “general learning disability” had both full scale and GAI scores below the 2nd percentile. This student was retained because they had been identified in the elementary school system as having a communications exceptionality-learning disability and had come to college expecting to receive the same accommodations as had been provided in high school.

Accuracy of childhood learning disability diagnoses

The accuracy of childhood SLD diagnoses was evaluated by examining whether diagnostic labels were supported by objective evidence of academic impairment in the corresponding domain (e.g., diagnosed with a SLD in reading and had objective evidence of impairment in some area of reading). Across academic areas, a substantial minority of students diagnosed with a SLD did not demonstrate standardized achievement scores at or below the 16th percentile in the academic domain associated with the diagnosis (see Table 2). As noted above, 3.1% of students were diagnosed with a SLD despite being given no achievement tests at all.

For reading, 86.2% of students diagnosed with a reading-based SLD demonstrated at least one objective reading deficit (i.e., a deficit in at least one reading area measured), whereas 12.2% did not show evidence of impairment and in 1.6% of cases, the individuals were not given any measures of reading skills at all or the score was missing/not reported. The association between a childhood diagnosis of reading disability and objective reading impairment was statistically significant, $\chi^2(2, N = 325) = 54.33$, $p < .001$ (Cramer's $V = .41$), indicating moderate alignment between diagnostic labeling and objective evidence. However, fewer than half (41.5%) of students diagnosed with a reading disability demonstrated a deficit in phonological

Table 1. Characteristics of childhood assessment documentation ($N = 325$).

Assessment Feature	<i>n</i>	%
Information processing assessed	321	98.8
Intellectual functioning assessed	320	98.5
Recommendations provided	317	97.5
Referral question stated	315	96.9
Academic achievement assessed	315	96.9
Summary/conclusion section	314	96.6
Behavioral observations	303	93.2
Background information included	300	92.3
Completed by licensed provider	297	91.4
Multiple background sources	284	87.4
Emotional/behavioral measures	216	66.5
Clear diagnostic statement	170	52.3
Symptom validity testing	149	45.8
Phonological processing assessed	128	39.4
Performance validity testing	25	7.7

Note. Percentages are based on the full sample.

Table 2. Accuracy of childhood learning disability diagnoses by academic domain.

Domain	Diagnosed (<i>n</i>)	Impairment Present <i>n</i> (%)	Impairment Absent <i>n</i> (%)	Impairment Missing <i>n</i> (%)	χ^2	Effect Size Cramer's <i>V</i>
Reading	123	106 (86.2)	15 (12.2)	2 (1.6)	54.33***	.41
Writing	136	111 (81.6)	22 (16.2)	3 (2.2)	22.22***	.27
Math	81	72 (88.9)	9 (11.1)	0 (0.0)	60.14***	.43

Note. Objective impairment defined as performance $\leq$ 16th percentile. Impairment Missing indicates that no test of academic domain was given/available. *** $p < .001$.

processing, despite its central role in contemporary models of reading disorder (Vellutino et al., 2004).

A similar pattern was observed for writing and mathematics. Among students diagnosed with a writing disability, 81.6% demonstrated objective writing impairment, whereas 16.2% did not. Additionally, 2.2% of cases diagnosed with a SLD in writing were not given any measures of writing skills at all or the score was missing/not reported. The association between childhood diagnosis and objective impairment was statistically significant, χ^2 (2, $N = 325$) = 28.07, $p < .001$ (Cramer's $V = .29$). For mathematics, 88.9% of students diagnosed with a math disability demonstrated objective impairment, while 11.1% did not, χ^2 (2, $N = 325$) = 60.14, $p < .001$ (Cramer's $V = .43$) (see Table 2).

A diagnosis of nonverbal learning disability (NVLD) was assigned in nine childhood reports. Although NVLD is not a DSM diagnosis, it has been described in the research literature as a syndrome characterized by intact basic reading and spelling skills alongside marked impairment in mathematics and specific neuropsychological deficits (especially visuospatial) requiring specialized assessment (Casey, 2012; Fisher et al., 2022). In all nine cases, the neuropsychological measures required to support this nonstandard diagnosis were absent. Furthermore, across these cases, mathematical skills were either within normal limits ($n = 8$) or not assessed ($n = 1$). Contrary to the defining features of NVLD, five cases demonstrated impaired reading skills and three demonstrated impaired spelling skills. In one case, the diagnosis appeared to be based solely on a discrepancy between verbal and nonverbal intellectual abilities, despite both scores falling within the average range.

Diagnostic stability from childhood to young adulthood

Diagnostic stability was examined by comparing childhood SLD diagnoses with diagnoses assigned at adult reassessment. Stability was evaluated separately for reading, written expression, and mathematics (see Table 3).

For reading, 59.3% of students diagnosed with a reading disability in childhood continued to receive a reading disability diagnosis in adulthood, whereas 40.7% did not. This association was statistically significant, χ^2 (1, $N = 325$) = 41.43, $p < .001$, with a moderate effect size ($\phi = .36$).

For writing, 59.6% of students with a childhood writing diagnosis retained this diagnosis in adulthood, χ^2 (1, $N = 325$) = 25.91, $p < .001$ ($\phi = .28$). For mathematics, diagnostic stability was similar, with 59.3% of childhood math diagnoses persisting into adulthood, χ^2 (1, $N = 325$) = 58.01, $p < .001$ ($\phi = .42$). Across academic domains, approximately 40% of childhood SLD diagnoses were not confirmed at adult reassessment.

For those diagnosed with NVLD, follow up testing failed to confirm this diagnosis for any of the students. Two were diagnosed with a math disability, one with a disability in reading, writing, and math, one with a SLD in reading, and five were given no diagnosis upon retesting.

Of students diagnosed with any form of LD in childhood (including LD-Not Otherwise Specified), 190 (60.9%) were confirmed to have a LD of some type at adult reassessment, whereas 122 (39.1%) were not. Diagnostic stability at this global level was therefore almost equal to domain-specific stability, indicating that many individuals continued to meet criteria for a SLD of some type in adulthood even when the specific

Table 3. Diagnostic stability from childhood to young adulthood by domain.

Domain	Retained <i>n</i> (%)	Not Retained <i>n</i> (%)	χ^2	Effect Size (ϕ)
Reading	73 (59.3)	50 (40.7)	41.43***	.36
Writing	81 (59.6)	55 (40.4)	25.91***	.28
Math	48 (59.3)	33 (40.7)	58.01***	.42

Note. Stability defined as same domain-specific diagnosis at both time points. *** $p < .001$.

academic domain differed from the childhood diagnosis. A subset of students met criteria for a SLD in more than one academic domain at childhood assessment. Exploratory analyses comparing students with single-domain versus multi-domain diagnoses did not reveal meaningful differences in diagnostic accuracy or longitudinal stability. At follow-up, however, a substantial proportion of all previously labeled students were assigned no diagnosis ($n = 41$), an unspecified SLD ($n = 3$), or a diagnosis unrelated to SLD (e.g., anxiety or attention-deficit/hyperactivity disorder; $n = 79$).

In contrast, 13 students who did not receive a SLD diagnosis in their last childhood assessment (but were nevertheless provided with academic accommodations for learning problems) were diagnosed with a SLD at adult reassessment. Of these, reviews of prior documentation suggested that these cases reflect false-negative childhood evaluations rather than adult-onset SLDs. Five had received a prior diagnosis other than a SLD, and eight had received no diagnosis. Among the latter group, three had been evaluated by professionals not licensed to diagnose SLDs, and one had been diagnosed by a physician without the administration of any standardized intellectual or academic achievement testing.

For 11 of the 13 students who did not receive a previous SLD diagnosis (excluding two who had received no academic testing), objective academic impairment was documented in at least one academic domain at the time of the most recent childhood or adolescent assessment. Upon reassessment, these previously documented areas of impairment remained, and a SLD diagnosis was made. Collectively, these findings indicate that apparent late identification primarily reflects limitations of earlier assessment practices rather than the emergence of new SLDs in adulthood.

To examine whether characteristics of childhood assessment reports predicted diagnostic stability from childhood to adulthood, a binary logistic regression analysis was conducted. Exploratory analyses did not indicate meaningful differences in diagnostic accuracy or stability as a function of gender; therefore, subsequent analyses were conducted across the full sample. Diagnostic stability served as the dependent variable, and predictors included the presence of referral information, background history, multiple sources of

background information, behavioral observations, test scores or percentiles, interpretation of test results, assessment of cognitive, academic, and behavioral functioning (as defined above), a clear diagnostic statement, a summary or conclusion section, recommendations, if the examiner was a licensed psychologist, and if there was the presence of any academic deficit.

The overall model identified two assessment features that significantly predicted diagnostic stability. Any academic deficit was associated with higher odds of diagnostic stability ($B = 1.916$, $SE = 0.437$, $Wald = 19.238$, $p < .001$) corresponding to an odds ratio of 6.79. Similarly, reports that included a measure of phonological processing were more likely to yield a stable diagnosis over time ($B = 0.697$, $SE = 0.279$, $Wald = 6.233$, $p = .013$), with an odds ratio of 2.01. No other report characteristics significantly predicted diagnostic stability.

Educational setting at follow-up

Comparisons between students enrolled in college versus university programs at follow-up revealed significant differences in the prevalence of adult SLD diagnoses (see Table 4). College students were more likely than university students to receive diagnoses of reading, writing, and mathematics SLD in adulthood (all $ps \leq .001$), with small-to-moderate effect sizes ($\phi = .18-.25$). In contrast, there were no significant differences between college and university students in the rates of childhood SLD diagnoses across academic domains, suggesting that group differences emerged primarily at the point of adult reassessment rather than reflecting differential identification in childhood.

Diagnostic era: DSM-IV versus DSM-5

Childhood SLD diagnoses were examined as a function of diagnostic era, with 220 students receiving their initial diagnosis prior to the implementation of DSM-5 (i.e., DSM-IV era) and 105 receiving their initial diagnosis under DSM-5 criteria.

Students diagnosed during the DSM-IV era were more likely to have been assigned childhood SLD diagnoses that were not supported by clear objective

Table 4. Adult learning disability diagnoses by educational setting.

Domain	College <i>n</i> (%)	University <i>n</i> (%)	χ^2	Effect Size (ϕ)
Reading	85 (48.3)	36 (24.2)	20.11***	.25
Writing	90 (51.1)	50 (33.6)	10.17**	.18
Math	61 (34.7)	26 (17.4)	12.19***	.19

Note. Percentages calculated within educational settings. ** $p < .01$, *** $p < .001$.

Table 5. Examples of non-standard childhood learning disability diagnostic labels.

Diagnostic Theme	Example Labels
Processing-only labels	"Learning disability in processing speed"; "Learning disability in working memory"; "Learning disability in auditory processing"; "Learning disability in visual processing"
Hybrid academic-cognitive labels	"Learning disability in reading and executive functioning"; "Learning disability in written expression and processing speed"; "Learning disability in mathematics and working memory"
Vague or non-specific labels	"General learning disability"; "Nonverbal learning disability (without visuospatial impairment)"; "Learning disability NOS"
Invented or non-standard constructs	"Visual dyslexia"; "Language-based learning disorder"; "Learning efficiency disorder"; "Symbol processing disorder"
Skill-based or compensatory labels	"Study skills learning disability"; "Academic efficiency deficit"; "Learning disability with accommodations recommended only"

Note. Labels reflect terminology used in childhood assessment reports. All labels were coded as nonstandard for analytic purposes. Labels are anonymized and grouped thematically. Examples are provided for descriptive purposes only and are not exhaustive.

evidence of academic impairment. Specifically, 179 of 220 students (84%) demonstrated at least one documented academic deficit at the time of initial assessment (reading: $n = 127$; writing: $n = 132$; math: $n = 115$, with some students having impairment in more than one academic area), whereas 34 students (16%) showed no objective impairment in any academic domain despite receiving a SLD diagnosis. In addition, just over half of DSM-IV – era diagnoses involved nonstandard or idiosyncratic diagnostic labels ($n = 119$; 54.3%).

In contrast, diagnoses made under DSM-5 criteria were more consistently supported by documented academic impairment. Among students diagnosed post-DSM-5, 96 of 105 (91.4%) demonstrated at least one objective academic deficit at baseline (reading: $n = 69$; writing: $n = 80$; math: $n = 53$, with some students having impairment in more than one academic area), whereas only 8 students (7.6%) showed no impairment in any academic area. The use of nonstandard diagnostic labels was also substantially lower in the DSM-5 cohort, although still present in just over one-quarter of the assessment reports ($n = 28$; 26.7%).

Despite these differences in diagnostic characteristics, rates of diagnostic confirmation at adult reassessment did not differ significantly between diagnostic eras. SLD diagnoses were reconfirmed in adulthood for 58.2% initially diagnosed under DSM-IV criteria and for 67% of students diagnosed under DSM-5 criteria.

Nature of diagnostic labels

Analysis of childhood assessment reports revealed substantial heterogeneity in the diagnostic labels used to describe learning difficulties. Fifty-one initial assessments (15.7%) simply diagnosed a "learning disability" without specifying an academic domain or identifying a specific area of functional impairment. An additional 48 reports (14.8%) did not provide a formal diagnosis but instead "identified" students as meeting criteria for a communication exceptionality – learning disability, an

administrative school board classification rather than a formal clinical diagnosis.

Among the 48 students identified through this school-based process, 21 were identified by professionals who were not licensed to diagnose SLDs. Objective evidence of academic impairment was frequently absent in this group. Notably, 11 students identified with an exceptionality had no documented functional impairment in any area of reading, writing, or mathematics. Upon adult reassessment, only 21 of the 48 identified students (43.8%) met criteria for a SLD.

Beyond these cases, 31 (9.5%) additional childhood diagnoses did not correspond to any recognized DSM category (not including those diagnosed with NVLD) and instead referenced isolated cognitive processes or idiosyncratic combinations of deficits (see Table 5 for examples). In contrast, adult reassessments more consistently employed standardized, domain-specific diagnostic terminology (e.g., SLD in reading, writing, and/or mathematics). Collectively, these findings indicate substantial variability in how learning difficulties were conceptualized and communicated in childhood assessments, with important implications for diagnostic clarity and continuity of care.

Discussion

The present study examined both the accuracy and stability of SLD/LD diagnoses from childhood into young adulthood in a clinically referred postsecondary sample. By explicitly distinguishing diagnostic accuracy (i.e., whether childhood diagnoses were supported by objective evidence of impairment at the time they were made) from diagnostic stability (i.e., whether the same diagnoses persisted across developmental periods), this study addresses a long-standing conceptual ambiguity in the SLD literature. The findings indicate that although most childhood SLD diagnoses were supported by contemporaneous objective evidence of academic impairment, diagnostic stability into adulthood was only moderate, with approximately 40% of

childhood diagnoses not confirmed upon adult reassessment. Together, these results underscore the importance of reassessment at key developmental transitions and caution against assuming that childhood diagnoses necessarily reflect lifelong academic impairment.

Diagnostic accuracy versus diagnostic stability

A central contribution of this study is its demonstration that diagnostic accuracy and diagnostic stability are empirically and conceptually distinct. Across academic domains, the majority of childhood SLD diagnoses were supported by objective evidence of academic impairment, suggesting that many diagnoses were reasonable within the developmental and educational context in which they were made. At the same time, a substantial proportion of these diagnoses did not persist into adulthood, indicating that accurate diagnoses at one point in development may not reflect permanent or lifelong impairment.

This pattern challenges long held clinical assumptions that equate childhood academic difficulty with immutable SLDs. Developmental change, compensatory skill acquisition, targeted intervention, and shifting academic demands may all contribute to changes in functional status over time. Importantly, diagnostic instability does not necessarily imply that childhood diagnoses were incorrect; rather, it suggests that learning may follow heterogeneous developmental trajectories, consistent with prior longitudinal findings in reading and mathematics (Badian, 1999; Rosenblum et al., 2010; Torppa et al., 2015).

Assessment practices and diagnostic durability

Consistent with prior research (Rosenblum et al., 2010), the present findings highlight the role of assessment practices in shaping diagnostic outcomes. Although most childhood assessments included measures of intellectual functioning and academic achievement, fewer than half assessed essential foundational skills like phonological processing when diagnosing a reading disability, despite its central role in contemporary models of reading disorder (Vellutino et al., 2004). Moreover, only approximately half of reports contained a clear diagnostic statement using accepted nomenclature.

Regression analyses indicated that overall report comprehensiveness was not predictive of diagnostic stability. Instead, stability was specifically associated with the presence of normatively defined academic impairment in at least one domain and with inclusion of a phonological processing measure. Reports that documented objective academic impairment and assessed

phonological processing were more likely to yield diagnoses that were confirmed at follow-up. This latter finding may reflect the limited use of this diagnostically sensitive measure in many childhood evaluations rather than the unique importance of any single test component. Nonetheless, the results suggest that diagnostic durability depends less on the sheer breadth of assessment than on the documentation of meaningful functional impairment and the inclusion of conceptually central measures at the time of initial diagnosis.

Notably, only about two-thirds of childhood assessments included any measures of emotional, behavioral, or personality functioning, limiting the ability to evaluate alternative explanations for academic underachievement such as anxiety, mood disturbance, attention problems, or broader psychosocial factors. Consequently, in a substantial minority of cases, SLD diagnoses were assigned without systematically ruling out non-cognitive contributors to academic difficulty.

Together, these findings raise concerns about the interpretability and long-term utility of some childhood assessment documentation. Diagnoses that lack clarity, omit conceptually relevant measures, or fail to adequately consider alternative explanations for academic difficulties may be more vulnerable to revision or non-confirmation when individuals are reassessed using contemporary standards. From a clinical perspective, comprehensive assessment is not merely a matter of thoroughness but directly influences the durability and credibility of diagnostic conclusions across developmental periods and educational contexts.

Assessment validity and the absence of performance validity testing

Another important limitation of the childhood assessments reviewed concerns the absence of any formal evaluation of performance validity. Very few childhood psychoeducational assessments included performance validity tests or other objective indicators of test-taking effort. This pattern is consistent with prior reports indicating that, despite strong empirical support for validity testing in pediatric assessment (e.g., Clegg et al., 2021; Tonks et al., 2020), such measures are rarely incorporated into school-based psychoeducational evaluations (DeRight & Carone, 2013).

Concerns regarding the influence of effort and engagement on SLD diagnosis are longstanding. Adelman et al. (1989) demonstrated that a substantial proportion of adolescents diagnosed with reading disability were capable of adequate reading performance when appropriately motivated. Nearly 80% of participants previously classified as having a reading disability

demonstrated improved performance under conditions designed to enhance engagement, suggesting that earlier low scores reflected disengagement or avoidance rather than fixed academic incapacity. These authors cautioned against making disability diagnoses based on data obtained under conditions of low motivation and emphasized the importance of assessment practices that promote engagement.

Because performance credibility was rarely evaluated in childhood assessments, confidence in the interpretability and long-term durability of these diagnoses is constrained. A substantial literature demonstrates that clinicians relying solely on clinical judgment are often unable to reliably detect exaggerated or inconsistent responding (Dandachi-FitzGerald et al., 2017; Guilmette, 2013). Although the prevalence of noncredible performance in pediatric psychoeducational contexts is unknown, experimental and case-based evidence suggests that low effort or disengagement can meaningfully distort performance on commonly used academic measures, particularly fluency-based tasks (Kirk et al., 2020; Kirkwood et al., 2010).

In this context, diagnostic instability may reflect variability in motivation or engagement at the time of the original assessment rather than true resolution of a SLD. Without objective indicators of performance validity, it is not possible to determine whether childhood academic difficulties reflected enduring impairment or transient contextual factors, a limitation that becomes particularly salient when childhood documentation is later used to justify accommodations in post-secondary settings.

Non-standard and unsupported diagnoses

The prevalence of nonstandard diagnostic labels in childhood documentation further complicates diagnostic stability. A subset of reports employed vague or idiosyncratic labels (e.g., “general learning disability,” “learning disability in processing speed”) or invented labels that do not correspond to recognized DSM categories (e.g., “learning efficiency disorder”). Particularly illustrative were diagnoses of NVLD. Although NVLD has been described in the research literature as a syndrome involving specific neuropsychological profiles and marked mathematical impairment (Casey, 2012), none of the childhood assessments assigning this label included the specialized testing required to support such a diagnosis, and most failed to document impairment in mathematics. None of these NVLD diagnoses were confirmed upon adult reassessment.

These findings underscore the risks associated with applying poorly defined or nonstandard diagnostic

constructs in applied settings. When diagnostic labels lack clear operational definitions or are applied without adherence to proposed or accepted criteria, their long-term stability and clinical utility are necessarily limited, particularly when diagnostic documentation carries legal or institutional consequences.

DSM-IV versus DSM-5 diagnostic frameworks

Changes in diagnostic criteria were examined as a potential contributor to diagnostic instability. A majority of childhood assessments were conducted prior to the publication of DSM-5, when SLD diagnoses frequently relied on IQ – achievement discrepancy models and less explicit impairment thresholds. Consistent with this framework, a notable proportion of pre-DSM-5 cases demonstrated no objective academic impairment at the time of diagnosis, and non-standard or unsupported diagnostic labels were substantially more common.

In contrast, childhood assessments conducted after the publication of DSM-5 were significantly more likely to document objective academic impairment and less likely to rely on non-conforming diagnostic labels, reflecting closer alignment with contemporary diagnostic standards. Despite these differences in diagnostic practices, rates of diagnostic confirmation in adulthood did not differ significantly between pre- and post-DSM-5 cases. Taken together, these findings suggest that DSM-5 criteria improved diagnostic *specificity and documentation quality* at baseline but did not, by themselves, ensure greater long-term diagnostic stability. Thus, changes in diagnostic criteria appear to have influenced the *nature* and documentation of childhood diagnoses rather than producing uniformly greater diagnostic instability over time.

Educational identification versus clinical diagnosis

The observed heterogeneity in childhood diagnostic nomenclature also reflects broader structural differences between educational identification processes and clinical diagnostic practices. In jurisdictions such as Ontario, Canada, students may be identified as having a learning disability through school-based processes (e.g., Identification, Placement, and Review Committees) for the purpose of educational planning, without the requirement to establish a formal psychological diagnosis consistent with accepted nomenclature (Harrison et al., 2008). While appropriate for guiding school-based supports, such identification does not necessarily yield documentation that meets postsecondary or clinical standards.

More than half of students who had been identified through school-based processes as having a communication exceptionality-learning disability did not receive a SLD diagnosis at adult reassessment. This finding illustrates the limited correspondence between educational identification categories and formal clinical diagnoses, particularly when childhood documentation does not include a clear diagnostic statement or objective evidence of impairment. This pattern is consistent with prior concerns that school-based identification processes are designed to guide educational programming rather than to establish diagnoses consistent with accepted clinical nomenclature (Harrison et al., 2007, 2008). As a result, students may receive supports during childhood yet lack documentation that translates into postsecondary or clinical contexts.

Importantly, this distinction between identification and diagnosis is often poorly understood by students and their families (Harrison et al., 2008). School-based identification is frequently experienced and communicated as a “diagnosis,” despite its administrative purpose and differing evidentiary standards. As a result, many students enter postsecondary education expecting that prior identification will confer continued eligibility for accommodations, only to encounter requirements for formal diagnostic documentation and current evidence of functional impairment. This mismatch between educational identification and clinical diagnostic standards likely contributes to confusion, frustration, and perceptions of inconsistency when accommodations are reassessed in adulthood (Harrison et al., 2007).

These findings highlight the importance of distinguishing educational identification from clinical diagnosis when determining eligibility for accommodations in postsecondary settings. The present findings suggest that reliance on educational identification alone may contribute to diagnostic ambiguity and instability when individuals transition to postsecondary settings, where formal diagnoses and current evidence of functional impairment are typically required. This distinction is critical for understanding why some students experience difficulty translating childhood documentation into adult accommodations, despite having received support earlier in their educational careers.

Postsecondary context and domain-general diagnostic Confirmation

Adult SLD diagnoses were confirmed more frequently among students enrolled in community college programs than among those enrolled in university programs across all academic domains, including reading, written expression, and mathematics. These differences

emerged despite comparable rates of childhood SLD diagnoses across postsecondary settings, indicating that variation in adult diagnostic confirmation cannot be attributed to differential identification earlier in development.

Further analyses demonstrated that community college and university students did not differ in the likelihood of having received a legitimate childhood diagnosis, a formal clinical assessment, or a nonstandard or school-based identification. Thus, differences in adult diagnostic confirmation were not explained by variability in the quality or legitimacy of childhood diagnostic practices across postsecondary groups.

The consistency of this pattern across academic domains suggests that postsecondary context plays a meaningful role in whether SLD are confirmed in adulthood. One potential explanation concerns the durability and evidentiary strength of childhood diagnoses themselves. As shown in the present study, a substantial minority of childhood SLD diagnoses were characterized by vague or nonstandard labels, absence of a clear diagnostic statement, or insufficient objective evidence of academic impairment. In some cases, diagnoses were assigned despite achievement scores within normal limits, and in a small but concerning subset, without any standardized academic achievement testing. Diagnostic formulations lacking objective academic data are inherently difficult to evaluate for accuracy and may be especially vulnerable to non-confirmation when reassessed using contemporary diagnostic standards.

It is therefore plausible that some students who progressed to university despite early academic difficulties either benefited from effective remediation and supports that reduced functional impairment or were initially diagnosed on the basis of incomplete or poorly operationalized assessments. In such cases, adult reassessment may appropriately fail to confirm a SLD diagnosis either because the disorder resolved with intervention, or because the original diagnostic formulation lacked sufficient empirical support or no longer met current criteria (e.g., IQ-Achievement discrepancy only).

Notably, diagnostic change should not be interpreted as error in all cases. Apparent diagnostic instability may reflect a combination of developmental improvement, successful intervention, compensatory adaptation, and initial diagnostic imprecision. Without distinguishing among these pathways, stability estimates alone risk obscuring the mechanisms underlying diagnostic change.

These findings underscore that adult reassessment evaluates current measurable academic performance

and functional impairment rather than simply reaffirming a historical diagnosis. Although basic academic skills themselves are not context-dependent, whether weaknesses reach diagnostic thresholds or produce functional impairment may vary as educational demands, supports, and opportunities for compensation change. This highlights the importance of reassessment at key educational transitions, particularly when diagnostic documentation is used to justify accommodations in postsecondary or high-stakes test settings.

Limitations

Several limitations warrant consideration, most notably the variability in childhood assessment practices and documentation. First, the archival nature of the study meant that assessment batteries and reporting practices varied across time and practitioners, and not all potentially relevant variables (e.g., language of instruction such as French immersion) were systematically documented. As a result, such factors could not be examined empirically. Second, the sample consisted of clinically referred postsecondary students seeking reassessment, which may limit generalizability to non-referred populations. Third, objective impairment thresholds were applied uniformly across tests and eras, which enhances consistency but may not capture more nuanced patterns of academic difficulty. Operational definitions of impairment were based on conventional psychometric thresholds and may not capture clinically meaningful but subthreshold patterns of relative weakness.

A small number of childhood diagnoses were assigned by licensed professionals without comprehensive psychoeducational assessment. These cases were retained to reflect real-world diagnostic practices and preserve ecological validity; excluding them would have artificially inflated stability estimates.

Language of instruction may also contribute to the interpretation of early reading difficulties. In a small number of cases, childhood reading disability diagnoses were made for students who had been educated exclusively in French immersion programs in the early grades and then experienced academic struggles when switched to English. Although some of these students continued to demonstrate SLDs upon adult reassessment, others did not, raising the possibility that early reading difficulties in children who have been educated primarily in a second language may, in some cases, be misinterpreted as evidence of a persistent SLD. Because information about language of instruction was not systematically documented across all childhood reports and involved

very small numbers, this issue could not be examined empirically in the present study. Future research should also examine whether the number and combination of affected academic domains influence the long-term stability of SLD diagnoses.

Implications and conclusions

Despite these limitations, the present study provides important empirical clarification regarding the long-term interpretation of SLD diagnoses. The findings indicate that while many childhood SLD diagnoses are supported by objective impairment at the time they are made, diagnostic stability into adulthood is far from universal. These results underscore the importance of distinguishing diagnostic accuracy from diagnostic stability and caution against assuming that childhood diagnoses necessarily confer lifelong impairment or entitlement to academic accommodations and supports without reassessment.

These findings also raise questions about the timing and permanence of SLD diagnoses in childhood. Given that a substantial proportion of children diagnosed with a SLD did not meet criteria upon adult reassessment, a more developmentally cautious approach may be warranted, one that emphasizes identification of academic risk and provision of targeted intervention without assuming chronicity. In some cases, delaying formal diagnostic labeling until later adolescence, when academic demands stabilize and intervention response can be evaluated, may reduce diagnostic instability while preserving access to supports through provisional identification and targeted intervention frameworks.

From a clinical and policy perspective, the findings support routine reassessment at key developmental transitions and highlight the need for clear diagnostic standards, targeted assessment practices, and careful consideration of developmental change in the identification and support of individuals with learning difficulties.

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ORCID

Allyson G. Harrison  <http://orcid.org/0000-0002-0426-2011>

Nathaniel Davin  <http://orcid.org/0000-0002-2687-4617>
 Emma Jamieson  <http://orcid.org/0009-0003-5166-9695>

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