

## **The Science Beneath the Behaviour: Why Understanding Must Come Before Intervention**

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Working with behaviour requires a special type of practitioner: a brave, open-minded one who is willing to slow down, remain curious, and look beneath what is immediately visible.

Many parents arrive in counselling hoping I can help “fix” a behaviour: school refusal, shutdown, explosive transitions, gaming, avoidance, or emotional collapse. I understand the urgency. Behaviour affects the whole family system. It disrupts mornings, work, finances, relationships, and the emotional capacity of everyone in the home.

Parents are not wrong to want answers. When a child refuses school or a teenager shuts down, it does not happen in isolation. Parents may feel scared, depleted, frustrated, embarrassed, or powerless. They may have already tried consequences, rewards, reasoning, pleading, and professional advice before they arrive in our offices.

And yet, one of the first shifts I often make with families is this:

A child or teen is not something to fix.

A child or teen is someone to understand.

This does not mean we ignore the behaviour. It means we become more accurate in how we respond to it.

When I refer to the science beneath behaviour, I am referring to the nervous system, attachment, trauma, neurodevelopment, sensory processing, executive functioning, and the body’s drive toward safety.

Behaviour is not random. It often makes sense when we understand the system it is emerging from.

## **Behaviour Is Communication**

Behaviour gets our attention because behaviour is visible. A child hiding under a desk, a teen refusing school, an adult avoiding meetings, or a partner shutting down during conflict can quickly become the focus of concern. Behaviour disrupts routines. Behaviour has consequences. Behaviour demands response.

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What is less visible is the experience underneath.

Anxiety is less visible. Sensory overwhelm is less visible. Executive functioning strain, social confusion, shame, depression, autistic burnout, ADHD-related dysregulation, attachment distress, fatigue, fear of failure, and the need for predictability can all be hidden beneath the behaviour that others are trying to stop.

The behaviour may be the loudest part of the story, and it is rarely the whole story.

As clinicians and health professionals, we are often trained to assess, plan, and intervene. Parents are often desperate for relief. Schools need attendance. Employers need participation. Families need mornings to function. All of this matters.

Yet when we move too quickly toward behaviour management, we risk missing the person beneath the presentation. The client may feel managed rather than met. The parent may feel blamed. The professional may become focused on results rather than understanding.

School refusal may communicate, “I am overwhelmed,” “I feel unsafe,” “I cannot manage the sensory, social, or academic demands,” or “I do not know how to explain what is happening inside me.”

Defiance may communicate, “I need control because I feel out of control,” “I do not understand what is expected,” “I am anxious,” or “I cannot transition this quickly.”

Gaming may communicate, “I need predictability,” “I need mastery,” “I need connection,” or “I need a place where I feel competent.”

Shutdown may communicate, “I have exceeded my capacity,” “I cannot process one more thing,” or “I need quiet, time, and safety.”

This shift matters. If we misread anxiety as opposition, we may increase pressure. If we misread sensory overwhelm as poor behaviour, we may intensify shame. If we misread shutdown as defiance, we may demand more from a nervous system that has already exceeded capacity.

Therapeutic approaches such as Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, and person-centred therapy can all be useful. Yet before any approach is applied, the clinician must first understand what the behaviour is doing for the person.

## **Presence Before Intervention**

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I often remind clinicians I supervise that presence is not passive. Presence is a disciplined clinical stance.

Presence asks us to slow down before we interpret. It asks us to listen not only to the words being spoken, but also to the nervous system in front of us. It asks us to notice tone, pacing, facial expression, body posture, silence, withdrawal, agitation, and the relational field between client and clinician.

Presence is the practice.

This is not always easy. We live and work in systems that often reward quick answers. Families want relief. Schools want plans. Employers want solutions. Professionals want to be useful. Meaningful change often begins when we pause long enough to ask better questions.

What is this behaviour protecting?

What is this child unable to say directly?

What demand has exceeded this person's capacity?

What sensory, social, emotional, or cognitive load is present?

What would help this nervous system feel safe enough to participate?

Presence allows us to respond rather than react. It creates the conditions for curiosity, and curiosity is often the beginning of good clinical work.

## **What Neurodivergent Clients Teach Us**

Neurodivergent clients have taught me a great deal about behaviour.

Autism, ADHD, sensory processing differences, dyslexia, dyspraxia, learning differences, and other neurodevelopmental profiles can shape how a person processes information, communicates, learns, regulates, and participates in relationships. Neurodiversity reminds us that human brains do not all move through the world in the same way.

Poor eye contact may be regulation, not disrespect.

Silence may be processing, not refusal.

Rigidity may be anxiety, not manipulation.

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Special interests may support regulation, identity, mastery, and connection.

Disengagement may be fatigue, not apathy.

Meltdowns may be overload, not misbehaviour.

Shutdowns may be nervous system collapse, not defiance.

Many neurodivergent children, teens, and adults are not failing to engage. They are often trying to survive environments that were not designed with their nervous systems in mind.

This is where clinicians, educators, physicians, occupational therapists, psychologists, psychiatrists, and family members can make an enormous difference. When we understand cognitive diversity, we stop expecting every client to learn, communicate, regulate, or heal in the same way.

Some clients are visual thinkers. Some are verbal processors. Some need movement. Some need written instructions. Some require more time to respond. Some need to know why a task matters before they can engage. Some need sensory accommodations before emotional work can even begin.

When we assume one standard pathway for change, we may misread difference as resistance.

## **Three Clinical Lenses Beneath Behaviour**

In my clinical teaching and consultation work, I often return to three clinical lenses that help professionals understand behaviour more clearly: anxiety and threat response, nervous system state, and self-identity.

### ***The first lens is anxiety and threat response.***

What looks oppositional may be fear. What looks avoidant may be anticipatory anxiety. What looks irritable may be chronic threat activation. A child who refuses school may not be trying to control the household. They may be trying to avoid humiliation, sensory overload, bullying, academic failure, or an intolerable internal state.

The clinical question becomes: What would help this client feel safer?

### ***The second lens is nervous system state.***

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Behaviour often reflects the state of the body. Fight may look like anger. Flight may look like avoidance. Freeze may look like shutdown. Fawn may look like compliance or people-pleasing. Collapse may look like disengagement.

When we understand behaviour through the body, we become less likely to moralize it. We become more interested in regulation, pacing, sensory load, recovery time, breath, movement, rest, and relational safety.

The clinical question becomes: What is this body trying to regulate?

### *The third lens is self-identity.*

Many children, teens, and adults have internalized years of being told they are difficult, lazy, rude, dramatic, weird, unmotivated, or broken. Over time, behaviour becomes connected to shame, dignity, belonging, and competence.

For neurodivergent clients especially, therapy often includes the gentle rebuilding of self-understanding. The goal is not simply to reduce behaviours. The goal is to help the client develop a more compassionate and accurate relationship with self.

The clinical question becomes: How do we help this person feel seen, understood, and capable?

## **Relationship Before Strategy**

The therapeutic relationship is not a soft extra. It is the ground from which change becomes possible.

Carl Rogers understood the healing power of empathy, congruence, and unconditional positive regard. Natalie Rogers carried this further through person-centred expressive arts, reminding us that the whole person must be welcomed into the therapeutic space. Daniel Siegel and Allan Schore have both contributed greatly to our understanding of how relationships shape regulation, integration, and well-being.

The research may be sophisticated, and the clinical truth is simple: people heal in relationships where they feel safe enough to be known.

For neurodivergent clients, rapport may take longer. Trust may be built through predictability, direct communication, sensory respect, clear expectations, reduced shame, autonomy, humour, and genuine interest in the client's world.

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Before we ask clients to become more flexible, we may need to examine where our systems, expectations, and interventions have become too rigid.

## **From Fixing to Collaborative Planning**

Understanding does not mean we do nothing. Understanding means we intervene more wisely.

Rather than imposing a plan onto the child, teen, adult, or family, we create a plan with them.

We explore stressors, sensory triggers, sleep, eating routines, transitions, school or work demands, executive functioning supports, emotional regulation tools, communication preferences, strengths, interests, and meaningful goals.

Parents need support in this process too. A parent who cannot get to work because their child refuses school is not simply impatient. They may be overwhelmed, scared, and depleted. Helping the child often requires helping the parent understand what is happening and what supports are realistic.

Clinicians also need support. Good intentions are not enough. Neurodiversity-informed practice requires ongoing education, consultation, supervision, and interdisciplinary collaboration.

Clinicians benefit from learning how to recognize masking, sensory overload, autistic burnout, ADHD-related emotional dysregulation, executive functioning differences, demand avoidance, shutdowns, meltdowns, social exhaustion, and learning style mismatches.

In supervision, I often remind practitioners that our first task is not to win against the behaviour. Our first task is to understand the function of the behaviour.

When appropriate and with consent, collaboration between counsellors, physicians, psychologists, psychiatrists, occupational therapists, educators, vocational specialists, and families can create more consistent support across environments. When professionals share a deeper understanding of the behaviour, the care plan becomes more compassionate, cohesive, and effective.

## **Behaviour Is the Doorway**

The parent still needs help getting their child to school. The teen may still need support reducing gaming. The family still needs mornings to function. The adult still needs tools for work and relationships.

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Understanding behaviour does not excuse harm, remove accountability, or eliminate the need for change. Rather, understanding helps us choose interventions that match the person in front of us.

One of the most important things I encourage parents and caregivers to do is to deepen the relationship with their child, whether that child is in the early years, adolescence, or young adulthood. The relationship leads. Before a child can be guided, supported, or challenged, they need to feel known.

As Thích Nhất Hạnh reminds us, “Understanding is love’s other name.” (Hạnh, 2014)

Again, behaviour is not always the problem. Sometimes behaviour is the doorway into the nervous system, the unmet need, and the inner world of the person.

Presence is the practice.

Understanding is the intervention.

Change begins when the person beneath the behaviour feels seen.

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