INTERPRETING BEHAVIOUR IN CONTEXT:

A PRACTICE-BASED REFLECTION ON ADHD

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PRACTICE AND RESEARCH PROFILE

- Clinician and PhD scholar with extensive experience in child protection.
- Specialising in exploring the connections between attachment, trauma, neurodevelopment and behavioural responses.
- Integrating academic research with frontline practice to offer practical insights into child behaviour and family dynamics.
- Works independently as a lecturer, author and trainer across social care, education and health sectors.

HOLDING BOTH TRUTHS

This is *not*:

- A denial of ADHD
- A criticism of those who find diagnosis or medication helpful

This *is*:

- A reminder that ADHD-type behaviours can also be shaped by:
  - Relational disruptions
  - A lack of safety or consistent care
  - Emotional unpredictability

Key Point:

- Inattention, impulsivity and hyperactivity have many routes; interpretation must be guided by context.

DEFINITIONS OF ADHD

- *"...a behavioural (or neurodevelopmental) **condition** that makes focusing on everyday requests and routines challenging."*
- *"...the **condition** is characterised by persistent patterns of **inattention**, **hyperactivity** and/or **impulsivity** that interfere with daily functioning."*
- *"….They {children} may be fidgety, noisy and unable to adapt to changing situations. Children with ADHD can be defiant, socially inept or aggressive."*

A DIFFERENT LENS

- The word **"condition"** suggests something fixed and medical.
  - Biological basis
  - Consistent and Enduring
  - Located within the individual
- If we shift to thinking of ADHD to a **description** of behaviours, it allows:
  - More curiosity about what those behaviours might be telling us.
  - Greater space to consider **alternative explanations.**
  - Particularly important for children in the **child protection system,** where histories of loss, unpredictability, or unsafe care may shape behaviour.

BEYOND THE SYMPTOM LIST

- Doctors rarely diagnose based solely on **symptom descriptions**
- Internet symptom checkers show a **range of possibilities** – not a single answer
- Behaviours like impulsivity, hyperactivity, or inattention can be linked to **many different causes**
- Careful investigation, context and continuing **curiosity** are key

CHALLENGES WITH CURRENT PATHWAYS

- The "**Right to Choose**" option allows ADHD diagnosis to be sought privately.
- These assessments often **do not access the child's wider history**.
- For looked-after children or those with significant relational disruptions and complex histories, this can mean:
  - **Important context is missed**.
- Behaviours can be assessed in isolation – detached from the experiences that may have shaped it.

RATES OF DIAGNOSIS

- ADHD prevalence in the general population has been recorded at 2–5% (Polanczyk et al., 2007; 2014).
- Rates are significantly higher in care-experienced children (Gonzalez et al., 2019; Ogundele, 2020; Heady et al., 2022).
- ADHD is one of the fastest-growing psychiatric diagnoses in safeguarding (Willis, Dhakras & Cortese, 2017).
- There is no biological marker for ADHD (Parlatini et al., 2024) — diagnosis relies on subjective descriptions of behaviour.

Key Point:

- If behaviour drives diagnosis, we must first understand what is driving the behaviour.

EARLY EXPERIENCES SHAPE BEHAVIOUR

- Children exposed to violence, inconsistency or stress learn to respond in ways that help them stay safe.
- Attention, memory and emotional regulation may be affected when their focus is on **monitoring (**or coping with the after-effects of**) danger** rather than on learning.
- Over time, these responses can become part of how the child learns to understand and navigate the world.
- Without a safe adult helping them make sense of feelings, these reactions become reinforced.

Key Point:

- What might look like a symptom may actually be a strategy.

THEORY OF CONSTRUCTION EMOTIONS (BARRETT, 2017)

- Emotions and behaviours are the result of **'guesses'** that your brain constructs in the moment – driven by the primary mission of survival (Barrett 2017; 2020)
- Emotions and behaviours are not 'built in' to you at birth. **They are just built.**
- Experiences help us to assign meaning and respond accordingly.
- *"You are not at the mercy of your emotions (and behavioural responses)……".*
- ……your brain creates them through our experiences, knowledge and **prediction.**

How we make our emotions *(developed from Lisa Feldmann Barrett's Theory of Constructed Emotion) – CAN BE LOCATED ON THE INTERNET*

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Hanbury, L. (2025). ***Exploring ADHD and Child Trauma: A Practitioner's Guide to Supporting Children and Young People.*** **Jessica Kingsley Publishers.**

WHEN BEHAVIOUR IS A SURVIVAL RESPONSE

- Children who have had to organise around chaos, fear or unpredictability often learn ways to stay safe – "*what do I need to pay attention to in order for me to avoid danger?*"

Reflection Point:

- The question should not be "*what is the behaviour I am seeing?*" — but "*what purpose might it serve? How might this behaviour be functioning as a way to keep them safe*".

ADHD Association	Could it be a Survival / Protective Response?
Hyperactivity	Hypervigilance — staying alert to detect threat quickly
Inattention	Dissociation or mental distancing when overwhelmed

CASE REVIEW: FAMILY U (OVERVIEW)

- All children in the household had a behavioural or developmental diagnosis
- Abuse was only uncovered later, after disclosure
- A formal diagnosis reassured professionals and replaced curiosity
- Multiple agencies accepted explanations without further enquiry

FAMILY U: DIAGNOSIS AS A SMOKESCREEN

- Carers used diagnoses to explain or justify concerning behaviours
- Professionals across services (police, education, health, social care) accepted these explanations
- Diagnoses included ADHD, autism, depression, bipolar and Tourette's
- Professionals felt less confident challenging once the diagnoses were applied

Key Point:

- Diagnosis reduced curiosity rather than prompted it.

REVIEW QUOTES

- *"What is particularly striking is the way in which the children were presented in terms of medical diagnoses."*
- *"Information available to the review since the children's removal into care raises questions about the various medical and developmental labels… Rather it would appear that all the children were showing symptoms of complex emotional damage, trauma and significant attachment difficulties."*
- *"……the medical model and system… should be changed to focus on a more multi-agency approach with less focus on diagnosis and medication and more on what the cause of the presenting behaviour might be."*

PROFESSIONAL CURIOSITY

- Curiosity is often expected — but not always supported in practice.
- High caseloads and time pressure limit opportunities to pause and think.
- There is little practical guidance on *how* to apply curiosity in real time.

Frequently cited in national Child Safeguarding Practice Reviews:

- Professionals to **challenge assumptions**, even when a diagnosis is already in place.
- Behaviour to be understood **within relational** and **historical context**, not in isolation.
- Agencies to **share thinking**, rather than working in silos.

WHEN DIAGNOSIS LIMITS CURIOSITY

- ADHD (and autism) are appearing more frequently in safeguarding reviews.
- While diagnosis can be helpful, it can also *unintentionally* narrow thinking.
- Once a diagnosis is recorded, professionals may feel less able to:
  - Reflect further ***other possible causes*** of behaviour
  - Stop asking ***why*** the behaviour exists
  - Respectfully challenge when they feel something is not quite right
- Reviews show that a formal diagnosis can **silence curiosity**, even when instinct suggests further exploration is needed.

WHAT FAMILY U TEACHES US

Serious safeguarding concerns - children with diagnoses ***MAY*** be at higher risk of missed harm:

- Professionals stopped asking questions once diagnoses were accepted
- Abuse and trauma remained hidden behind diagnostic behavioural labels
- Only one interpretation of the behaviour was accepted without question

Reflection Points:

- Having a diagnosis (in some cases), ***may*** obscure the truth
- May make it difficult to explore relational dynamics once a diagnosis has been given

Common assumption	Adding context
"It's not normal for a child to be so aggressive"	It is if it kept you alive – being loud and forceful is what kept them safe.

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WHY CHALLENGE?

- If we accept the wrong explanation, we may **intervene in the wrong way**.
- It can unintentionally reinforce a child's **internal belief** that they are **"the problem."**
- It risks **invalidating their past experiences of harm or instability**.
- A diagnosis should never be the *end* of thinking — it should open *more* questions.

Key Point:

- We are not challenging *the diagnosis itself* — we are ensuring it serves the child, not silences their story.

AWARENESS OF PAST EXPERIENCES ADDS CONTEXT TO PRESENTING BEHAVIOURS

- **Trauma-informed approaches** - Recognise how past adversity can shape current coping strategies, responses, and triggers.
- **Systemic practice and principles** - Understand behaviours in the context of relationships, family systems, and wider social influences.
- **Relational Cultural Theory** - Explore how connection, disconnection, and relational experiences influence wellbeing and behaviour.
- **Polyvagal Theory** - Consider how the nervous system's responses to safety and threat influence emotional regulation and social engagement.

USEFUL QUESTIONS TO EXPLORE IN PRACTICE

- **Trauma-Informed:**
  - *What has happened in this person's life that could help explain this behaviour?*
  - *Are there patterns or triggers that seem to link to past experiences?*

- **Systemic Practice:**
  - *How do relationships within the family or wider network influence what is happening now?*
  - *Who plays a key role in supporting or influencing this person's behaviour?*

- **Relational Cultural Theory:**
  - *Where might disconnection be affecting this person's sense of safety or belonging?*
  - *How can we strengthen opportunities for meaningful connection?*

- **Polyvagal Theory:**
  - *Does this person's body feel safe enough to engage and connect?*
  - *What helps them move from a state of threat to a state of calm?*

SUPPORTING CURIOSITY

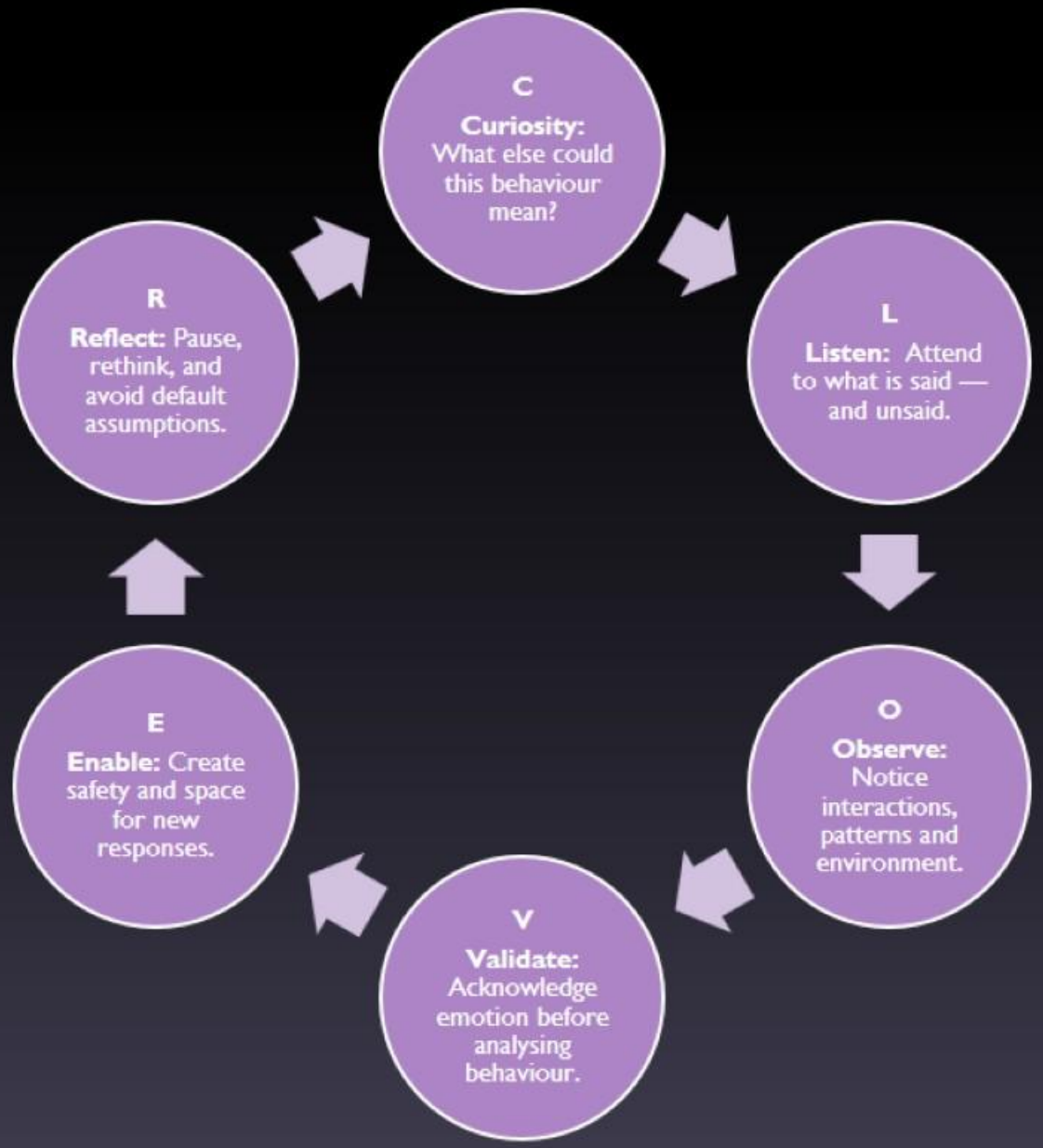
Theories that encourage professionals to understand behaviour in context include:

- **Power Threat Meaning Framework** (Johnstone & Boyle, 2018)
- **Dynamic Maturational Model of Attachment and Adaptation (DMM)** — Crittenden (1994, 2006)
- **Traditional Attachment Theory (ABCD model)** — Bowlby (1969), Ainsworth (1978)
- **Theory of Constructed Emotion** — Barrett (2017)
- **Ecological Systems Theory** — Bronfenbrenner (1979)

These theories invite us to see displays of behaviour as relational, situational and contextual

THE **CLOVER** APPROACH:

A reflective and practical model for all professionals:



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CLOVER IN CHILD PROTECTION PRACTICE

- Supports curiosity without accusation
- Encourages inter-agency thinking and challenge
- Prevents diagnosis from ending enquiry
- Creates space for trauma-aware interpretation

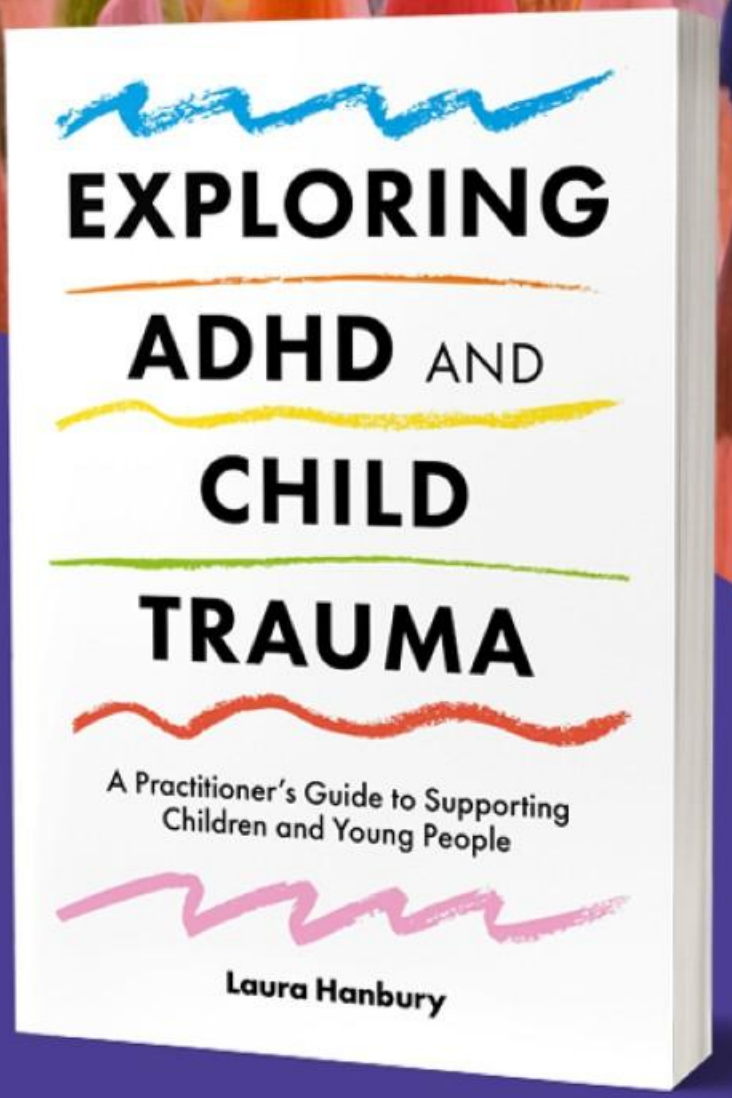
Reflection Point:

- Curiosity should not be an optional practice — it's protective

TAKEAWAY FOR PRACTITIONERS

- For some, diagnosis and medication bring clarity and support
- For others, something crucial may get missed
- Especially in **safeguarding**:
  - Stay curious
  - Explore history
  - Challenge assumptions
  - Look beyond labels
- **Reflection Quote (Timimi, 2017):**
  "If the answer to 'why is this child hyperactive or unable to focus?' is 'because they have ADHD', the next question must be: 'How do you know?'"

A curious, reflective approach to understanding behavior and providing compassionate support.



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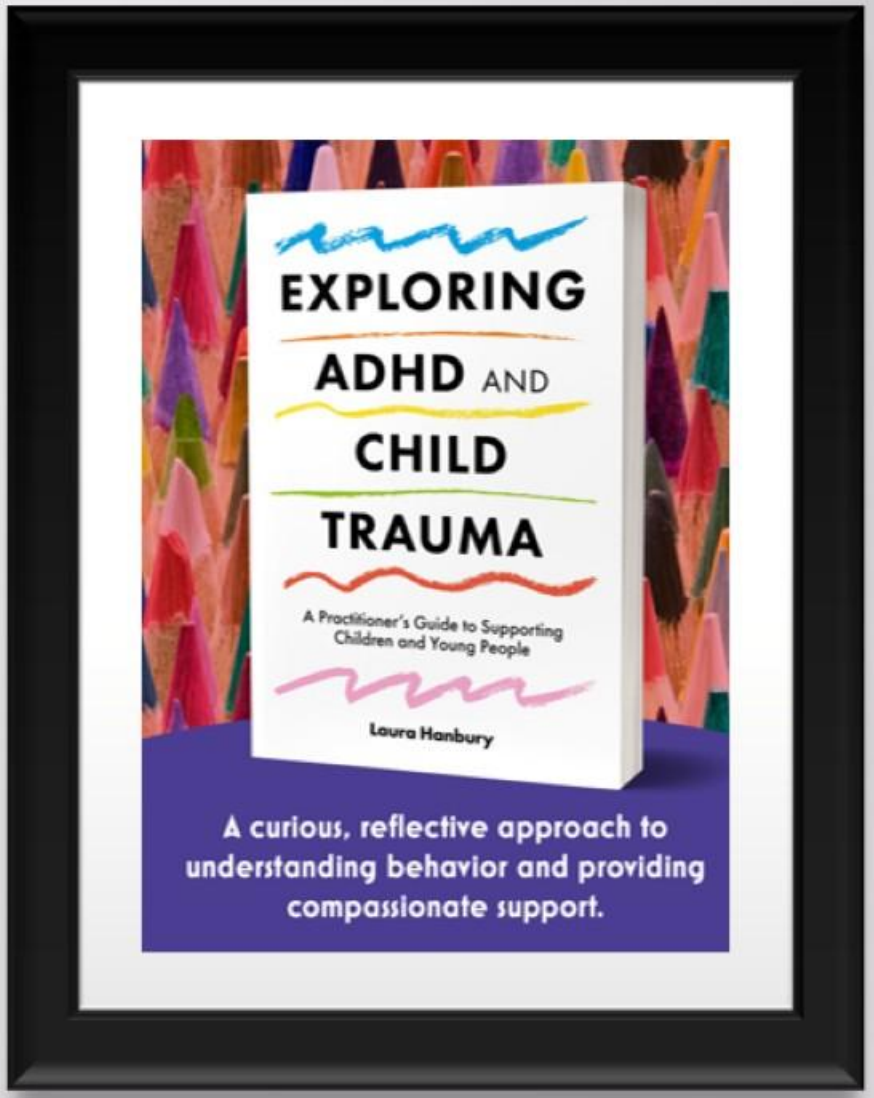

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