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“Behaviour”: A Field Guide to Diagnostic Overshadowing

A Satirical Review Article (Peer-Reviewed by Autistic Barbie, Title Pending)

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Abstract

This review argues that “behaviour” is frequently deployed not as description but as an interpretive technology that produces **diagnostic overshadowing**: the conversion of pain, sensory distress, trauma responses, medical needs, and environmental mismatch into “noncompliance” or “behaviour of concern.” Drawing on Hacking’s account of classification—where categories and persons can “emerge hand in hand” and reshape the “space of possibilities for personhood” (Hacking, 1986)—this paper proposes that “behaviour” functions as an administrative slot that can override alternative explanations and restrict access to support. Rosenhan’s demonstration of institutional interpretive capture is used as an analogue: once a label is dominant, ordinary actions can be reinterpreted as confirmatory evidence (Rosenhan, 1973). The paper concludes with a needs-led alternative framework that prioritises hypothesis diversity, sensory/medical humility, and support access without compliance theatre.

Keywords

behaviour framing; diagnostic overshadowing; autism; intellectual disability; labeling; institutional bias; compliance theatre; dynamic nominalism

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1. Introduction: The Behavioural Turn (and Other Weather Events)

Within disability and service systems, “behaviour” has drifted from a neutral descriptor into a totalising explanatory regime. Under this regime, actions are not simply observed; they are **translated**. Distress becomes “escalation,” refusal becomes “noncompliance,” communication becomes “attention seeking,” and withdrawal becomes “non-engagement.” The result is predictable: the person is rendered legible primarily as a behavioural problem, while medical, sensory, environmental, trauma-related, and relational explanations are treated as secondary, optional, or inconvenient.

This is diagnostic overshadowing not as an occasional error, but as an institutional default.

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2. Conceptual Framework: Hacking and the Manufacture of Person-Kinds

Hacking’s central insight is that some classifications of people do not merely describe pre-existing kinds; they can become **world-building**. In his account, categories and the people classified by them may “emerge hand in hand,” with the label helping to organise institutions, professional roles, documentation systems, and expectations (Hacking, 1986). In other words, classification can become causal.

Hacking further argues that these processes can change “the space of possibilities for personhood” (Hacking, 1986). Under a behavioural regime, the space of personhood often collapses into a narrow menu of morally weighted options: comply, escalate, be managed, be excluded.

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3. Behaviour Framing as Diagnostic Overshadowing in Practice

“Behaviour” framing intensifies diagnostic overshadowing by treating the person’s actions as sufficient explanation in themselves. Once the behavioural story is selected, other hypotheses are deprioritised: pain becomes “attention,” sensory overload becomes “avoidance,” shutdown becomes “refusal,” and survival strategies become “manipulation.” The person’s reality is overwritten by the system’s preferred narrative.

This produces a common pathway:

1. **Label primacy:** diagnosis/disability becomes the dominant lens.
2. **Interpretive capture:** ambiguous actions are converted into “behavioural evidence.”
3. **Evidence inversion:** requests for support become demands for proof of compliance.
4. **Access gating:** help is withheld until the person performs approved “behaviour work.”
5. **Moralisation:** failure is attributed to attitude, parenting, or insufficient discipline.

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4. Rosenhan and the Self-Sealing Logic of Labels

Rosenhan’s analysis demonstrates how institutional contexts can become vulnerable to interpretive capture: once a label is applied, ordinary actions may be reinterpreted as confirmatory symptoms (Rosenhan, 1973). The relevance here is structural: classification can recruit its own evidence in closed interpretive systems.

In disability contexts, “behaviour” framing can create a parallel loop:

- A person enters the system narrativised as a behavioural risk.
- Behaviour plans become the primary record of reality.
- Alternative explanations are discounted as “excuses” or “lack of insight.”
- Attempts to communicate need are translated into “more behaviour.”

The system becomes difficult to falsify because disagreement is treated as further evidence.

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5. The Ritual Requirement: “Show Evidence You Implemented Strategies”

A particularly consequential expression of behavioural ideology is the conditionality clause:

> "You need to show evidence of implementing behaviour strategies before we will help."

This is frequently less a request for best practice than a gatekeeping ritual: support becomes contingent on performing compliance with a preferred explanatory framework. The burden shifts to disabled people and families to produce documentation that demonstrates alignment with institutional ideology, even where the ideology does not match lived reality.

This is diagnostic overshadowing with paperwork.

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6. Discussion: Why "Have You Tried…" Sounds Like Help and Functions Like Bias

Prescriptive advice—"Have you tried X?", "Have you tried Y?", "If you were more consistent…"—often assumes the problem is skill or discipline, that the correct method exists, and that outcomes are a direct function of compliance. This framing is incompatible with the empirical reality that the same outward behaviour can arise from entirely different causes: pain, sensory overload, trauma, sleep disruption, communication barriers, environmental mismatch, medication effects, or rare biological variation.

What helps one person may be irrelevant or harmful to another. Behaviour does not "switch off" on demand.

If you want to help, a better question is: **"How can I help?"**

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7. Conclusion: Toward Needs-Led Interpretation

The corrective to behaviour framing is not the abolition of observation, but the restoration of humility and hypothesis diversity.

Three minimal standards for ethical interpretation are proposed:

1. **Inquiry before ideology:** treat behaviour as communication within context, not character.

2. **Sensory and medical humility:** investigate pain, health, environment, and overload as first-order hypotheses.

3. **Access without compliance theatre:** supports should not be contingent on performing approved narratives.

A person is not a behaviour plan. A family is not a compliance unit. Care should not require the performance of “evidence-based suffering” to be believed.

Peer Review Statement

Reviewed and conditionally accepted by **Autistic Barbie (Title Pending)**, who requested:

1. “Increase academic shade, but keep it quotable.” (Addressed.)

2. “Add one line reminding neurotypicals to ask *how can I help*.” (Done.)

References (APA 7th)

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