In Focus: Understanding and Supporting Students with ADHD and Autism

Sam Goldstein, Ph.D.
Assistant Clinical Professor
University of Utah School of Medicine

www.samgoldstein.com
info@samgoldstein.com
@doctorsamgoldstein
@drsamgoldstein
@drsamgoldstein
@drsamgoldstein
@drsamgoldstein
@commonsensescience

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RESOURCES

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Sam obtained his Ph.D. in School Psychology from the University of Utah and is licensed as a Psychologist and Certified School Psychologist in the State of Utah. He is also board certified as a Pediatric Neuropsychologist and listed in the Council for the National Register of Health Service Providers in Psychology. He is a Fellow of the American Psychological Association and the National Academy of Neuropsychology. Sam is an Adjunct Assistant Professor in the Department of Psychiatry at the University of Utah School of Medicine. He has authored, co-edited, or co-authored over 50 clinical and trade publications, three dozen chapters, nearly three dozen peer-reviewed scientific articles, and eight psychological and neuropsychological tests. He is in development for a behavioral assessment tool to evaluate DMDD. His clinical volume about DMDD was just published by Springer. Sam is the former Editor in Chief of the *Journal of Attention Disorders.* Since 1980, he has served as the Clinical Director of the Neurology, Learning, and Behavior Center in Salt Lake City, Utah.

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Relevant Disclosure

- Author of the Disruptive Mood Questionnaire
- Co-author: Tenacity in Children
- Editor of Handbook of DMDD
- Coauthor: CEFI, ASRS, RSI, CAS 2 and RISE
- Coauthor: Handbook of DSM 5 in Children
- Coauthor: Handbook of Executive Functioning
- Compensated Speaker
- AI note-taking is fine.

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Presentation Outline

Time-Ordered Agenda

8:30 – 9:00 a.m. | Welcome and Overview
Introduction and objectives of the session; Framing neurodiversity: From deficits to differences; Overview of ADHD and Autism Spectrum Disorder (ASD) in schools; Setting the tone: Understanding, empathy, and empowerment

9:00 – 9:30 a.m. | Neurodevelopmental Foundations
The science of attention, self-regulation, and executive function; Shared and distinct features of ADHD and ASD' Brain–behavior connections and developmental trajectories' Q&A: Common misconceptions

9:30 – 10:00 a.m. | Assessment and Identification
Evidence-based assessment tools and processes; Differentiating ADHD from ASD and comorbid presentations; Role of educators and school psychologists in data collection; Case example discussion

10:00 – 10:15 a.m. | Break

10:15 – 10:45 a.m. | Evidence-Based Interventions: Core Strategies
Classroom and counseling supports that work; Supporting executive function, attention, and self-regulation; Instructional and behavioral frameworks (MTSS, PBIS, SEL integration)

10:45 – 11:15 a.m. | Addressing Co-Occurring Challenges
Emotional regulation, anxiety, and social communication difficulties; Helping students build resilience and problem-solving skills; Interactive case study

11:15 – 11:45 a.m. | Collaboration and Systems Support
Partnering with families, teachers, and multidisciplinary teams; Promoting consistent interventions across settings; Advocacy and resource navigation for educators

11:45 a.m. – 12:15 p.m. | Lunch Break

12:15 – 12:45 p.m. | Strengths-Based and Inclusive Practices
Building self-efficacy and positive identity in neurodiverse students; Designing inclusive classrooms and school cultures; Using student interests to drive engagement and growth

12:45 – 1:15 p.m. | Practical Tools and Resources
Evidence-based programs and digital tools; Recommended readings, organizations, and supports for ongoing learning; Handouts and implementation guides

1:15 – 1:45 p.m. | Integrating Research into Practice
Translating neuropsychological principles into daily routines; Monitoring progress and adjusting interventions; Group reflection: "What will you do differently tomorrow?"

1:45 – 2:15 p.m. | Inspiration and Resilience in Practice
The role of mindset, patience, and perspective; Uplifting stories of student growth and transformation; Dr. Goldstein's resilience model and closing reflections

2:15 – 2:30 p.m. | Q&A and Wrap-Up
Open discussion and participant takeaways; Final thoughts: Empowering educators to change lives

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Why Address ADHD and ASD Together?

- Some symptoms overlap.
- Some behaviors associated with both disorders overlap.
- Some impairments overlap.
- Some short term outcomes are similar.
- Some treatments are equally effective for both disorders.

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However. . . . .

- Most symptoms of ASD are not associated with ADHD.
- Most impairments in ASD are not associated with ADHD.
- The life course, associated risks and outcome are very different between the two conditions.

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Differential Diagnosis

- Differential diagnosis in childhood development disorders is not just a clinical formality. It directly shapes what happens to a child in the classroom and beyond.
- Accurate differential diagnosis is critical because placements will vary. A child with autism spectrum disorder may benefit from structured routines and visual supports in a specialized setting, while a child with ADHD might succeed in a general education classroom with behavioral supports and environmental adjustments.
- When we clearly understand the primary diagnosis, we can choose the least restrictive and most supportive environment rather than relying on guesswork.

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Differential Diagnosis

- Treatment focus will be different. For example, speech and language therapy may be central for a child with a language disorder, while occupational therapy may be more urgent for a child with sensory processing challenges.
- A student with an emotional or behavioral disorder may need counseling and behavior intervention planning as the primary focus.
- Without accurate diagnosis, interventions may target the wrong skills, leading to frustration for both the child and the teacher.

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Differential Diagnosis

- Access to services will also vary. Eligibility for specialized programs, therapy hours, funding, and accommodations often depends on diagnostic criteria.
- A clear and accurate diagnosis helps ensure that the child receives appropriate services in a timely manner.
- It also helps schools justify support plans and communicate effectively with outside providers.

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Differential Diagnosis

- Work with families will be different as well. Families process diagnoses in unique ways.
- Some may need education about the condition, others may need emotional support, and some may need guidance navigating services.
- The way we collaborate with families depends partly on the child's specific needs and the long-term expectations associated with the diagnosis.

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Differential Diagnosis

- At the same time, many childhood developmental disorders share important similarities.
- Difficulties with communication, executive functioning, social interaction, emotional regulation, and adaptive skills often overlap across diagnoses.
- Because of these shared features, we can develop a universal intervention plan that is applicable to all childhood development disorders in the classroom.

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Universal Plan: EVIDES

A universal intervention plan focuses on common needs rather than labels. This will include:

- Clear routines and predictable structure
- Visual supports and explicit instructions
- Positive behavior support systems
- Opportunities for social skills practice
- Differentiated instruction
- Regular communication with families
- Ongoing progress monitoring

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Universal Plan: EVIDES

- These strategies benefit students with autism, ADHD, learning disabilities, speech and language disorders, and other developmental conditions. In fact, they often support typically developing students as well.
- In practice, this means we use differential diagnosis to guide individualized decisions while also implementing classroom-wide supports that address shared challenges. The diagnosis informs the details. The universal plan ensures that no student is left without meaningful support.
- When we combine accurate diagnosis with broad, inclusive intervention strategies, we create classrooms that are both responsive and equitable.

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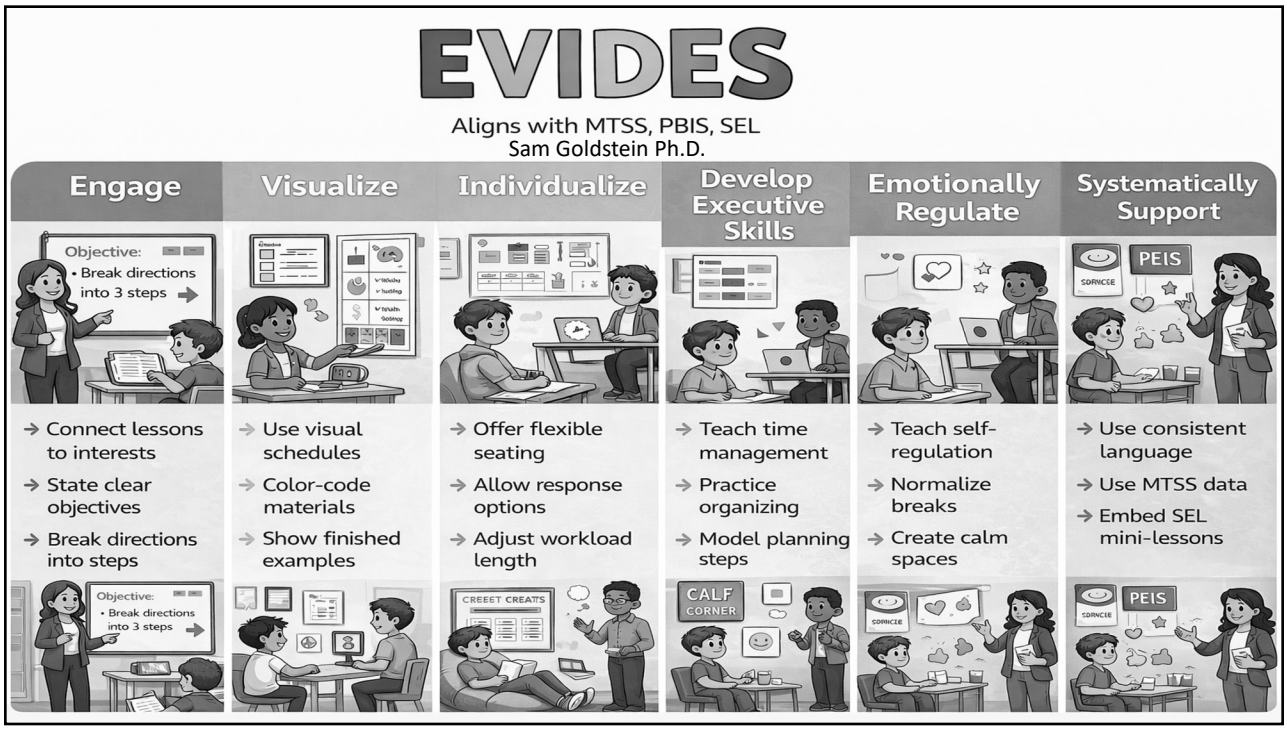

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Is it Really that Difficult to tell the Difference in the DSM IV?

ADHD	Autism
• Unusual behavior	• Inattentive
• Poor communication	• Impulsive
• Limited language	• Hyperactive
• Lack of empathy	• Disorganized
• Poor eye contact	• Procrastination
• Failure to establish friends.	• Forgetful
• Poor perspective taking	• Tasks left unfinished.

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Diagnosis

Differential diagnosis with the DSM may not be that difficult. . . . if the application of the DSM diagnostic criteria is complete and correct

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Why Address This Issue?

Autism and ADHD: Overlapping and discriminating symptoms

Susan Dickerson Mayes *, Susan L. Calhoun, Rebecca D. Mayes, Sarah Molitoris

Department of Psychiatry, Penn State College of Medicine, Hershey, PA, United States

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ABSTRACT

Children with ADHD and autism have some similar features, complicating a differential diagnosis. The purpose of our study was to determine the degree to which core ADHD and autistic symptoms overlap in and discriminate between children 2–16 years of age with autism and ADHD. Our study demonstrated that 847 children with autism were easily distinguished from 158 children with ADHD. All children with autism had 15 or more of the 30 Checklist for Autism Spectrum Disorder symptoms (mean 22), and none of the children with ADHD did (mean 4). Three of the symptoms were present only in children with autism. Almost all 30 symptoms were found in over half of the children with autism, whereas none were present in the majority of children with ADHD-Inattentive type (ADHD-I) or in children with ADHD-Combined type (ADHD-C) without comorbid oppositional-defiant disorder. In contrast, ADHD symptoms were common in autism. Children with low and high functioning autism and ADHD-C did not differ on maternal ratings of attention deficit, impulsivity, and hyperactivity. For children with normal intelligence, nonsignificant differences were found between children with autism, ADHD-C, and ADHD-I on neuropsychological tests including measures of attention, working memory, processing speed, and graphomotor skills.

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Why Address This Issue?

J Abnorm Child Psychol (2009) 37:443–453
DOI 10.1007/s10802-008-9282-0

PDD Symptoms in ADHD, an Independent Familial Trait?

J. S. Nijmeijer · P. J. Hoekstra · R. B. Minderaa · J. K. Buitelaar · M. E. Altink · C. J. M. Buschgens · E. A. Fliers · N. N. J. Rommelse · J. A. Sergeant · C. A. Hartman

Published online: 3 December 2008

Abstract The aims of this study were to investigate whether subtle PDD symptoms in the context of ADHD are transmitted in families independent of ADHD, and whether PDD symptom familiality is influenced by gender and age. The sample consisted of 256 sibling pairs with at least one child with ADHD and 147 healthy controls, aged 5–19 years. Children who fulfilled criteria for autistic disorder were excluded. The Children's Social Behavior Questionnaire (CSBQ) was used to assess PDD symptoms. Probands, siblings, and controls were compared using analyses of variance. Sibling correlations were calculated for CSBQ scores after controlling for IQ, ADHD, and comorbid anxiety. In addition, we calculated cross-sibling cross-trait correlations. Both children with ADHD and their siblings had higher PDD levels than healthy controls. The sibling correlation was 0.28 for the CSBQ total scale, with the CSBQ stereotyped behavior subscale showing the strongest sibling correlation (r=0.35). Sibling correlations remained similar in strength after controlling for IQ and ADHD, and were not confounded by comorbid anxiety. Sibling correlations were higher in female than in male probands. The social subscale showed stronger sibling correlations in elder than in younger sibling pairs. Cross-sibling cross-trait correlations for PDD and ADHD were

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Why Address This Issue?

J Autism Dev Disord (2009) 39:395–404
DOI 10.1007/s10803-008-9636-9

ORIGINAL PAPER

Positive Effects of Methylphenidate on Social Communication and Self-Regulation in Children with Pervasive Developmental Disorders and Hyperactivity

Laudan B. Jahromi · Connie L. Kasari · James T. McCracken · Lisa S-Y. Lee · Michael G. Aman · Christopher J. McDougle · Lawrence Scahill · Elaine Tierney · L. Eugene Arnold · Benedetto Vitiello · Louise Ritz · Andrea Witwer · Erin Kustan · Jaswinder Ghuman · David J. Posey

Published online: 28 August 2008

Abstract This report examined the effect of methylphenidate on social communication and self-regulation in children with pervasive developmental disorders and hyperactivity in a secondary analysis of RUPP Autism Network data. Participants were 33 children (29 boys) between the ages of 5 and 13 years who participated in a four-week crossover trial of placebo and increasing doses of methylphenidate given in random order each for one week. Observational measures of certain aspects of children's social communication, self-regulation, and affective behavior were obtained each week. A

Keywords Methylphenidate · Pervasive developmental disorders · Hyperactivity · Autism spectrum disorder

Introduction

Children with pervasive developmental disorders (PDD) exhibit deficits in social interaction, language, and also show restrictive interests or stereotyped behaviors. Some

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What is ADHD?

- ADHD is a biopsychosocial condition characterized by core symptoms of inattention, hyperactivity and impulsivity leading to/interacting with cognitive deficits causing impairment in all walks of life.
- ADHD appears to primarily involve the basal ganglia, cerebellum and variably the frontal lobes, depending on associated learning difficulties.
- ADHD appears to primarily involve the neurotransmitter dopamine

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What is ADHD?

- ADHD is a condition stemming from inefficient self-regulation also closely involving planning and executive functioning.
- Co-morbidity with ADHD probably confounds findings from different study groups (Hendren et al, 2000).
- The Symptoms of ADHD lead to a nearly infinite number of consequences.

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Three Areas of Functioning Challenges in ADHD

Understanding Patterns in Repetition, Stimulation, and Task Persistence

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Overview of the Three Areas

- 1. Repetition and Automatic Behavior
- 2. Stimulation and Focus
- 3. Repetition Load and Task Quitting

These areas help explain patterns in consistency, engagement, and persistence.

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Area 1: Repetition and Automatic Behavior

- Requires more repetitions to make behavior automatic.
- May appear as 'repeat offenders.'
- They know what to do.
- Struggle to do it consistently.
- Difficulty performing independently without prompts.

Key Concept: Skill acquisition requires higher repetition before internalization.

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Area 2: Stimulation and Focus

- As tasks become less stimulating, focus declines.
- Example: Color → Black and White.
- Reduced novelty leads to reduced engagement.
- Interest is closely tied to visual or sensory input.

Key Concept: Motivation is influenced by stimulation level.

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Area 3: Repetition Load and Task Quitting

- As repetitions increase, persistence decreases.
- Moving to the next level may feel too long or demanding.
- Delayed reinforcement reduces motivation.
- May quit before completion.

Key Concept: Endurance and delayed gratification are areas of challenge.

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Self-regulation

- The ability to inhibit
- The ability to delay
- The ability to separate thought from feeling
- The ability to separate experience from response
- The ability to consider an experience and change perspective
- The ability to consider alternative responses

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Self-regulation

- The ability to choose a response and act successfully towards a goal
- The ability to change the response when confronted with new data
- The ability to negotiate life automatically
- The ability to track cues
- They are CUELESS not CLUELESS!

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Practical Implications

- Increase structured repetition with guided support.
- Maintain engagement through stimulating formats.
- Break tasks into shorter, achievable segments.
- Provide immediate reinforcement.
- Gradually build independence and endurance.

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DSM 5 TR View of ADHD

Essential features:

- A. Persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and is more severe than is typically observed in individuals at comparable level of development.
- B. Some hyperactive-impulsive or inattentive symptoms must have been present before seven years of age.
- C. Some impairment from the symptoms must be present in at least two settings.
- D. There must be clear evidence of interference with developmentally appropriate social, academic or occupational functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorders and is not better accounted for by another mental disorder.

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What is ASD?

- Kanner, together with Hans Asperger, initiated the modern study of autism.
- He introduced the label *early infantile autism* in 1943 in his paper : Kanner, L. (1943). Autistic disturbances of affective contact. *Nervous Child, 2,* 217-250.

Leo Kanner

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What is ASD?

- Inability to relate to others
- Disinterest in parents and people
- Language difficulties
- fascination with inanimate objects
- Resistance to change in routine
- Purposeless repetitive movements
  - A wide range of cognitive skills
  - Where they possess an innate inability for emotional contact

Leo Kanner

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ASD Background

- Autism Spectrum Disorder (ASD) is a neurodevelopmental condition marked by deficits in social interaction, communication, and repetitive behaviors.
- The etiology of ASD is complex, involving both genetic and environmental factors.
- Recent studies emphasize the need for individualized and technology-driven interventions to improve quality of life and functional outcomes (Qin et al., 2024).
- Despite progress in understanding ASD, challenges remain in diagnosis and treatment, mainly due to the disorder's heterogeneity and co-occurring conditions, which complicate the diagnostic process (Hus & Segal, 2021).

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Broadening the Spectrum

- There's no single published tally of all autism-related meta-analyses since 1966, but the peer-reviewed literature contains many dozens likely over 100 meta-analyses covering prevalence, interventions, cognitive/behavioral profiles, biomarkers, and other aspects of ASD. Some reviews of subdomains have explicitly counted dozens of meta-analyses within those narrower focuses. .
- Likely over 100,000 total subjects from around the world.
- Five psychosocial dimensions identified: emotion recognition, theory of mind, cognitive flexibility, planning and inhibition.
- For all 5 dimensions group differences between normal and those with ASD have declined since 2000.
- This is attributed to differences in diagnostic criteria, assessment practices and community awareness.

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Simons Foundation Powering Autism Research for Knowledge (SPARK Study of Autism)

- SPARK is a large-scale research initiative funded by the Simons Foundation. Its goal is to advance understanding of autism by collecting genetic and behavioral information from individuals with autism and their families.
- The study focuses on:
- Identifying genetic factors linked to autism
- Understanding differences in development and behavior
- Connecting families with research opportunities
- Accelerating discoveries that may improve support and services
- SPARK is one of the largest autism research studies in the United States, and families can participate by providing saliva samples for genetic testing and completing online questionnaires about development and behavior.

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SPARK Key Findings

- Used generative mixture modeling on a large SPARK cohort of children with autism.
- Identified four robust autism subtypes based on genetic and phenotypic patterns.
- Subtypes corresponded with different developmental, psychiatric, and genetic profiles.
- Each subtype is linked to distinct patterns of common, inherited, and de novo mutations.
- The developmental timing of disrupted genes aligned with subtype-specific clinical outcomes.

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SPARK Findings: Four distinct subtypes of autism, each with unique clinical presentations, genetic profiles, and developmental trajectories:

- **Social and Behavioral Challenges** (~37%)
  Core autism traits, intact developmental milestones, frequent co-occurring conditions like ADHD, anxiety, or OCD
- **Mixed ASD with Developmental Delay** (~19%)
  Delayed early milestones, fewer psychiatric co-morbidities, a mix of de novo and inherited genetic mutations.
- **Moderate Challenges** (~34%)
  Milder core ASD traits, typical developmental progress, minimal psychiatric co-morbidities.
- **Broadly Affected** (~10%)
  Severe core traits, high levels of co-occurring conditions (e.g., intellectual disability, psychiatric issues), and greater burden of rare de novo mutations

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Diagnosis

- ASD diagnosis typically involves using standardized tools such as the Autism Diagnostic Observation Schedule (ADOS-2) and Autism Spectrum rating Scales (ASRS).However, these tools do not specifically diagnose
- This leads to potential misdiagnosis, especially in those with co-occurring cognitive or sensory impairments (Bishop & Lord, 2023).
- Early detection is critical, as timely intervention can significantly influence developmental outcomes.
- Advances in diagnostic technologies, including machine learning and biomarkers, enhance the precision of ASD diagnoses (Yu et al., 2024; Rasul et al., 2024).

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Treatment

- The treatment of ASD is highly individualized, with a range of behavioral, educational, and pharmacological interventions available.
- Applied Behavior Analysis (ABA) remains one of the most well-established therapies, particularly for improving children's intellectual functioning and adaptive behaviors (Eckes et al., 2023).
- Other interventions, such as Cognitive Behavioral Therapy (CBT), have proven effective in managing emotional and social challenges (You et al., 2023).
- Emerging therapies, including transcranial pulse stimulation and virtual reality-based interventions, offer promising alternatives for addressing the core symptoms of ASD and improving social skills (Cheung et al., 2023; Dechsling et al., 2021).

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Outcome

- Long-term outcomes for individuals with ASD vary widely, influenced by early intervention, co-occurring conditions, and the level of intellectual functioning.
- Early comprehensive treatment models have improved cognitive, language, and adaptive functioning, especially when intensive interventions involve parental participation (Shi et al., 2021).
- However, many individuals with ASD continue to face challenges in adulthood, particularly in areas such as employment and independent living (Scheeren et al., 2022).
- The outcomes' trajectory highly depends on the severity of symptoms and access to sustained, individualized support (Elias & Lord, 2021).

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DSM 5 Autism Spectrum Disorder

- Combined social and communication categories.
- Tightened required criteria reducing the number of symptom combinations leading to a diagnosis.
- Omitted Retts and Childhood Disintegrative Disorders.
- Clarifies co-morbidity issues.
- Eliminated PDD NOS and Aspergers in favor of Autism Spectrum Disorder.
- Created Social Pragmatic Communication Disorder.
- Still no specified profile for adults, just guidelines.

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DSM 5 Versus DSM 5 TR

- The criteria for diagnosing ASD including the two main domains:
  - Social communication/interaction
  - Restricted, repetitive behaviors/interests
- The requirement for symptoms to be present in early development
- The specifiers (e.g., intellectual impairment, language level, comorbid conditions)
- DSM-5-TR did not revise the diagnostic criteria for Autism Spectrum Disorder, but it did expand and refine the surrounding descriptions, with more up-to-date evidence and better consideration of cultural, gender, and mental health contexts.

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DSM 5 Versus DSM 5 TR

Clarification of Language and Terminology

•The DSM-5-TR refined the language in the text sections accompanying the diagnostic criteria.

•These changes aimed to improve clarity, reduce ambiguity, and provide updated guidance for clinicians.

•For example, the text was updated to reflect current research on autism and neurodiversity perspectives, though the criteria themselves were not altered.

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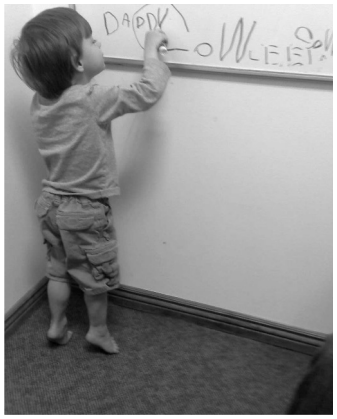
Core DSM and ICD Autistic Symptoms

- Impaired social relations.
- Impaired communication skills.
- Impaired behavior.



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Social Development and Autism

- Social competence is an ability to take another's perspective concerning a situation and to learn from past experience and to apply that learning to the ever changing social landscape (Margaret Semrud-Clikeman)
- The social development of autistic children is qualitatively different from other children
- In normal children perceptual, affective and neuroregulatory mechanisms predispose young infants to engage in social interaction from very early on in their lives..

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Social Information Processing

- Encoding of relevant stimuli.
- Interpretation of cues (both cause and intent).
- Goal setting.
- Comparison of the present situation to past experience.
- Selection of possible responses.
- Acting on a chosen response.

Crick and Dodge (1994)

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Young Children with Autism

- Have little interest in the human face.
- Lack differential preference for speech sounds.
- Lack imitative capacity.
- Lack interest in physical comfort.
- Don’t attach to caretakers well.

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Joint Attention

- Joint attention refers to behaviors that coordinate the focus of two people on the same object, event, or experience.
- These behaviors include pointing, showing objects, shifting gaze between a person and an object, sharing facial expressions, and using gestures or vocalizations to direct another's attention.
- Through joint attention, an individual not only notices something of interest but intentionally seeks to share that experience with someone else.

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Joint Attention

- Joint attention typically begins to emerge between 6 and 9 months of age.
- Early forms include following another person's gaze or pointing gesture. As development progresses, infants begin to initiate joint attention by pointing to objects, holding them up to show others, or alternating their gaze between an item and a caregiver to ensure shared focus.
- These behaviors reflect growing awareness that others have separate attention and perspectives that can be influenced.

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Joint Attention

- Importantly, joint attention serves as a foundational precursor to more advanced social and communication skills.
- It supports language development by creating shared contexts in which words can be learned. It also fosters social reciprocity, emotional sharing, and the development of theory of mind.
- Through repeated joint attention experiences, children learn that communication is not only about requesting needs but also about sharing interests, emotions, and experiences with others.

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Pretend Play in Autism

- Pretend play is often limited or may be entirely absent. When it does occur, it typically lacks the flexibility, creativity, and reciprocity expected for the child's developmental level. Play themes tend to be repetitive and may revolve around the same narrow scenarios, scripts, or interests. There is little variation in roles, storylines, or use of materials.
- The play may also appear rigid, with the child insisting on specific sequences, rules, or arrangements and becoming distressed if these are altered. Rather than developing a shared narrative, the child may engage in isolated acts such as lining up figures, reenacting the same short script, or repeating actions, without expanding the storyline or integrating new ideas.

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Pretend Play in Autism

- Socially, play is often one-sided. The child may not invite others into the play, respond to peers' ideas, or build on shared imaginative scenarios. Instead of collaborative, back-and-forth interaction, the play may function more as a solitary activity occurring in the presence of others.
- Overall, imagination appears limited in scope and depth. There may be minimal symbolic transformation of objects (e.g., using one object to represent another), few original story elements, and reduced ability to create complex, evolving pretend scenarios.

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Theory of Mind

- A line of research has proposed that the social deficits in autism reflect differences in a specific cognitive ability often described as the capacity to attribute mental states to oneself and to others.
- This capacity involves understanding that people have thoughts, beliefs, intentions, desires, and emotions that may differ from one's own.
- It also involves using that understanding to explain and predict another person's behavior.

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Theory of Mind

This idea is commonly referred to as theory of mind. In typical development, children gradually learn that other people can hold beliefs that are false, can misunderstand situations, or can act based on information that is different from what the child knows. For example, a child who understands theory of mind can predict that if Sarah did not see her toy being moved, she will look for it where she last left it, not where it actually is. This ability usually becomes more sophisticated during the preschool years.

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Theory of Mind

It is suggested that many of the social challenges observed in autism may stem from differences in this mental state understanding. If a child has difficulty inferring what someone else is thinking or feeling, it may be harder to interpret facial expressions, understand sarcasm, follow conversational turns, or respond appropriately in social situations. Social misunderstandings may occur not because the child lacks interest in others, but because interpreting unspoken social information is cognitively demanding.

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Theory of Mind

- This perspective frames autism-related social differences as linked to a specific, possibly innate cognitive system that develops differently. It emphasizes that social interaction depends on more than language or intelligence; it requires the ability to represent invisible mental states. When that system functions differently, social communication can be affected in systematic ways.
- At the same time, research has shown that autism is complex and cannot be explained by theory of mind differences alone. Social functioning also involves attention, sensory processing, executive functioning, emotional regulation, and motivation. Many individuals with autism can and do develop strong social understanding, especially with support and experience.
- Even so, the theory of mind framework has had a major impact on both research and intervention. It has shaped assessment tools, guided social skills interventions, and helped educators understand why explicit teaching of perspective-taking, emotion recognition, and conversational rules can be helpful in the classroom.

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EVIDES Framework

Engage • Visualize • Individualize • Develop Executive Skills • Emotionally Regulate • Systematically Support

Supporting ADHD & ASD within MTSS, PBIS, and SEL

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EVIDES Overview

The research base strongly supports the effectiveness of structured, evidence-based social–emotional and behavioral interventions for students with **ADHD and ASD**, particularly when implemented within **Multi-Tiered Systems of Support (MTSS)** and aligned with **Positive Behavioral Interventions and Supports (PBIS)** and **Social–Emotional Learning (SEL)** frameworks.

Across studies, consistent findings show that interventions targeting executive functioning, emotional regulation, social cognition, and behavioral self-management improve both academic and social outcomes.

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EVIDES works effectively for both ADHD and ASD because it is grounded in evidence-based practices that target core neurodevelopmental needs shared across these populations, namely executive functioning, emotional regulation, social communication, and behavioral self-management.

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Research demonstrates that structured social–emotional and behavioral interventions improve classroom engagement, peer relationships, and academic outcomes for students with ADHD and ASD when implemented systematically and with fidelity.

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EVIDES aligns naturally with **MTSS frameworks** by offering tiered levels of support that range from universal classroom strategies to targeted and individualized interventions.

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Studies show that embedding SEL and behavioral supports within MTSS increases both effectiveness and sustainability, particularly for students at risk for emotional and behavioral disorders. This alignment ensures that EVIDES is not an isolated program but part of a coordinated system of prevention and intervention.

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The model also reflects the principles of PBIS, emphasizing proactive skill-building, reinforcement of positive behaviors, and data-informed decision-making. PBIS literature consistently shows improved behavioral and academic outcomes when behavioral expectations are explicitly taught and reinforced across school contexts.

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Furthermore, EVIDES integrates SEL competencies **of** self-awareness, self-management, social awareness, relationship skills, and responsible decision-making, which have been shown to significantly benefit students with ASD and ADHD SEL-focused interventions increase emotional literacy, reduce disruptive behavior, and enhance peer engagement.

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Importantly, the literature demonstrates that:

- ADHD and ASD share overlapping executive functioning and social-emotional regulation needs.
- Tiered interventions embedded within MTSS improve accessibility and scalability.
- PBIS enhances behavioral consistency and schoolwide fidelity.
- SEL-based programming improves self-awareness, relationship skills, and self-management in both populations.
- Interventions are most effective when delivered flexibly across classroom instruction and counseling settings.
- This body of research supports a unified, neurodevelopmentally responsive framework such as EVIDES, designed to address both ADHD and ASD within integrated school systems.

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E – Engage with Clarity and Relevance

- Across contemporary classroom research, a consistent finding emerges: clarity, structure, relevance, and proactive engagement strategies are strongly associated with higher student engagement and improved behavior outcomes.
- Studies show that when teachers clearly state goals, simplify directions, use pre-correction and active supervision, and intentionally connect lessons to student interests, students demonstrate greater on-task behavior, reduced disruptions, and stronger academic achievement.
- Proactive classroom management, not reactive discipline, combined with active learning structures creates predictable, accessible entry points that lower cognitive overload and reduce confusion.

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E – Engage with Clarity and Relevance

The literature emphasizes five core principles that align directly with Engage with Clarity and Relevance:

1. Goal clarity improves engagement and comprehension.
2. Simplified, chunked instructions reduce off-task behavior.
3. Pre-correction prevents behavioral breakdowns.
4. Active learning increases cognitive and behavioral engagement.
5. Relevance and cultural responsiveness increase motivation.

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E – Engage with Clarity and Relevance

State Objectives in Plain Language

- Post and verbally explain learning targets using student-friendly wording.
- Avoid jargon; translate standards into "I can…" statements.
- Pair objectives with concrete success criteria ("You'll know you've got it if…").
- Revisit objectives mid-lesson and during closure.
- Connect objectives to prior learning ("Yesterday we learned…, today we'll use it to…").
- Model what meeting the objective looks like.
- Ask students to restate the objective in their own words.
- Research consistently identifies goal clarity as a foundational component of effective classroom management and instructional quality.

69

E – Engage with Clarity and Relevance

Break Directions into 1–3 Clear Steps

- Provide directions in short, sequenced chunks.
- Use numbered steps visually and orally.
- Pause after each step and check for understanding.
- Ask a student to repeat the steps back.
- Use visual icons or gestures to anchor steps.
- Provide written and spoken instructions simultaneously.
- Pre-highlight materials students will need before starting.
- Chunking reduces cognitive load and improves task initiation, particularly for students with executive functioning challenges.

70

E – Engage with Clarity and Relevance

Connect Lessons to Student Interests

- Survey students about hobbies and career goals.
- Embed real-world examples relevant to students' communities.
- Offer choice in examples, topics, or product format.
- Use culturally relevant texts and scenarios.
- Invite students to generate examples tied to their interests.
- Frame tasks around authentic problems.
- Ask, "Where might you use this outside school?"
- Engagement increases when students perceive content as meaningful and culturally relevant.

71

E – Engage with Clarity and Relevance

Use Active Learning Structures

- Incorporate think–pair–share regularly.
- Use whiteboards or quick writes for frequent response.
- Integrate cooperative learning roles.
- Build structured academic talk opportunities.
- Alternate mini-lesson → practice → feedback cycles.
- Use movement-based engagement when appropriate.
- Include retrieval practice and self-explanation strategies.
- Active learning increases behavioral and cognitive engagement and reduces passivity.

72

E – Engage with Clarity and Relevance

Implement Pre-Corrections

- State expectations before transitions (“When we move to groups, voices stay at level 2.”).
- Remind students of success behaviors before independent work.
- Pair reminders with positive tone and specific language.
- Use behavior-specific praise immediately after compliance.
- Identify predictable problem times and plan preventive cues.
- Pre-correct academic behaviors (“Remember to show your reasoning.”).
- Practice routines before high-risk tasks.
- Pre-correction is identified as a low-intensity, high-impact strategy that reduces disruptive behavior and improves engagement.

73

E – Engage with Clarity and Relevance

Establish Clear Entry Points

- Begin lessons with a short, accessible warm-up.
- Use worked examples before independent practice.
- Provide sentence starters for academic responses.
- Offer guided notes.
- Model the first problem together.
- Ensure the first task is achievable to build momentum.
- Preview vocabulary before complex texts.
- Clear entry points reduce avoidance behaviors and increase initial engagement.

74

E – Engage with Clarity and Relevance

Use Active Supervision

- Move continuously throughout the room.
- Scan and interact positively.
- Provide quick corrective feedback.
- Reinforce expected behaviors publicly and privately.
- Circulate during independent work rather than staying seated.
- Active supervision is associated with increased on-task behavior and reduced discipline incidents.

75

E – Engage with Clarity and Relevance

Clarity Through Feedback

- Give immediate, behavior-specific praise.
- Use corrective feedback tied directly to expectations.
- Keep feedback brief and actionable.
- Avoid vague comments like “good job.”
- Provide academic feedback aligned to the objective.
- Clear feedback strengthens both behavior and learning .

76

E – Engage with Clarity and Relevance

Build Predictable Structures

- Use consistent lesson routines.
- Keep transitions under 60 seconds when possible.
- Use visual timers.
- Teach and practice procedures explicitly.
- Maintain consistent response signals.
- Predictability enhances engagement and reduces cognitive strain.

77

Clarity reduces cognitive load.
Relevance increases motivation.
Pre-correction prevents disruption.
Active learning sustains engagement.
Predictable structure supports all learners.

78

V – Visualize Structure and Expectations

Research across autism (ASD), ADHD, and executive functioning literature consistently shows that visual structure, predictable routines, and externalized supports reduce anxiety, decrease cognitive overload, and increase task engagement. Visual schedules and exemplars function as *external working memory*, reducing demands on internal processing systems. Predictable classroom routines are particularly protective for students with ASD, while visual cues, timers, and rubrics support working memory and time management challenges common in ADHD.

79

V – Visualize Structure and Expectations

Across the literature, five themes emerge:

1. Predictability reduces anxiety and behavioral escalation (ASD).
2. Visual supports externalize working memory demands (ADHD).
3. Clear structure improves executive functioning performance.
4. Exemplars and rubrics clarify expectations and reduce ambiguity.
5. Visual organization improves independence and task initiation.

80

V – Visualize Structure and Expectations

Post Daily Schedules

- Display a visual agenda (icons + words).
- Highlight the current activity.
- Preview schedule changes early.
- Provide individual mini-schedules for students who need them.
- Use “First–Then” boards during transitions.
- Cross off completed activities for closure.
- Include estimated time blocks.
- Teach students how to independently reference the schedule.

81

V – Visualize Structure and Expectations

Use Timers and Visual Time Supports

- Display countdown timers during work periods.
- Use analog visual timers that show time “disappearing.”
- Pre-warn students before transitions (“2-minute warning”).
- Pair timers with task checklists.
- Teach students to estimate and track their own time.
- Use color-coded time blocks (green = work, yellow = transition).
- Practice time routines early in the year.

82

V – Visualize Structure and Expectations

Use Visual Rubrics and Clear Criteria

- Post simplified rubrics before assignments.
- Highlight 3–4 priority criteria.
- Provide student-friendly language.
- Model how to use the rubric for self-check.
- Use checklists instead of dense grading grids.
- Allow students to highlight where they met criteria.
- Align rubrics directly to posted objectives.

83

V – Visualize Structure and Expectations

Provide Finished Exemplars

- Show a model of “meets expectations.”
- Show annotated examples.
- Compare strong vs. weak samples.
- Think aloud while analyzing the exemplar.
- Use student-created models when possible.
- Pair exemplars with rubric criteria.
- Keep exemplars visible during work time.

84

V – Visualize Structure and Expectations

Color-Code Materials and Systems

- Assign colors by subject.
- Use matching color folders and digital labels.
- Color-code steps in multi-step tasks.
- Highlight key directions in distinct colors.
- Use consistent color systems school-wide when possible.
- Teach students how to organize using the system.
- Keep color meaning consistent across units.

85

V – Visualize Structure and Expectations

Externalize Working Memory

- Post written directions even after verbal explanation.
- Keep anchor charts visible.
- Use graphic organizers.
- Provide step-by-step flow charts.
- Offer guided notes.
- Use “reference boards” for vocabulary.
- Allow digital checklists.

86

V – Visualize Structure and Expectations

Create Predictable Routines

- Start class with the same entry task.
- Use consistent signals for attention.
- Maintain routine transition procedures.
- Pre-teach changes before they occur.
- Practice routines explicitly.
- Keep classroom layout stable.
- Prepare students for substitute days.

87

V – Visualize Structure and Expectations

Make Expectations Visible, Not Implied

- Post behavioral expectations visually.
- Use picture cues for classroom norms.
- Provide visual participation signals.
- Show examples of academic discourse stems.
- Display group-work role cards.
- Use visual noise-level indicators.
- Model and display “what it looks like / sounds like.”

88

Visuals reduce cognitive load.
Predictability reduces anxiety.
External supports strengthen executive functioning.
Concrete models reduce ambiguity.
Structured environments increase independence.

89

I – Individualize Supports

Research on MTSS (Multi-Tiered Systems of Support), executive functioning, neurodiversity, and differentiated instruction consistently shows that individualized supports increase engagement when they preserve rigor while reducing unnecessary barriers. The most effective classrooms:

- Maintain high expectations
- Adjust access, not standards
- Use interest and autonomy as motivators
- Provide graduated supports (Tier 1–3)
- Address executive functioning explicitly

90

I – Individualize Supports

Across the literature, six themes emerge:

1. Adjusting workload length (not complexity) protects rigor.
2. Flexible seating and movement improve regulation and attention.
3. Alternative response formats increase demonstration of mastery.
4. Interest-based motivators increase persistence and engagement.
5. Tiered supports within MTSS reduce escalation.
6. Executive function (EF) coaching improves long-term independence.

91

I – Individualize Supports

Flexible Seating & Movement Breaks

- Offer standing desks, wobble stools, floor seating, or stability balls.
- Allow structured movement breaks every 20–30 minutes.
- Use “movement before meltdown” proactive breaks.
- Provide discreet regulation tools (resistance bands, fidgets).
- Build in brain breaks tied to content.
- Allow students to choose seating aligned with task type.
- Teach students when and how to request movement appropriately.

92

I – Individualize Supports

Alternative Response Formats

- Allow oral responses instead of written.
- Use video or audio submissions.
- Offer graphic organizers instead of essays (when appropriate).
- Permit typing instead of handwriting.
- Provide sentence stems or structured outlines.
- Use project-based or visual demonstration options.
- Allow demonstration of mastery through presentation or model creation.

93

I – Individualize Supports

Adjust Workload Length Not Rigor

- Reduce number of practice problems, not complexity.
- Assign odd-numbered questions targeting skill mastery.
- Use “show mastery with 3 strong examples.”
- Shorten written output while keeping analytical depth.
- Prioritize essential standards.
- Offer chunked deadlines.
- Replace busywork with high-impact tasks.

94

I – Individualize Supports

Use Interest-Based Motivators

- Incorporate student-selected topics into assignments.
- Connect content to career pathways.
- Use gamified systems thoughtfully.
- Offer structured choice boards.
- Allow passion-project extensions.
- Use culturally responsive examples.
- Reinforce effort tied to personal goals.

95

I – Individualize Supports

Tier 1: Universal Supports (All Students)

- Clear routines and visual expectations.
- Flexible response formats embedded into instruction.
- Scheduled movement breaks.
- Positive behavior supports.
- Explicit instruction in executive skills.
- Choice within assignments.
- Universal design principles.

96

I – Individualize Supports

Tier 2: Targeted Supports (Some Students)

- Check-In/Check-Out (CICO)
- Daily goal setting with adult mentor.
- Behavior point sheets aligned to expectations.
- Afternoon reflection and feedback.
- Home–school communication loop.
- Small-group executive functioning coaching.
- Structured study hall.
- Scheduled adult mentoring.
- Targeted social skills instruction.

97

I – Individualize Supports

Tier 3: Intensive Individualized Supports

- Functional Behavior Assessment (FBA).
- Individualized Behavior Intervention Plan (BIP).
- One-on-one executive function coaching.
- Structured reinforcement plans.
- Counseling integration.
- Wraparound services.
- Data-driven progress monitoring.

98

I – Individualize Supports

Tier 3 interventions are most effective when:

- Based on function (not punishment).
- Explicitly teach replacement behaviors.
- Include adult coaching in executive functioning.
- Are aligned with school-wide MTSS systems

99

Individualization removes barriers, it does not lower expectations.

Rigor remains constant; access becomes flexible.

Tiered systems prevent escalation.

Executive skills must be taught, not assumed.

Motivation increases when identity and interest are honored.

100

D – Develop Executive Function Skills

- Teach planning, organization, time management
  - Model assignment planners
  - Teach backward planning
  - Chunk long tasks
  - Use self-monitoring checklists
  - Explicit instruction and repetition required

101

D – Develop Executive Function Skills

Across executive functioning (EF) research, a clear consensus emerges: executive skills do not automatically develop through academic exposure alone. They require explicit instruction, modeling, guided practice, and repetition. Studies show that when teachers directly teach planning, organization, time management, self-monitoring, and task initiation strategies, students demonstrate improved academic performance, persistence, and independence.

102

D – Develop Executive Function Skills

- Executive skills must be explicitly taught, not assumed.
- Planning improves when students learn backward design from deadlines.
- Chunking reduces cognitive overload and increases task completion.
- Self-monitoring strengthens metacognition and independence.
- Repetition and scaffolded modeling are required for skill internalization.

103

D – Develop Executive Function Skills

Teach Planning, Organization & Time Management

- Define planning explicitly (“Planning means deciding what steps to take before you begin.”).
- Teach students to identify task requirements before starting.
- Model how to prioritize using “Must Do / Should Do / Could Do.”
- Provide structured binder or digital folder systems.
- Teach students to estimate task duration before beginning.
- Practice calendar mapping weekly.
- Use color-coded subject planners.
- Have students verbalize their plan before starting.

104

D – Develop Executive Function Skills

Model Assignment Planners

- Project a sample planner and complete it live.
- Break down multi-step projects in front of students.
- Demonstrate how to record interim deadlines.
- Show how to revise plans when behind.
- Model thinking aloud: “This essay is due Friday, so I need a draft by Wednesday.”
- Compare effective vs. ineffective planning examples.
- Revisit planners mid-week for adjustment.

105

D – Develop Executive Function Skills

Teach Backward Planning

- Start with the due date and work backward.
- Identify final product expectations first.
- Break project into milestone checkpoints.
- Assign mini-deadlines.
- Use visual timeline templates.
- Teach “If–Then” planning (“If I finish step 1 by Tuesday, then…”).
- Practice backward planning on short tasks before long projects.

106

D – Develop Executive Function Skills

Chunk Long Tasks

- Divide assignments into 10–20 minute work blocks.
- Provide step-by-step checklists.
- Assign “complete Part A only” before continuing.
- Use visual progress trackers.
- Pair chunking with short breaks.
- Teach students to create their own chunks.
- Use guided notes to reduce initial load.

107

D – Develop Executive Function Skills

Use Self-Monitoring Checklists

- Provide “Did I…?” checklists for assignments.
- Teach students to rate effort and focus.
- Use reflection prompts at the end of tasks.
- Integrate self-editing rubrics.
- Encourage verbal self-instructions.
- Build daily goal-tracking sheets.
- Gradually fade checklist support over time.

108

D – Develop Executive Function Skills

Teach Task Initiation Strategies

- Use “2-minute start” rules.
- Provide sentence starters.
- Teach “start messy” to reduce perfection paralysis.
- Pair task initiation with timer cues.
- Use peer accountability partners.
- Pre-highlight first step before independent work.
- Practice initiating tasks during low-stakes activities.

109

D – Develop Executive Function Skills

Use Explicit Instruction + Repetition

- Teach one EF skill at a time.
- Practice skills across subjects.
- Use consistent language school-wide.
- Re-teach after long breaks.
- Provide guided practice before independent application.
- Gradually release responsibility.
- Offer feedback tied directly to strategy use.

110

Executive skills are teachable.
Planning must be modeled.
Chunking reduces overload.
Self-monitoring builds independence.
Repetition turns strategy into habit.

111

E – Emotionally Regulate and Co-Regulate

Across research in social-emotional learning (SEL), trauma-informed education, school psychology, and neurodevelopment, a strong consensus emerges: students cannot access higher-order thinking when emotionally dysregulated. Emotional regulation is foundational to executive functioning, attention, and learning. Studies consistently show that:

1. Co-regulation from adults precedes independent self-regulation.
2. Explicit instruction in emotion labeling improves behavioral outcomes.
3. Breathing and grounding strategies reduce physiological stress activation.
4. Predictable calm-down spaces reduce escalation.
5. Normalizing breaks prevents shame-based dysregulation cycles.

The evidence aligns around one core principle:

Regulation is relational before it is independent.

112

E – Emotionally Regulate and Co-Regulate

Create Calm-Down Spaces

- Designate a predictable, non-punitive regulation area.
- Include soft lighting or visual calming cues.
- Provide grounding tools (stress balls, textured objects).
- Post step-by-step calming routines visually.
- Include breathing prompt cards.
- Limit time to structured intervals (e.g., 3–5 minutes).
- Teach how and when to use the space.
- Debrief after use, not during escalation.

113

E – Emotionally Regulate and Co-Regulate

Teach Emotion Labeling Explicitly

- Teach a range of emotions beyond “mad/sad/happy.”
- Use emotion charts and visual scales.
- Model naming your own emotions appropriately.
- Practice identifying emotions in literature or scenarios.
- Teach intensity scales (1–5).
- Use sentence stems (“I feel ___ because ___.”).
- Reinforce emotion labeling before problem-solving.

114

E – Emotionally Regulate and Co-Regulate

Use Breathing & Grounding Routines

- Teach box breathing (4-4-4-4).
- Practice 5-4-3-2-1 sensory grounding.
- Use guided breathing visuals.
- Pair breathing with physical cues (hand on chest).
- Practice routines during calm times, not just crises.
- Integrate regulation breaks into transitions.
- Teach students to select preferred calming strategies.

115

E – Emotionally Regulate and Co-Regulate

Normalize Breaks

- Frame breaks as a strategy, not a consequence.
- Teach students how to request a break appropriately.
- Provide visual break cards.
- Set time-bound, structured breaks.
- Reinforce returning from break successfully.
- Integrate universal micro-breaks into lessons.
- Avoid removing break access as punishment.

116

E – Emotionally Regulate and Co-Regulate

Co-Regulation First, Independence Later

- Use calm voice tone and slow pacing.
- Match student affect before redirecting.
- Sit at eye level during escalation.
- Validate feelings before correcting behavior.
- Provide simple choices during dysregulation.
- Delay problem-solving until student is regulated.
- Gradually fade adult support over time.

117

E – Emotionally Regulate and Co-Regulate

Teach Regulation as a Skill (Not a Trait)

- Integrate mini-lessons on stress responses.
- Teach brain basics (upstairs brain/downstairs brain).
- Role-play regulation strategies.
- Reflect after dysregulation (“What helped?”).
- Track personal regulation strategies in journals.
- Use consistent regulation language school-wide.
- Reinforce effort in regulation, not perfection.

118

Regulation precedes learning.
Co-regulation builds neural pathways.
Emotion language increases control.
Breathing regulates biology.
Breaks prevent escalation.

119

S – Systematically Support Within Frameworks

Research on PBIS (Positive Behavioral Interventions and Supports), MTSS (Multi-Tiered Systems of Support), and schoolwide SEL implementation consistently shows that student outcomes improve when supports are systematic, data-driven, and implemented with fidelity across adults. Fragmented approaches reduce impact; integrated frameworks increase both academic and behavioral gains.

Across PBIS and MTSS literature, five major conclusions emerge:

1. Consistent language across adults improves behavior outcomes.
2. Schoolwide SEL instruction strengthens Tier 1 prevention.
3. Data-based decision-making increases intervention accuracy.
4. Behavior tracking improves early identification.
5. Implementation fidelity determines effectiveness.

The core principle:

Systems outperform isolated strategies.

120

S – Systematically Support Within Frameworks

Use Consistent PBIS Language

- Teach 3–5 positively stated schoolwide expectations.
- Use common phrases across classrooms (“Be Safe, Be Respectful, Be Responsible”).
- Reinforce behaviors using behavior-specific praise aligned to expectations.
- Post visual reminders in every classroom.
- Pre-correct using PBIS language before transitions.
- Provide corrective feedback tied directly to expectations.
- Align consequences with restorative practices.

121

S – Systematically Support Within Frameworks

Embed Weekly SEL Mini-Lessons

- Schedule protected SEL instruction time.
- Teach skills such as emotion regulation, perspective-taking, and conflict resolution.
- Use role-play to practice skills.
- Reinforce SEL vocabulary during academic lessons.
- Integrate SEL into content areas.
- Revisit key skills monthly.
- Include student reflection components.

122

S – Systematically Support Within Frameworks

Use MTSS Data to Guide Intensity

- Conduct universal screening for behavior and SEL needs.
- Use Tier 1 data (referrals, attendance, engagement) to evaluate systems.
- Identify students needing Tier 2 supports (e.g., Check-In/Check-Out).
- Monitor progress every 4–6 weeks.
- Adjust interventions based on response.
- Use functional behavior assessment for Tier 3.
- Ensure team-based decision making.

123

S – Systematically Support Within Frameworks

Track Behavior & Attention Patterns

- Record time-of-day patterns.
- Track triggers and antecedents.
- Monitor attention duration.
- Identify task types associated with disengagement.
- Use simple daily behavior report cards.
- Graph data visually for teams.
- Share patterns with families collaboratively.

124

S – Systematically Support Within Frameworks

Ensure Consistency Across Adults

- Provide staff training in PBIS/MTSS language.
- Develop shared behavior matrices.
- Align classroom and non-classroom expectations.
- Hold regular team calibration meetings.
- Create substitute-friendly behavior guides.
- Use consistent reinforcement systems.
- Address staff drift through coaching.

125

S – Systematically Support Within Frameworks

Integrate Academic & Behavioral Systems

- Align academic interventions with behavioral supports.
- Use the same data platform for attendance, behavior, and grades.
- Discuss academic engagement during behavior meetings.
- Include executive functioning within MTSS planning.
- Avoid separating “academic” and “behavior” teams.
- Share intervention plans across departments.

126

Systems prevent escalation.
Consistency builds predictability.
Data guides intensity.
SEL strengthens Tier 1.
Fidelity determines outcomes.

127

Counseling Guidelines (EVIDES in Action)

- Build trust using student interests
  - Validate experiences
  - Provide predictable routines
  - ADHD: structure focus
  - ASD: explicit social clarity
- Use emotion charts
  - Draw thought bubbles
  - Map problem-solving steps
  - Use social narratives or scripts
  - Make abstract concepts concrete

128

Counseling Guidelines (EVIDES in Action)

- Increase on-task behavior (measurable intervals)
  - Reduce class exits
  - Use coping strategies independently
  - Tie goals to observable behavior
- Teach cognitive reframing
  - Practice impulse pause strategies
  - Use self-monitoring sheets
  - Track goals
  - ADHD: impulse control & persistence
  - ASD: perspective-taking & flexibility

129

Counseling Guidelines (EVIDES in Action)

- Role-play triggers
  - Rehearse calming routines
  - Build coping menu
  - Use mindfulness or biofeedback
  - Repetition builds automaticity
- Communicate with teachers
  - Align coping strategies across settings
  - Use MTSS data
  - Support caregiver consistency
  - Interventions fail in isolation

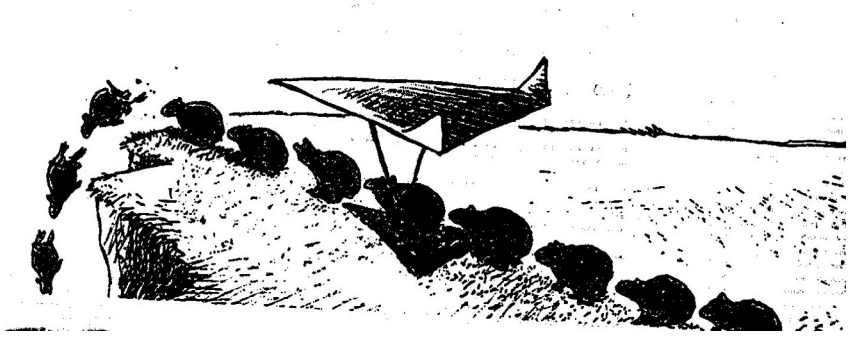
130

Resilience Encompasses:

- A process leading to good outcomes despite high risk;
- The ability to function competently under stress.

131

What Factors Contribute to Resilient Outcomes?



Lemmings

132

Biology is not destiny but it does effect probability. In every risk group there are those who manage to transition successfully into adult life despite their adversities.

133

Factors Within:

The Child

The Family

The Culture

134

Four Waves of Resilience Research

- Identifying person and variable-focused factors that make a difference.
- Identifying and understanding the operation of these factors within systems with a process focus.
- Intervening on an individual level to foster resilience.
- Intervening on a system-wide level to foster resilience.

135

U.S. Large Scale Logitudinal Studies

- The Kauai Study (698 children born in 1955)
- Minnesota Parent-Child Project (190 children born in 1975).
- Project Competence (205 children in 3rd -6th grades started in 1977).
- Virginia Study of Divorce and Remarriage (122 children in 1971).
- Rochester Study (180 children in 1970).
- Chicago Study (1200+ children in 1983).

136

Worldwide Large Scale Longitudinal Studies

- British National Child Development Study (17,000 children born in 1958).
- British Cohort Study (14,000+ children born in 1970).
- Dunedin Multidisciplinary Health and Development Study (1,000+ children born in 1972 - 1973).
- Queensland Study (8,500+ children born in 1981).
- Lundby Study (590 children born in 1997)
- Copenhagen High Risk Study (207 children from age 15 on begun 30 years ago).

137

Risk and Protective Factors: In the Individual

Risks

- Female gender
- Early puberty
- Difficult temperament: inflexibility, low positive mood, withdrawal, poor concentration
- Low self-esteem, perceived incompetence, negative explanatory and inferential style
- Anxiety
- Low-level depressive symptoms and dysthymia
- Insecure attachment
- Poor social skills: communication and problem-solving skills
- Extreme need for approval and social support

Protective

- High IQ
- Positive social skills
- Willingness to please adults
- Religious and club affiliations
- Positive physical development
- Academic achievement

Substance Abuse and Mental Health Services Administration (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Summarized from:

http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

138

Risk and Protective Factors: In the Individual

Risks

- Low self-esteem
- Shyness
- Emotional problems in childhood
- Conduct disorder
- Favorable attitudes toward drugs
- Rebelliousness
- Early substance use
- Antisocial behavior
- Head injury
- Marijuana use
- Childhood exposure to lead or mercury (neurotoxins)

Protective

- High self-esteem
- Emotional self-regulation
- Good coping skills and problem-solving skills
- Engagement and connections in two or more of the following contexts: school, with peers, in athletics, employment, religion, culture

Substance Abuse and Mental Health Services Administration (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Summarized from:

http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

139

Risk and Protective Factors: In the Family

Risks

- Inadequate or inappropriate child rearing practices,
- Home discord
- Maltreatment and abuse
- Large family size
- Parental antisocial history
- Poverty
- Exposure to repeated family violence
- Divorce
- Parental psychopathology
- Teenage parenthood
- A high level of parent-child conflict
- A low level of positive parental involvement
- Family dysfunction
- Poor parental supervision
- Sexual abuse

Protective

- Participation in shared activities between youth and family (including siblings and parents)
- Providing the forum to discuss problems and issues with parents
- Availability of economic and other resources to expose youth to multiple experiences
- The presence of a positive adult (ally) in the family to mentor and be supportive
- Family provides structure, limits, rules, monitoring, and predictability
- Supportive relationships with family members
- Clear expectations for behavior and values

Substance Abuse and Mental Health Services Administration (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Summarized from:

http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

140

Risk and Protective Factors: In Peers

Risks

- Spending time with peers who engage in delinquent or risky behavior
- Gang involvement
- Less exposure to positive social opportunities because of bullying and rejection

Protective

- Positive and healthy friends to associate with
- Engagement in healthy and safe activities with peers during leisure time (e.g., clubs, sports, other recreation

Substance Abuse and Mental Health Services Administration (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Summarized from:

http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

141

Risk and Protective Factors: School and Community

Risks

- Poor academic performance
- Enrollment in schools that are unsafe and fail to address the academic and social and emotional needs of children and youth
- Low commitment to school
- Low educational aspirations
- Poor motivation
- Living in an impoverished neighborhood
- Social disorganization in the community in which the youth lives
- High crime neighborhoods

Protective

- Enrollment in schools that address not only the academic needs of youth but also their social and emotional needs and learning
- Schools that provide a safe environment
- A community and neighborhood that promote and foster healthy activities for youth

Substance Abuse and Mental Health Services Administration (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Summarized from:

http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

142

To be a *charismatic adult* and nurture hope and resilience, we must understand and reinforce the components of a *resilient mindset* in children and teens.

143

Resilient children are comfortable and appreciate that others truly care about them and can be of support and help.

144

Resilient children recognize the boundaries of their control and focus their energy on these areas of control, acting proactively.

145

Resilient children develop competence in effective problem solving and decision making. They are flexible in reaching goals through multiple means.

146

Resilient children possess and develop self-control and self-discipline.

147

Resilient children believe they can contribute to and make a positive difference in the world.

148

Resilient children possess islands of competence or strengths that define their identity.

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Resilient children can deal effectively with mistakes and failure.

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Stress Hardiness

- Committed to finding a meaningful purpose in life.
- A belief that you can influence your surroundings and outcome of events,
- A belief that you can learn and grow from both positive and negative life experiences.

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Focus on Well Being!

- COMPETENCE in academic, social and vocational areas
- CONFIDENCE or a positive identity
- CONNECTIONS or healthy relations
- CHARACTER or positive values, integrity, and values
- CARING and compassion

(Lerner et al, 2000)

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Five Strategies To Foster a Resilient Mindset

- Teach empathy by practicing empathy.
- Teach responsibility by encouraging contributions.
- Teach decision making and problem solving skills that foster self-discipline.
- Offer encouragement and positive feedback.
- Help children deal with mistakes.

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Important Conclusions

- Autism Spectrum Disorder represents a unique, measurable condition distinct from normal behavior and development.
- DSM-5 TR and ICD 11 still require revision.
- ASD is best represented by a 3 factor model with associated symptoms and behaviors.
- ADHD is best represented by a two factor model with associated symptoms and behaviors.
- ASD and ADHD **overlap** on one of these factors.

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EVIDES is a comprehensive classroom framework that integrates engagement, visual structure, individualized supports, executive function development, emotional regulation, and systematic implementation. It emphasizes clarity and relevance (Engage), predictable visual supports (Visualize), flexible access without lowering rigor (Individualize), explicit executive skill instruction (Develop), co-regulation before independence (Emotionally regulate), and consistent PBIS/MTSS systems (Systematically support). Together, these pillars create structured, inclusive, and data-informed learning environments where academic success and behavioral growth reinforce one another.

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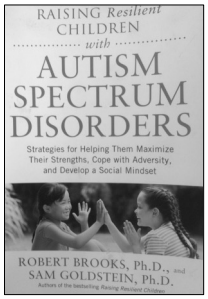
Concluding Thoughts

Were They but There at Night

There is a boulder field where every stone
Is a glazed, glittering gem, like stars fallen from the sky.
All except one, a plain grey rock alone in the center
Feeling excluded and shunned.
People come, tourists, painters, photographers, collectors
To view each shining boulder, a pleasure to the beholder.
Ooh! Ahh! Look at this one! Come quick!
Pockets bulge with fragments and paint cans run dry
But the grey rock remains ignored
An ugly blotch on a sweeping mural.
The sun sets, everyone leaves,
And they miss the centerpiece of the field.
For when night falls, the grey rock in the center
It glows in the dark.

—Devin Teichert



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EXTREME BRAINS is a lively, thought-provoking podcast in which Sam, David, and James—three friends with sharp wit and unique perspectives—gather around a microphone to critique current events, explore life's challenges, and unpack the absurdity of modern times. Whether dissecting the day's headlines, debating life's perplexing questions, or finding humor in the chaos, this podcast offers listeners an engaging mix of critical insight, camaraderie, and laughs.

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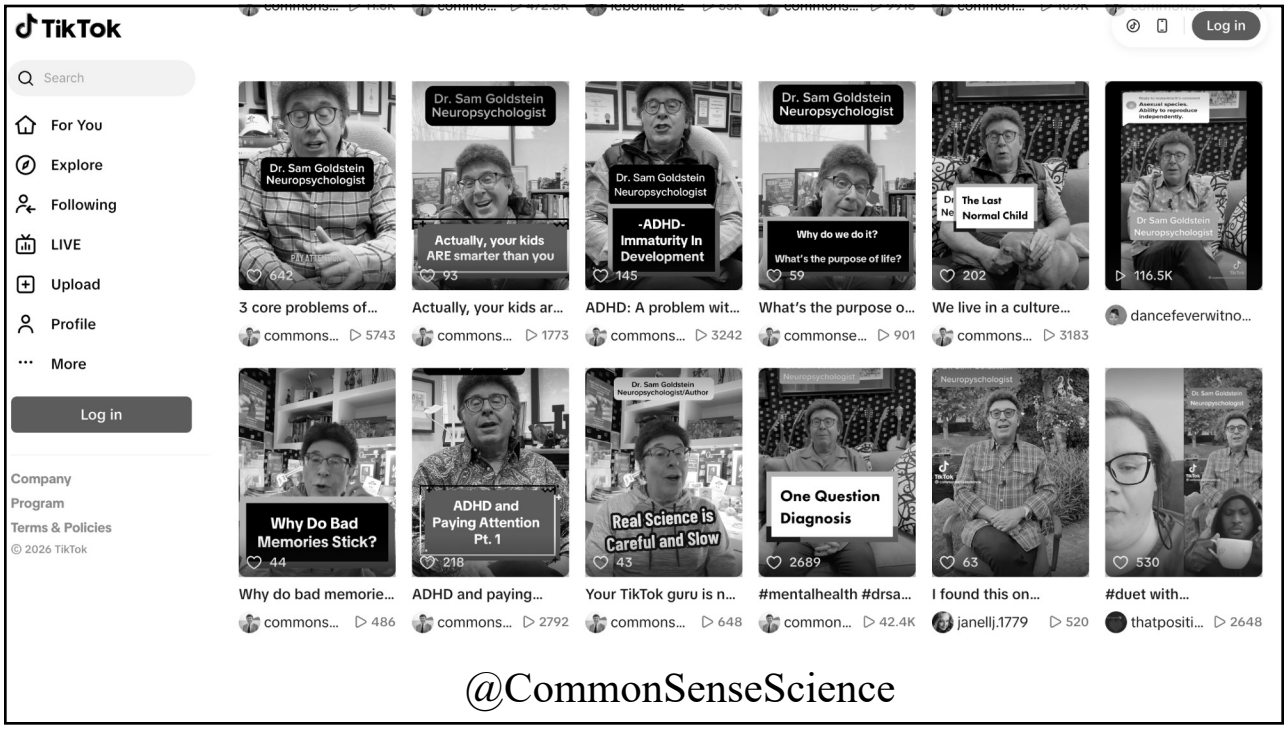

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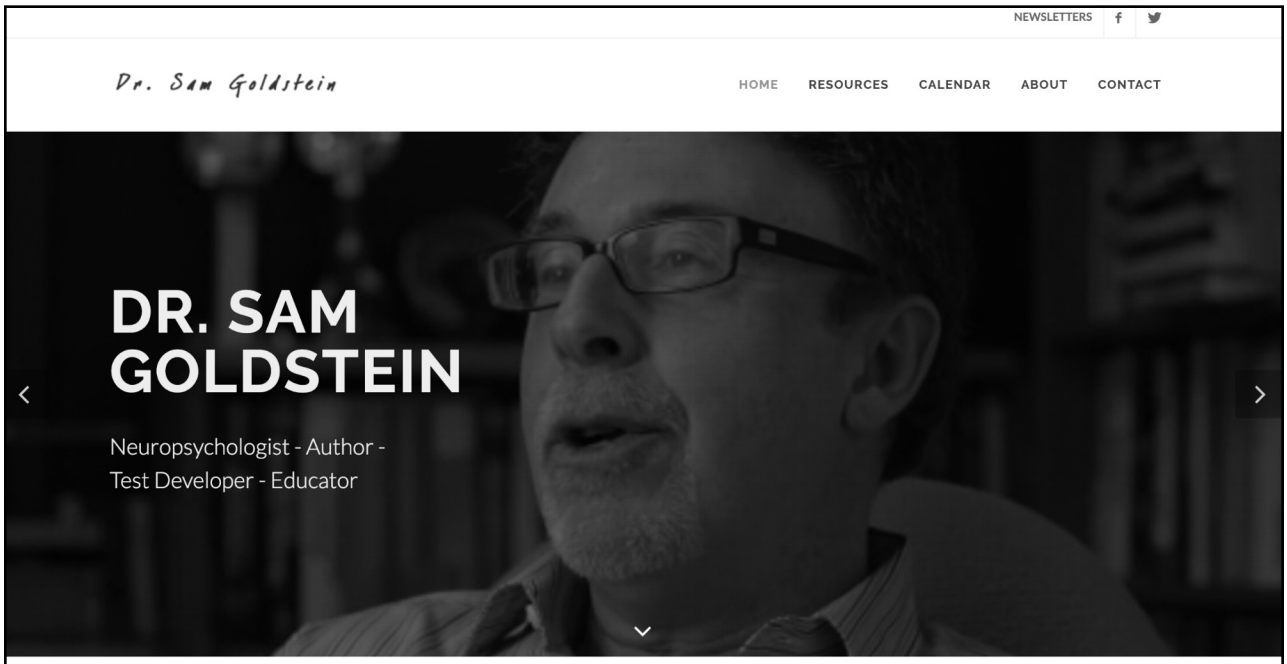

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