Social Emotional Learning: When Autism and Mental Health Collide

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Autism 101

- ASD is a developmental disorder that affects a person’s ability to socialize and communicate with others and often results in restricted, repetitive patterns of behavior, interests, or activities.
- Autism Spectrum: A wide range of symptoms, skills, and levels of impairment or disability that people with ASD can display.
- The prevalence rate is 1 in 68 children.
- Boys are 4 times more likely than girls to develop autism.
- ASD is an equal opportunity disability.

Information courtesy of the National Alliance of Mental Illness (NAMI)
https://www.nami.org/Learn-More/Mental-Health-Conditions/Autism

Autism 101

- Symptoms of autism start to appear during the first three years of life.
- All people with ASD will have symptoms that affect social interactions and relationships.
- ASD also causes difficulties with verbal and nonverbal communication and preoccupation with certain activities.

Information courtesy of the National Alliance of Mental Illness (NAMI)
https://www.nami.org/Learn-More/Mental-Health-Conditions/Autism
**Typical Symptoms of ASD**

- Delay in language development
- Repetitive and routine behaviors
- Difficulty making eye contact
- Sensory problems
- Difficulty interpreting facial expressions
- Problems with expressing emotions
- Fixation on parts of objects
- Absence of pretend play
- Difficulty interacting with peers
- Self-harm behavior
- Sleep problems

Information courtesy of National Alliance of Mental Illness (NAMI)

https://www.nami.org/Learn-More/Mental-Health-Conditions/Autism

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**According to The National Alliance on Mental Illness (NAMI):**

- Mental illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning.
- Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

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**Manifestation/Comorbid Diagnosis**

- Children (and adults) with autism often have a comorbid mental health disorder that may go undiagnosed.
- Health care providers, educators and other care providers have little guiding information on this topic.
- Signs of comorbid mental health disorder are frequently missed or dismissed as “just the autism”.
- Teachers are left unprepared and unequipped to identify what is motivating their students with autism who have challenging behaviors.
- The assumption of most people is that all behaviors are related to a student’s autism diagnosis.
- This assumption will leave mental health issues that exist untreated and may, in fact, exacerbate symptoms.

Information courtesy of The University of South Florida

http://card.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf
Overlooked

- “Recent epidemiological studies have suggested that nearly three out of every four individuals with ASD meet criteria for another (comorbid) mental health disorder. Unfortunately, comorbidities are often overlooked in the ASD population, with serious negative consequences on quality of life, school and family functioning, and access to appropriate treatment.”

Information courtesy of The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

Genetic Markers

- The largest genetic study of neurodevelopmental disorders found shared genetic risk factors between autism, ADHD, schizophrenia, major depression and bipolar disorder.
- The study included genetic information on more than 60,000 people.
- The researchers “found that changes, or mutations, in four distinct genetic areas were significantly more common in people with any one of these five disorders of brain function. Two of the alterations were in genes that appear to be involved in balancing calcium levels in brain cells. (Calcium plays a role in communication between cells.)”
- “This is a noteworthy study long in the making,” says Andy Shih, Ph.D., Autism Speaks senior vice president of scientific affairs. “It confirms many of the ideas that have been advanced in recent years and points to opportunities to development novel treatments based on shared biological pathways.”

Information courtesy of Autism Speaks

Comorbid Prevalence

Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample

OBJECTIVE:
- Autism spectrum disorders are now recognized to occur in up to 1% of the population and to be a major public health concern because of their early onset, lifelong persistence, and high levels of associated impairment. Little is known about the associated psychiatric disorders that may contribute to impairment. We identify the rates and type of psychiatric comorbidity associated with ASD and explore the associations with variables identified as risk factors for child psychiatric disorders.

METHOD:
- A subgroup of 112 two- to 14-year old children from a population-derived cohort was assessed for other child psychiatric disorders (3 months’ prevalence) through parent interview using the Child and Adolescent Psychiatric Assessment. DSM-V diagnoses for childhood anxiety disorders, depressive disorders, oppositional defiant and conduct disorders, attention-deficit/hyperactivity disorder, tic disorders, trichotillomania, enuresis, and encopresis were identified.

Information taken directly from the US National Library of Medicine National Institutes of Health
RESULTS:
• Seventy percent of participants had at least one comorbid disorder and 41% had two or more. The most common diagnoses were social anxiety disorder (29.2%, 95% confidence interval [CI] 13.2-45.1), attention-deficit/hyperactivity disorder (28.2%, 95% CI 13.3-43.0), and oppositional defiant disorder (28.1%, 95% CI 13.9-42.2). Of those with attention-deficit/hyperactivity disorder, 84% received a second comorbid diagnosis. There were few associations between putative risk factors and psychiatric disorder.

CONCLUSIONS:
• Psychiatric disorders are common and frequently multiple in children with autism spectrum disorders. They may provide targets for intervention and should be routinely evaluated in the clinical assessment of this group.
• Other research suggests that just over two-thirds of children with autism have been diagnosed with one or more psychiatric disorders. The most common include anxiety, obsessive compulsive disorder (OCD) and ADHD.

ADHD
• ADHD appears to be the most common comorbid psychiatric disorder among children with autism.
• In one research study ADHD occurred in approximately 50% of one sample.
• "ADHD in combination with ASD may confer significantly increased risk for a more complicated symptom presentation; nearly 85% of individuals with comorbid ASD/ADHD met criteria for an additional disorder."

ADHD
• ADHD (in the general population) presents with the following symptom "clusters":
  1. Hyperactivity, impulsivity, and inattention.
• There are three subtypes of an ADHD diagnosis:
  1. Hyperactive/impulsive subtype: Consists of symptoms like interrupting others, blurting out answers, being "on the go," difficulty sitting still and talking excessively.
  2. Inattentive subtype: Symptoms include distractibility, forgetfulness, difficulty with sustaining focus on tasks or activities, organizational problems, and making careless errors.
  3. Combined subtype includes symptoms from both hyperactivity/impulsivity and inattention.
**ADHD & ASD**

- All of the symptoms of ADHD may be observed in a similar manner in individuals with ASD.
- Children with ASD are significantly more likely to exhibit the inattentive subtype (rates of 65% in a recent ASD sample) and children without developmental disorder typically exhibit the combined subtype.
- Children with ADHD and autism symptoms were more likely to have substantial problems than children who only have one of the conditions.
- Personal Experience:
  - Increase in scripting behaviors
  - Increase in diminished forethought
  - Significant lack of danger awareness
  - Significant impulse control issues
  - Inability to even focus on immediate gratification
  - Decreases ability to learn in academic and social emotional learning

Information taken directly from the US National Library of Medicine National Institutes of Health

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**So How Do I Help These Kids?**

- “The answer: with a lot of patience, creativity, and consistency. As a teacher, your role is to evaluate each child’s individual needs and strengths. Then you can develop strategies that will help students with ADD/ADHD focus, stay on task, and learn to their full capabilities.”

Information courtesy of The Help Guide

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**ADHD Accommodations**

- **Information delivery**
  - Give instructions one at a time and repeat as necessary.
  - Work on the most difficult material early in the day.
  - Use visuals: charts, pictures, color coding.

- **Student work**
  - Shortened assignments
  - Test the student with ADHD in the way he or she does best, such as orally or filling in blanks.
  - Show the student how to use a pointer or bookmark to track written words on a page.
  - Computers, computers, computers!

- **Organization**
  - Seating

Information courtesy of The Help Guide
Personal Experience

- Unstructured time is the enemy!
- Materials have to be visually and technologically engaging
- Don’t be afraid to use reinforcers!
- Take a deep breath
- Realize that a small gain is still a gain
- Sometimes a song and dance is exactly what you need
- Heavy work can help
- Structuring the environment is a must
- Practice, practice, practice

Comorbid Depression

- Depression and Mood Disorders have produced the most variable comorbidity rates of all the mental health conditions, ranging from very rare (less than 1%) to upwards of 30%.
- In one study, 10% of the children with autism had at least 1 episode of major depression meeting DSM-IV criteria
- Rates for sub-threshold symptoms (a period of depression or irritability which did not meet DSM-IV depression/dysthymic disorder criteria) range from 11% to nearly 25%
- Prevalence of mood/depressive disorders appear to increase in adolescence and adulthood, occurring in 25% and 30-37% of individuals

Information taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

Depression

- Marked changes of mood and a loss of interest in activities and relationships.
- Depressed mood is typically indicated by either subjective report (e.g., feels sadness or emptiness) or observation made by others (e.g., appears tearful or irritable).
- Additional symptoms include:
  - feelings of lethargy, fatigue, or loss of energy,
  - changes in sleep and/or eating habits (either too much or too little),
  - reported feelings of worthlessness or excessive or inappropriate guilt,
  - difficulty concentrating or indecisiveness,
  - and recurrent thoughts of death, suicidal thoughts, suicide attempts or plans for committing suicide.

Information taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf
**Depression & ASD**

- Increase in tearfulness or irritability and/or absence of “happiness” or smiling in individuals who frequently did so in the past.
- Loss of interest in activities or friends.
- Resistance to participating in activities that were once engaged in willingly.
- Agitation or restlessness, pacing, hyperactivity, or wandering.
- Development of, or an increase in tantrums, meltdowns, or aggression.
- Development of, or an increase in stereotyped behaviors.
- Decreased or increased sleep, resists bedtime and/or wakes up frequently at night.
- Difficulty staying awake during the day.
- Decrease in attention to tasks.
- Decrease in productivity and/or apathy.
- Self-deprecating comments.
- Deliberate, potentially lethal acts.

Information taken directly from The University of South Florida
http://card.fhs.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

**Pay Close Attention**

- Compared to other depressed individuals, those with autism may be less likely to express the feelings typically used to diagnose depression. These include saying one feels depressed, worthless, unable to concentrate or suicidal. In the absence of such statements, tell-tale signs can include neglect in personal hygiene and other self-care activities.

Information taken directly from Autism Speaks
https://www.autismspeaks.org/what-autism/treatment/treatment-associated-psychiatric-conditions

**So How Do I Help These Kids?**

- Take every suicidal thought or threat seriously.
- Do not “force” them to communicate to you.
- If a child is in “shut-down” mode recognize this as a necessary fight or flight reaction.
- Get to the know the child “well” so you can spot even slight mood shifts.
- Create a “check-in” system.
- Recognize that what they are feeling is very “real” to them and respond accordingly.
**Personal Experience**

- In verbal children you may see a decrease in communication.
- There may be an overall shut down in functioning.
- Regressive behaviors may occur such as toileting or hygiene issues.
- Aggressive behaviors may appear "out of nowhere" or seemingly "without a cause."
- Emotional outburst may send adults searching for a cause they cannot identify.
- Self-injurious behavior does not seem to have a reason and may be highly violent in nature.
- The child may seem "stubborn" in their shut-down behavior but there is an inner drive to withdraw.

**Comorbid Bipolar Disorder**

- One study indicated that the prevalence of bipolar disorder was 3 times that of major depressive disorder, accounting for 75% of their sample of individuals with ASD and comorbid mood disorders.
- Family history of mood disorders in first- and second-degree relatives may exacerbate risk for developing bipolar disorder.
- Only 10.7% of individuals with ASD without a comorbid mood disorder had a family history of mood disorder, compared with 37.5% of those with comorbid ASD/mood disorder.

Information taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

**Bipolar Disorder**

- Serious medical condition that causes dramatic mood swings from overly "high" and/or irritable to sad and hopeless, and then back again, often with periods of normal mood in between.
- Severe changes in energy and behavior go along with these changes in mood.
- For most people with bipolar disorder, these mood swings and related symptoms can be stabilized over time using an approach that combines medication and psychosocial treatment.

Information taken directly from The Center for Parent Information and Resources
http://www.parentcenterhub.org/repository/emotionaldisturbance/
Bipolar & ASD

• Mood is inflated, elated, irritable, angry or fluctuates between happy and irritable throughout the day regardless of circumstances.
• Decreased frustration tolerance, overactivity, hyperactivity.
• Aware at night and active about the house or awakens early and appears energetic despite their lack of sleep.
• In relationship to developmental level, an individual feels they can do or achieve more than is typical for them.
• Increase in the frequency and/or intensity of vocal stereotypes, perseverative questioning and/or repetitive speech.
• Increase in preoccupation with hobbies or recreational activities.
• Increase in the frequency or intensity of ritualistic or compulsive activities, rituals may become rapid or disorganized.
• Increase in the intrusiveness of interactions with others, less inhibited (disinhibition).
• Inability to follow previously understood rules and limits.
• Hallucinations, delusions, and paranoid thoughts.

Comorbid Anxiety Disorders

• A large number of individuals with ASD (over 40%) report meeting DSM-IV criteria for specific anxiety conditions.
• The most common anxiety diagnoses are:
  • Specific Phobias or fears (44%)
  • Social Anxiety (29.2%)
  • Generalized Anxiety (13.4%)
  • Panic Disorder (10.1%)
  • Obsessive Compulsive Disorder (OCD) is also very common, although rates in individuals with ASD have varied across studies from approximately 8% to more than 33%.
• However, some level of compulsive behavior may be observed in the majority (>85%) of individuals with ASD.
• Disorders which commonly co-occur with anxiety disorders in the general population, including Tourette syndrome and other tic disorders, have also been observed in ASD.

Anxiety

• Our current diagnostic system contains a variety of specific anxiety disorders, which differ primarily in the object or source of the anxiety, as opposed to the specific symptoms displayed.
• All anxiety disorders result in avoidance of the source of anxiety, or experiences of extreme distress when the source is encountered.
• Symptoms can be physiological, behavioral and/or cognitive:
  • Physical reactions include sleep difficulties, muscle tension, being easily fatigued, headaches, maniaschastic, shortness of breath, rapid heartbeat, and sweaty palms.
  • Cognitive symptoms include difficulty concentrating (inattention) or having one’s mind go “blank,” worry which is difficult to control and which occurs in a wide range of situations, activities and subjective feelings of restlessness or being “keyed up” or “on edge” and/or irritability.
  • Behavioral symptoms include agitation (fidgeting, playing with objects, difficulty stringing, difficulty working, difficulty operating), difficulty separating from caregivers, avoidance of certain objects and/or activities or distress (freezing, crying, trembling) when these objects/activities are encountered.

Information taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf
**Anxiety & ASD**

- Avoidance of new people, tasks, environments and/or materials.
- Increases in performance of rituals and/or rigid and inflexible behavior.
- Increases in reliance to rules or scripts.
- Increases in resistance to transitions or changes to routine.
- Narrowing of focus on attention on special interest.
- Withdraws from social situations or begins to avoid social situations.
- Low frustration tolerance and/or tantrums when things don’t go “as expected.”
- Perfectionistic behavior (may be related to anxiety over performance).
- Seeks constant reassurance through repetitive questioning and/or checking behaviors.

Information taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

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**Anxiety & ASD (Specific Phobias & OCD)**

- The most common phobias in children with ASD (found in 32% of one sample) were fear of needles and/or shots and crowds.
- Over 10% of the children with autism also had a phobia of loud noises, which is not common in typically developing children.
- Obsessive-compulsive disorder (OCD): The most common type of compulsion in children with ASD was a ritual involving other individuals; nearly half of the children diagnosed with OCD had compulsions that involved others having to do things a certain way.

Information taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

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**Anxiety & ASD**

- Another frequent compulsive behavior for children with ASD was the “need to tell/ask,” which typically involves having to ask the same question in extensive question-asking rituals or having to say the same statement over and over.
- Due to communications deficits outward manifestations may be the best clues. Some researchers suspect that outward symptoms of anxiety may be especially prominent among those with ASD.

Information courtesy of Autism Speaks
https://www.autismspeaks.org/what-autism/treatment/treatment-associated-psychiatric-conditions

Information taken directly from The University of South Florida
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Anxiety & ASD

- The triggers for anxiety can be many and varied but usually have a root which can be attributed to autistic processing, such as:
  - social understanding with peers and teacher
  - unspoken social or work task requirements
  - unexpected change
- These triggers can also be cumulative.
- Trying to deal with their anxiety in isolation is not the answer. Telling someone 'don't be silly', or to 'calm down', or 'you don't need to worry about that' doesn't work
- What works better is to listen and begin at the starting point of the child. (Start in their world)
- Accept their right to feel anxious. Imagine what it feels like to be that child.
- Try to predict the upcoming situations and events that might cause anxiety.
- The better you understand how your children are affected by their autism, the more relaxed they will feel.

Information taken directly from Network Autism

Obsessive Compulsive Disorder (OCD)

- Repetitive behaviors and restricted interests are among autism's core symptoms.
- A distinguishing hallmark of OCD is that the compulsive thoughts or behavior cause anxiety. By contrast, persons with autism are not generally bothered by their repetitive behaviors and restricted interests. Just the opposite, these behaviors and interests tend to bring comfort and enjoyment.
- Still, OCD may be more common among teens and adults with ASD than in the general population. The estimated prevalence of OCD in those with ASD ranges from 8 to 33%. The prevalence of OCD in the general population is about 2%.

Information taken directly from Autism Speaks

Think of it this way...

- "These children are not argumentative or challenging; they are confused and trying to overcome their confusion by seeking more data. Imagine a world where you have no choice but to follow rules that you don't know exist until you get them wrong, and rules which have no logical function. How would it feel? Constantly terrifying. You have no idea what comes next and how soon you will be told off for doing something that you didn't know shouldn't be done."

Sarah Hendrickx

Information taken directly from Network Autism
Behavioral Treatments for Anxiety & ASD

- Several types of cognitive behavioral therapy (CBT) have been developed to address anxiety in children and teens with ASD.
- CBT has been found to be helpful for verbal individuals and those without intellectual disability.
- CBT techniques include challenging negative thoughts with logic, role-playing and modeling of courageous behavior, and step-by-step exposure to feared situations.
- Therapies for children with autism often incorporate special interests of the child.

Information courtesy of Autism Speaks
https://www.autismspeaks.org/what-autism/treatment/treatment-associated-psychiatric-conditions

Personal Experience

- My brother has a diagnosed anxiety disorder to accompany his autism. He describes the sensation as being “swarmed.”
- When he begins feeling anxious and knows the calming techniques but cannot effectively utilize them because of this “swarming” effect.
- He appears obstinate and “unwilling” to cooperate when, in fact, he cannot comply.
- Careful attention must be paid to address the issue as “he” sees it.

The Medication Question

- Medication Decision Guide
- Journal Article: Use of Psychotropic Medication in Children and Adolescents With Autism Spectrum Disorders
  http://pediatrics.aappublications.org/content/130/supplement_2/s69.long
Teach a Student to Relax

- Remember that relaxation is a skill. Teach explicitly, practice regularly, and monitor progress (data collection).
- Pick the right time.
  - Without distractions to promote concentration.
  - Make the time.
  - Set aside a regular time to teach and practice relaxation skills.
- Create a habit.
  - Practice consistently until relaxation skills become a ritual or habit.
- Create a relaxing environment.
  - Provide a quiet, comfortable area for the student to learn and practice.
- Use praise and make it fun!
  - Encourage the student with praise for success as well as attempts.
- Focus on the goal.
  - Focus on a student using these skills when situations arise.

Responding to Emotional Outbursts

- Recognize that “meltdowns” do not “come out of nowhere.”
- Recognize that you can make a difference; avoid the assumption that there is “nothing” you can do.
- Recognize that you may experience emotions during the process as well.
- Remain calm; avoid a power struggle with the student.
- Recognize the warning signs or triggers for a “meltdown.”
- Reduce the stressors in the environment.

- Remove distractions from the environment or remove the student from the stressful environment.
- Respond to the student RATHER than the behavior.
- Focus on the present moment and issue at hand.
- Be concise; less is more with verbal directions.
- Avoid teaching, preaching, or explaining until the student recovers from distress.
- Focus directions on what you want the person to do rather than what you don’t want them to do.
Responding to Emotional Outbursts

- Use simple, direct language.
- Avoid rhetorical questions, ultimatums, generalizations, sarcasm, or gentle teasing.
- Speak to the student one-on-one, if possible.
- Try to encourage the student to rephrase, in his/her own words, important points you want them to retain to make sure they've understood.
- Mean what you say and say what you mean; follow-up words with actions.

Taken directly from The University of South Florida
http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

Responding to Emotional Outbursts

- Maintain realistic expectations for the student.
- Recognize that the student may struggle to understand you, particularly via non-verbal communication (i.e. facial expression, gestures, etc.).
- Focus on emotional equilibrium then provide support for recovery after equilibrium is regained.
- Allow quiet downtime with a relaxing activity.
- Praise student for positive aspects of situation, explicitly and generously.
- After recovery, teach the student how to respond appropriately in future similar situations.

Taken directly from The University of South Florida
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What can we do to prevent the meltdown??
1. Establish a Welcoming Environment

- Welcome all students to the classroom with open arms and positive regard.
- Establish early on that your classroom is a safe place where everyone is accepted.
- Encourage students with emotional disabilities by giving them responsibilities, like class helper for the day.
- Guide general education peers to ignore inappropriate behaviors that are not harmful.

Information taken directly from Education.com
http://www.education.com/slideshow/ways-help-students-emotional-disturbance/

2. Clearly Explain Classroom Conduct

- Present classroom rules with transparency so there are no questions about what is expected.
- Describe each rule with a clear example, and allow for questions and interactive feedback.
- Spell out rewards for when the rules are followed and consequences for when they are disobeyed.

Information taken directly from Education.com
http://www.education.com/slideshow/ways-help-students-emotional-disturbance/

3. Be Positive, Not Punitive

- Teach acceptable behaviors by frequently providing models and examples.
- Positively and consistently enforce rules.
- Reinforce desirable behaviors with specific and complimentary comments: “Arekel, I like the way you said, ‘I need help.’ Thank you for using your words to ask.”

Information taken directly from Education.com
http://www.education.com/slideshow/ways-help-students-emotional-disturbance/
4. Be Respectful, Not Reproachful

- Respond to students as humans with feelings, rather than just reacting to the behavior.
- Respectfully teach appropriate social behaviors before pointing a finger.
- When a student acts out:
  1. Ask him to stop and think about his action.
  2. Ask him what he should have done.
  3. Then request that he tries again more appropriately.

Information taken directly from Education.com
http://www.education.com/slideshow/ways-help-students-emotional-disturbance/

5. Show Tolerance

- Don’t expect them to be perfect.
- Give time to cool off.
- Allow students with emotional disabilities the freedom to participate in their own way.

Information taken directly from Education.com
http://www.education.com/slideshow/ways-help-students-emotional-disturbance/

6. Foster Social Skills

- Weave social skills instruction into your teaching.
- Review acceptable ways of asking and answering a question.
- Go over strategies for resolving conflicts and dealing with stress.
- Discuss how to respectfully work with others in groups, at lunch, and on the playground.

Information taken directly from Education.com
http://www.education.com/slideshow/ways-help-students-emotional-disturbance/
7. Get to Know the Student

- Use behavioral contracts with the student, and draw from strategies that have worked in the past.
- If certain class activities bring out particular behaviors, provide an alternative independent work activity for the student.
- Sometimes students with emotional disabilities work better alone, even when the rest of the class is working in groups.

8. Refocus Distorted Thinking

- Reframe students' negative perceptions, since positive thinking leads to positive actions and behaviors.
- Teach children to celebrate their successes rather than attribute them to luck or outside forces.
- Acknowledge positive thinking and decision making: "Good job stopping and thinking before acting!"

9. Shape Up the Surroundings

- Strategically seat the student near positive peer models and away from peers who cause trouble.
- Keep potentially harmful substances or objects away from easy access.
10. Modify Materials

- Avoid overwhelming him by breaking down items into smaller sections.
- Teach self-monitoring by providing checklists or charts so he can track his academics and behaviors.

Someone once told me...

“If you do not have a plan for your students they will have a plan for you!”

Resources Cited