Sunshine Coast Health Centre | Powell River, BC

Working with High-Risk Children & Adolescents

Collaborative & Strength-Based Interventions for Educators

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Who Is In This Room?

- Classroom Teachers
- School Counsellors
- Learning Assistants
- Administrators
- Support Workers
- Psychologists

Before We Begin: Setting the Stage

Confidentiality — Case examples are anonymized. What is shared in this room stays here.

Self-Care Permission — This content can be activating. Permission to step out, take breaks, or speak with the presenter.

Shared Expertise — Your classroom experience is data. We learn bidirectionally today — your observations matter.

Questions Welcome — Raise your hand or hold questions for built-in discussion pauses throughout the day.

A Psychologist's Lens for Educators — Today's goal: translate clinical science into tools you can use Monday morning.

Today's Learning Objectives

1. Reframe 'defiant' behaviour through a neurodevelopmental and trauma-informed lens grounded in executive function research
2. Conduct classroom-level risk triage and know when and how to escalate appropriately
3. Apply Motivational Interviewing and Solution-Focused strategies with resistant youth
4. Use Collaborative & Proactive Solutions (CPS) to reduce power struggles
5. Develop actionable, strength-based safety plans with families

MODULE 1

Paradigm Shift

Understanding the 'Why' Behind Challenging Behaviour

“Kids do well if they can. If a child could do well, they would do well.”

— Dr. Ross Greene, The Explosive Child (2010)

Two Philosophies: Which Describes Your School?

- **Compliance-Based Model**
- Children misbehave because they want to
- Consequences shape behaviour
- Authority is the primary tool
- Student must adapt to system
- Focus: control and compliance
- Result: power struggles, shame

- **Lagging Skills Model (CPS)**
- Behaviour signals unmet need or skill gap
- Problem-solving produces durable change
- Relationship is the primary tool
- System adapts with the student
- Focus: collaboration and skill-building
- Result: reduced conflict, increased trust

Greene, R. (2010). The Explosive Child. Harper. | Skiba et al. (2014). Urban Education, 49(6), 634–658.

Brain Development: Why Behaviour Isn't Simply a Choice

The prefrontal cortex (PFC) is the last brain region to mature — Longitudinal neuroimaging studies confirm PFC myelination continues into the mid-20s (Casey et al., 2008; Steinberg, 2010).

The PFC governs executive functions — Impulse control, working memory, cognitive flexibility, planning, emotional regulation — skills required to 'behave well.'

Limbic regions mature earlier — Subcortical regions involved in reward and emotional reactivity develop before the PFC, creating a developmental imbalance (Casey et al., 2008).

This imbalance is neurotypical in adolescence — Even neurotypical teens show measurably reduced inhibitory control vs. adults. For high-risk youth, this gap is wider.

Implication for teachers — Expecting adult-level impulse control from a developing brain is a category error. The expectation itself is the problem.

Casey, B.J. et al. (2008). The adolescent brain. Developmental Science, 11(1), 101–108. | Steinberg, L. (2010). A dual systems model of adolescent risk-taking. Developmental Psychobiology, 52(3), 216–224.

Executive Function: The Core Skills Behind Self-Regulation

Inhibitory Control — The ability to stop a prepotent response — not hitting, not shouting, waiting for a turn. The most foundational EF skill (Diamond, 2013).

Working Memory — Holding information in mind while using it — following multi-step instructions, staying on task, tracking a conversation.

Cognitive Flexibility — Shifting attention and adapting when plans change. Inflexibility under stress is a hallmark of compromised EF.

Emotional Regulation — Modulating emotional responses — requires intact inhibitory control and PFC-limbic connectivity (Zelazo & Carlson, 2012).

Planning and Organization — Projecting outcomes, sequencing steps, managing time — critically dependent on PFC maturity.

Diamond, A. (2013). Executive functions. Annual Review of Psychology, 64, 135–168. | Zelazo, P.D. & Carlson, S.M. (2012). Hot and cool executive function in childhood and adolescence. Child Development Perspectives, 6(4), 354–360.

Why Executive Function Matters

Long-term outcomes across the lifespan

13×

higher odds of adult income problems with low childhood EF

Moffitt et al., 2011

46%

of variance in school readiness predicted by EF, not IQ

Blair & Razza, 2007

2–4×

greater risk for ADHD, anxiety, depression with EF deficits

Willcutt et al., 2005

3+ yrs

earlier EF intervention = significantly better life outcomes

Diamond & Lee, 2011

The Executive Gap

Why neurodivergent learners fall further behind

What Is the Executive Gap?

Research and clinical observation show that many students — especially neurodivergent learners — have an executive function delay of approximately 3 to 5 years.

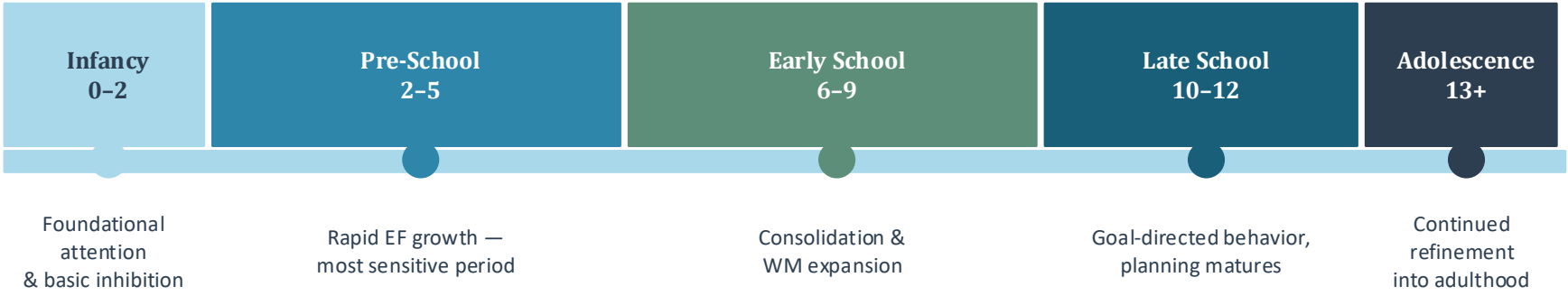
Different brain systems mature on different timelines. A child may be chronologically 10 but have EF more consistent with a 6-year-old. Holding them to age-level EF expectations creates ongoing failure.

The Negative Cycle

1. Child struggles to meet expectations
2. Adults interpret as lack of effort
3. Expectations increase (“You can do better”)
4. Stress increases
5. Executive function decreases further
6. Performance worsens

EF Development Across Childhood

Sensitive periods and developmental milestones (Zelazo et al., 2016; Anderson, 2002)



Key Research Milestones

- Age 3: Emergence of rule-based sorting; basic impulse suppression (Zelazo, 2006)
- Age 5: Dramatic leap in flexible rule application and working memory capacity
- Age 7–9: Working memory reaches near-adult capacity; cognitive flexibility strengthens
- Age 12: Inhibitory control approaches adult levels; EF network matures structurally

Executive Function Deficits: What They Look Like in the Classroom

- **What it looks like**
- Hits out before thinking — inhibitory control
- Can't follow 3-step instructions — working memory
- Meltdown when routine changes — cognitive flexibility
- Escalates instantly and can't calm down — emotional regulation
- Never starts or finishes projects — planning
- Argues the same point despite consequences — cognitive flexibility

- **What it is NOT**
- NOT defiance — a skill the child does not yet have
- NOT laziness — a capacity that is not yet developed
- NOT manipulation — a response to genuine distress
- NOT a character flaw — a neurodevelopmental lag
- NOT fixed — EF is trainable with the right scaffolding
- NOT uniform — EF deficits can be highly selective

Barkley, R.A. (2012). Executive Functions: What They Are, How They Work, and Why They Evolved. Guilford Press. | Diamond, A. (2013). Annual Review of Psychology, 64, 135–168.

The Neuroscience of Executive Function

Prefrontal cortex, dopamine, and neuroplasticity

Prefrontal Cortex (PFC)

- Last brain region to mature; primary seat of EF. Thick myelination continues until mid-20s, enabling increasingly sophisticated EF (Casey et al., 2008). The dorsolateral PFC is central to working memory and impulse control.

Dopamine & Norepinephrine

- Catecholamines modulate PFC function. Optimal — not maximal — levels are required. Dopaminergic signalling in the striatum is strongly implicated in cognitive flexibility. Miederer et al. (2025): dopamine drives adaptation to new information.

Neural Pruning & Synaptogenesis

- Overproduction then experience-dependent pruning of synapses. Pre-school years represent peak synaptogenesis. Environment shapes EF architecture through Hebbian learning mechanisms (Giedd et al., 1999).

Stress & the EF Brain

- Chronic stress (high cortisol) degrades PFC function and dysregulates EF. ACEs directly impair EF development. Autonomic arousal is a key barrier to EF access in children — regulation precedes cognition (Evans & Schamberg, 2009).

Hot vs. Cool Executive Function

Two distinct neural systems — Zelazo & Müller, 2002

Feature	Cold (Cool) EF	Hot EF
Trigger	Logic, data, and neutral tasks	Emotion, social status, and rewards
Brain Region	Dorsolateral Prefrontal Cortex	Ventromedial PFC / Limbic System
Peak Difficulty	Low (tasks are straightforward)	High (requires resisting intense feelings)
Adolescent Ability	Often adult-like by mid-teens	Significantly underdeveloped until mid-20s
Example	Knowing that speeding is dangerous	Speeding because your friends are cheering
Clinical Relevance	Deficits: ADHD, LD, ASD (often)	Deficits: conduct problems, trauma, anxiety, ER

Clinical note: Both systems need targeted development. Hot EF deficits are often more disabling in everyday life but less easily captured by standard cool EF measures.

EF Is State-Dependent and Adaptive

Niebaum, Zengilowski, Katz, Shah & Munakata (2025) — Trends in Cognitive Sciences

"Adaptive habits: understanding executive function and its development." — Executive functions are not fixed traits but dynamic, context-sensitive capacities.

State-Dependent Performance

- EF is highly sensitive to the child's momentary state — fatigue, hunger, anxiety, or emotional arousal all temporarily degrade performance. This is not defiance or laziness; it is neurobiology.

Adaptive Function

- EF is not a fixed cognitive muscle to be trained identically in every child. The system adapts based on context, goals, and environment — meaning one-size-fits-all approaches are limited.

Context Matters Clinically

- Assessment results obtained in calm, structured office settings may not reflect the child's real-world EF. Multi-context, multi-informant assessment yields a more ecologically valid picture.

Practical Implication

- Before attributing EF failure to skill deficit, assess the state: Is the child regulated? Is the environment supportive? Optimizing conditions often reveals stronger EF than previously measured.

Factors That Influence EF Development

Modifiable and non-modifiable contributors

⚠ Risk Factors

- Poverty & socioeconomic adversity (Evans & Schamberg, 2009)
- Parental stress, depression, or harsh parenting
- Adverse childhood experiences (ACEs) and trauma
- Prematurity, low birth weight
- Prenatal substance exposure (alcohol, opioids, cannabis)
- ADHD, ASD, or other neurodevelopmental conditions
- Language delays (EF & language are tightly coupled)

✓ Protective Factors

- Warm, responsive caregiving & secure attachment
- Cognitively stimulating home environment
- Bilingualism (Bialystok et al., 2012)
- Physical activity & sleep (Davis et al., 2011)
- Play — especially sociodramatic & pretend play
- Mindfulness training & self-regulation practices
- Music training (Moreno et al., 2011)

Clinical Note: EF deficits are NOT fixed. Neuroplasticity remains high in childhood — intervention works.

How Trauma Disrupts Executive Function Development

Chronic stress impairs PFC development — Glucocorticoid release from sustained stress exposure structurally alters PFC dendritic architecture during sensitive developmental periods (Arnsten, 2009).

Hippocampal effects on working memory — Maltreatment is associated with reduced hippocampal volume, directly impairing working memory and contextual learning (Goodman et al., 2019).

Hypervigilance competes with EF — Chronic threat detection occupies cognitive resources needed for learning, task completion, and impulse control (Mezzacappa, 2004).

Inhibitory control most affected — Children with maltreatment histories show the largest deficits specifically in inhibitory control tasks — the foundational EF skill (DePrince et al., 2009).

But EF is experience-dependent — Because EF develops with experience, enriched, safe, and structured environments can promote recovery — schools are a critical site of intervention.

Arnsten, A.F.T. (2009). Stress signalling pathways that impair prefrontal cortex structure and function. Nature Reviews Neuroscience, 10, 410–422. | DePrince, A.P. et al. (2009). Executive function performance and trauma exposure. Developmental Psychopathology, 21(2), 527–537.

Adversity Beyond Trauma: Poverty, Instability, and EF

Socioeconomic adversity independently predicts EF deficits — Noble et al. (2015) documented that income predicts brain surface area in regions supporting EF, even controlling for other variables.

Food insecurity impairs working memory — Blood glucose instability from irregular meals directly impairs PFC-dependent working memory during the school day.

Unpredictable home environments — Environmental unpredictability (not just poverty) specifically impairs cognitive flexibility and planning (Evans & Schamberg, 2009).

Chronic noise and crowding — Persistent background noise is associated with deficits in reading, sustained attention, and auditory processing (Evans, 2004).

Cumulative risk model — No single adversity is determinative — risk accumulates. Three or more adversity factors produces exponentially greater EF impairment (Sameroff, 2000).

Noble, K.G. et al. (2015). Family income, parental education and brain structure in children and adolescents. Nature Neuroscience, 18(5), 773–778. | Evans, G.W. & Schamberg, M.A. (2009). Childhood poverty, chronic stress, and adult working memory. PNAS, 106(16), 6545–6549.

ADHD: A Disorder of Executive Function, Not Attention

Barkley's reconceptualization — ADHD is primarily a deficit in behavioural inhibition, not attention per se — the inability to stop prepotent responses underlies all symptoms (Barkley, 1997).

PFC maturation lags by 2–5 years — Shaw et al. (2007) neuroimaging study: children with ADHD showed cortical thickness maturation patterns lagging 2–5 years behind controls.

Working memory impairment is central — Children with ADHD show 80th-percentile or lower working memory on neuropsychological testing — 'forgetting the rule in the middle of following it.'

Emotional dysregulation is underappreciated — Barkley (2010) argues emotional impulsivity — rapid, intense emotional responses — is as impairing as inattention and is EF-mediated.

Classroom implication — Repeating instructions, breaking tasks into single steps, external scaffolding, and frequent feedback are EF supports — not 'giving in.'

Barkley, R.A. (1997). Behavioral inhibition, sustained attention, and executive functions. Psychological Review, 104(1), 65–94. | Shaw, P. et al. (2007). Attention-deficit/hyperactivity disorder is characterized by a delay in cortical maturation. PNAS, 104(49), 19649–19654.

64%

of youth with 'behavioural problems' have experienced at least one ACE

Adverse Childhood Experiences directly impair EF development. Each additional ACE substantially increases risk for executive function deficits, mental health challenges, and educational failure.

Felitti et al. (1998). Am J Preventive Medicine, 14(4), 245–258. | Bethell et al. (2017). Health Affairs, 36(2), 347–356.

Trauma-Informed Perspective: Behaviour as Communication

Behaviour IS communication — Aggression, withdrawal, refusal — all are messages when language and regulation skills are unavailable.

Trauma responses are adaptive, not pathological — Ford et al. (2012): trauma-related behavioural responses represent learned adaptations to dangerous environments, not character defects.

Hypervigilance mimics defiance — Constant threat-scanning looks like inattention. Rapid defensive responses look like aggression. The function is survival.

Shame fuels escalation — Public correction activates threat circuitry. Privacy, dignity, and quiet correction de-escalate the same system.

Predictability is a neurobiological intervention — Consistent routines and warm relationships are empirically supported as buffers against stress-related EF impairment (Evans & Kim, 2013).

Ford, J.D. et al. (2012). Developmental trauma disorder. Journal of Child & Adolescent Trauma, 5(1), 3–21. | Evans, G.W. & Kim, P. (2013). Childhood poverty, chronic stress, self-regulation, and coping. Child Development Perspectives, 7(1), 43–48.

The Lagging Skills Model: A Closer Look

Core premise — If a child could meet an expectation, they would. Unsolved problems are the collision between expectations and lagging skills (Greene, 2010).

Five skill domains in CPS — 1) Executive Skills 2) Language & Communication 3) Emotional Regulation 4) Cognitive Flexibility 5) Social Thinking

Lagging skills are neurobiologically grounded — Each CPS skill domain maps directly onto well-characterized neurodevelopmental constructs (Pollastri et al., 2013).

The ALSUP tool — Assessment of Lagging Skills and Unsolved Problems — a structured checklist for identifying WHICH specific skills are lagging. Free at livesinthebalance.org.

Unsolved Problems — Specific, recurring situations where the child's lagging skills collide with adult expectations — these are the targets for Plan B conversations.

Greene, R.W. (2010). The Explosive Child. Harper. | Pollastri et al. (2013). Harvard Review of Psychiatry, 21(4), 188–200. | Ollendick et al. (2016). J Clinical Child & Adolescent Psychology, 45(2), 111–121.

ALSUP 2020

ASSESSMENT OF LAGGING SKILLS & UNSOLVED PROBLEMS

Collaborative & Proactive Solutions

THIS IS HOW PROBLEMS GET SOLVED

CHILD'S NAME _____ DATE _____

The ALSUP is intended for use as a **discussion guide** rather than as a freestanding check-list or rating scale. It should be used to identify specific lagging skills and unsolved problems that pertain to a particular child or adolescent.

LAGGING SKILLS

This section will help you understand why the child is responding so maladaptively to problems and frustrations. Please note that these **lagging skills are not the primary focal point of intervention**. In other words, you won't be discussing the lagging skills with the student, nor will you be teaching most of the skills explicitly. The primary targets of intervention are the unsolved problems you'll be documenting in the next section.

☐	Difficulty maintaining focus	☐	Difficulty seeing "grays"/concrete, literal, black & white, thinking
☐	Difficulty handling transitions, shifting from one mindset or task to another	☐	Difficulty taking into account situational factors that would suggest the need to adjust a plan of action
☐	Difficulty considering the likely outcomes or consequences of actions (impulsive)	☐	Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., "Everyone's out to get me," "Nobody likes me)"
☐	Difficulty persisting on challenging or tedious tasks	☐	Difficulty attending to or accurately interpreting social cues/ poor perception of social nuances
☐	Difficulty considering a range of solutions to a problem	☐	Difficulty shifting from original idea, plan, or solution
☐	Difficulty expressing concerns, needs, or thoughts in words	☐	Difficulty appreciating how their behavior is affecting others
☐	Difficulty managing emotional response to frustration so as to think rationally	☐	Difficulty starting conversations, entering groups, connecting with people/lacking other basic social skills
☐	Chronic irritability and/or anxiety significantly impede capacity for problem-solving or heighten frustration	☐	Difficulty empathizing with others, appreciating another person's perspective or point of view
☐	Sensory/motor difficulties	☐	Difficulty handling unpredictability, ambiguity, uncertainty, novelty

UNSOLVED PROBLEMS

Unsolved problems are the specific expectations a child is having difficulty meeting. The wording of an unsolved problem will translate directly into the words that you'll be using when you introduce an unsolved problem to the child when it comes time to solve the problem together. Poorly worded unsolved problems often cause the problem-solving process to deteriorate before it even gets started. Please reference the ALSUP Guide for guidance on the four guidelines for writing unsolved problems.

SCHOOL/FACILITY PROMPTS:

Are there specific tasks/expectations the student is having difficulty completing or getting started on?

Are there classmates this student is having difficulty getting along with in specific conditions?

Are there tasks and activities this student is having difficulty moving from or to?

Are there classes/activities the student is having difficulty attending/being on time to?

As you think about the start of the day to the end, are there any other expectations the student has difficulty reliably meeting or that you find yourself frequently reminding the student about?

HOME/CLINIC PROMPTS:

Are there chores//tasks/activities the child is having difficulty completing or getting started on?

Are there siblings/other children the child is having difficulty getting along with in specific conditions?

Are there aspects of hygiene the child is having difficulty completing?

Are there activities the child is having difficulty ending or tasks the child is having difficulty moving on to

As you think about the start of the day to the end, are there any other expectations the child has difficulty reliably meeting or that you find yourself frequently reminding the child about?

ALSUP Guide

- The *Assessment of Lagging Skills and Unsolved Problems* (ALSUP) is best used as a *discussion guide* rather than as a free-standing checklist or rating scale.

- Meetings should be focused almost totally on identifying lagging skills and unsolved problems. It is not the goal of the meeting to try to explain *why* a child has a particular lagging skill or unsolved problem, so hypotheses and theories about *cause* are to be avoided. It is also counterproductive to have participants go into great detail about the *behaviors* that a child exhibits in response to a given unsolved problem so story telling is to be avoided as well.

- It's best to discuss each lagging skill (rather than "cherry-picking"), starting at the top

- If a lagging skill is endorsed, don't continue moving down the list of lagging skills…move *over* to identify the unsolved problems associated with the lagging skill

- An unsolved problem is an *expectation a child is having difficulty meeting in association with a particular lagging skill*

- To identify unsolved problems, begin with the stem, "Can you give some examples of expectations (Theresa) is having difficulty meeting when you think of her having (then restate the endorsed lagging skill. For example, "Can you give some examples of expectations Theresa is having difficulty meeting when you think of her having difficulty making transitions?"

- Identify as many unsolved problems as possible for each endorsed lagging skill… don't move on after identifying only one unsolved problem.

- Many lagging skills may contribute to the same unsolved problem…don't spend valuable meeting time trying to be precise about which lagging skill best accounts for a given unsolved problem.

- Don't write the same unsolved problem in more than once, even if a later lagging skills reminds you of the same unsolved problem.

- There are some important guidelines for writing unsolved problems:

    ⇒ **They usually begin with the word *Difficulty***, and the word *Difficulty* is usually followed by a verb, for example:

    - Difficulty *getting started* on the double-digit division problems in math
    - Difficulty *completing* the map of Europe in geography
    - Difficulty *participating* in the discussions in morning meeting
    - Difficultly *moving* from choice time to math
    - Difficulty *ending* computer time to come to circle time
    - Difficulty *coming* into school in the morning
    - Difficulty *going* to the nurse for your medication before lunch

⇒ **Some verbs should be avoided:** accepting, appreciating, staying calm, asking for help, listening, paying attention, focusing, considering, understanding, persisting, controlling

⇒ **They should contain no reference to the child's *challenging* behaviors**, though reference to *expected* behaviors is fine (so you wouldn't write *Screams and swears when having difficulty completing the word problems on the math homework*…instead write *Difficulty completing the word problems on the math homework*)

⇒ **They should contain no adult theories** (so you wouldn't write *Difficulty writing the definitions to the spelling words in English…because his parents were recently divorced*)

⇒ **They should be split, not clumped** (so you wouldn't write *Difficulty raising hand* but rather *Difficulty raising hand during social studies discussions*)

⇒ **They should be specific**…there are two strategies to help:

- Include details related to who, what, where, and when
- Ask *What expectation is the child/student having difficulty meeting?*

•**Lagging Skill:** Difficulty shifting from one task to another (Cognitive Flexibility).

•**Unsolved Problem:** "Difficulty stopping the video game to come to the dinner table" or "Difficulty moving from Math class to Gym class.”

•**Lagging Skill:** Difficulty maintaining focus on long-term goals (Working Memory).

•**Unsolved Problem:** "Difficulty completing the three-step morning routine (brush teeth, get dressed, pack bag) without being reminded."

Lagging Skills: Translating Behaviour into Skill Deficits

- **The Behaviour You See**
- Hits classmate without apparent reason
- Cannot follow multi-step instructions
- Explosive refusal when routine changes
- Argues endlessly about fairness
- Cannot start or finish any work
- Shuts down when corrected
- Physically leaves the classroom

- **The Lagging Skill**
- Inhibitory control — cannot stop prepotent response
- Working memory — cannot hold multiple steps
- Cognitive flexibility — cannot adapt to change
- Perspective-taking — locked into own framework
- Planning / initiation — EF demand overwhelming
- Frustration tolerance — regulation skills absent
- Distress tolerance — avoidance is coping

Barkley, R.A. (2012). Executive Functions. Guilford Press. | Greene, R.W. & Ablon, J.S. (2006). Treating Explosive Kids. Guilford Press.

Academic EF Demands

How school tasks load on executive functions (Meltzer, 2010)

Academic Task	Inhibitory Control	Working Memory	Cognitive Flexibility	Planning
Reading Comprehension	•• Ignore distractors	••• Sentence integration	• Track perspectives	–
Mathematics (Arithmetic)	• Suppress algorithms	••• Carry numbers	•• Switch operations	•
Written Composition	•• Stay on topic	••• Manage ideas + syntax	•• Revise plans	••• Outline & organize
Listening & Note-Taking	••• Dual-task filtering	••• Real-time retention	•• Topic shifts	•
Test-Taking	••• Anxiety inhibition	•• Recall under pressure	• Re-examine questions	••• Time management
Social Interaction	••• Turn-taking, impulse	•• Track conversation	••• Perspective-taking	•

••• = high load •• = moderate • = low – = minimal demand

Strength-Based Profiling: Beyond Diagnostic Labels

Diagnostic labels describe, not define — ADHD, ODD, ASD — these describe patterns of behaviour, not a child's potential, identity, or future.

Islands of Competence — Dr. Robert Brooks: Every child has areas of genuine strength. Find them. Use them as anchors for relationship and engagement.

Resilience factors to map — Curiosity, humour, artistic talent, loyalty, physical skill, persistence, protectiveness, creativity.

Why this matters clinically — Bandura's (1997) self-efficacy theory: demonstrated competence in one domain generalizes to motivation and persistence in others.

Teacher task — Complete a strength inventory for one challenging student: list 5 genuine, specific strengths you have directly observed.

Brooks, R. & Goldstein, S. (2002). Raising Resilient Children. McGraw-Hill. | Bandura, A. (1997). Self-Efficacy: The Exercise of Control. W.H. Freeman.

Scaffolding Executive Function: What Teachers Can Do

External working memory supports — Visual schedules, checklists, step-by-step written instructions — these externalize the cognitive load and reduce WM demand.

Predictable routines — Consistent transitions, advance warnings ('5 minutes until we change'), and stable daily sequences reduce cognitive flexibility demand.

Chunk and sequence tasks — Break multi-step tasks into single-step units with checkpoints. This accommodates limited WM capacity.

Reduce stimulation during regulated states — Peak learning requires an optimal arousal state — reduce competing sensory/social demands when teaching complex content.

Teach self-monitoring explicitly — Metacognitive strategy training (checking work, self-rating effort) builds EF skills directly — not assumed, explicitly taught (Reid et al., 2005).

Reid, R. et al. (2005). Self-monitoring of attention versus self-monitoring of academic accuracy. Journal of Learning Disabilities, 38(1), 24–32. | Meltzer, L. (Ed.). (2010). Promoting Executive Function in the Classroom. Guilford Press.

EF Strategies for

Tools, techniques, and teen-adapted approaches

EF Skill	Tool / Strategy	Description & Goal
Planning & Organization	Digital Organization & Habit Stacking	Apps (Google Calendar, Trello, Evernote) for long-range planning; Habit Stacking links new behaviours to existing routines to reduce initiation failure.
Time Management	Pomodoro Technique + Time-Estimation	Focused work intervals (25 min) + short breaks. Teen first estimates task duration, then tracks actual time — builds metacognition about time blindness.
Working Memory	Active Study Strategies	Self-quizzing, writing summaries without the text, teaching material to someone else — all force active manipulation of WM rather than passive re-reading.
Inhibition & Self-Control	STOPP Method	Stop, Take a breath, Observe, Pull back, Proceed. Practised in calm states so it is available during high-emotion situations. Reduces impulsive social responses.
Cognitive Flexibility	Debate & Perspective-Taking	Argue a position they disagree with; consider viewpoints counter to their own. Directly exercises mental set-shifting and suppression of habitual views.
Goal-Directed Persistence	S.M.A.R.T. Goal Setting	Specific, Measurable, Achievable, Relevant, Time-bound goals. Structures motivation needed for long-term projects and self-directed academic work.
Emotional Regulation	Journaling & Mindfulness	Journaling processes and labels strong emotions. Mindfulness strengthens PFC's ability to observe emotional states without immediately acting on them.

Sleep: The Overlooked EF Intervention

Sleep as active EF consolidation (Sadeh et al., 2002; Gruber et al., 2010)

A single night of sleep restriction (2 hrs) causes EF impairment equivalent to mild ADHD (Gruber et al., 2010)

PFC Vulnerability

- PFC is particularly sensitive to sleep deprivation. Even subclinical reductions impact EF before other cognitive functions show impairment.

Recommended Hours (6–12)

- 9–11 hours per night (AAP, 2016). Only 30% of school-age children meet this. Screen-based displacement is the leading cause. Sleep is when EF consolidation occurs.

Academic Impact

- Children in the bottom sleep quartile scored 2 grade levels lower on math and literacy than those in the top quartile (Gruber et al., 2012). Sleep is educational intervention.

Clinical Intervention

- Sleep hygiene psychoeducation, consistent bedtimes, screens from bedrooms, CBT-I adapted for children. Parent coaching often needed as primary change agent.

REFLECTIVE ACTIVITY

The Lagging Skills Lens

Think of one student whose behaviour is most challenging for you.

On your notes sheet, answer:

1. What does the behaviour look like? Be specific and observable.
2. In what situations does it occur most often?
3. Which executive function or lagging skill might explain it?
4. What might this child be communicating when they do this?
5. What would a strength-based framing of this child look like?

10 minutes individual, then pair-share

MODULE 2

Risk Assessment & Crisis Management

What Teachers Need to Know — and When to Call for Help

The Teacher's Role in Risk Triage

Teachers are first responders — You see children daily and are often the first to notice signs of distress, ideation, or self-harm. Risk assessment requires clinical training. Your role: observe, document, refer promptly, and stay.

Three categories to recognize — 1) Suicidal ideation 2) Non-Suicidal Self-Injury (NSSI) 3) Aggression and violence risk

The Ask-Tell-Act sequence — ASK directly. TELL a school counsellor or psychologist immediately. ACT to maintain safety until support arrives.

Documentation matters — Write exact words, time, and context. This information is clinically irreplaceable.

Gould, M.S. et al. (2005). Evaluating iatrogenic risk of youth suicide screening programs. JAMA, 293(13), 1635–1643.

Distinguishing Suicidal Behaviour from NSSI

- **Non-Suicidal Self-Injury (NSSI)**
- Intent: to regulate emotion — NOT to die
- Common forms: cutting, burning, hitting self
- Often communicates overwhelm or numbness
- Still requires immediate clinical assessment
- Increases lifetime suicide risk if chronic
- Do NOT: overreact publicly or minimize privately
- Increased risk with poor EF inhibitory control

- **Suicidal Ideation and Behaviour**
- Intent: to end life or escape intolerable pain
- Passive (wishing to die) vs. Active (plan + means)
- Assess: ideation, plan, means, intent, timeline
- Acute risk = immediate referral, do not leave alone
- Means restriction is evidence-based (Yip et al., 2012)
- Do: stay calm, listen, refer, document

Nock, M.K. (2010). Self-injury. Annual Review of Clinical Psychology, 6, 339–363. | Klonsky, E.D. & Muehlenkamp, J.J. (2007). Self-injury. Journal of Social and Clinical Psychology, 26(1), 1–33.

Warning Signs Every Teacher Should Know

Verbal warnings — 'I wish I were dead,' 'nobody would miss me,' 'I can't do this anymore,' giving away possessions.

Behavioural shifts — Sudden calm after prolonged agitation (may indicate a decision has been made), social withdrawal, increased risk-taking.

Written or digital signals — Notes, social media posts, drawings depicting death or hopelessness — treat all seriously.

Recent acute stressors — Relationship breakup, humiliation, bullying, abuse disclosure, bereavement, academic failure — these elevate acute risk.

Access to means — Mentioning specific methods, firearms, or medications significantly elevates lethality risk (Yip et al., 2012).

Rudd, M.D. et al. (2006). Warning signs for suicide. Suicide and Life-Threatening Behavior, 36, 255–262. | Yip, P.S. et al. (2012). Australian & New Zealand Journal of Psychiatry, 46, 527–536.

How to Talk to a Student You're Worried About

Choose a private moment — Never address concerns in front of peers. 'Can you stay back for a minute?' preserves dignity.

Open with observation, not accusation — 'I've noticed you seem really down lately. I've been worried about you.'

Ask directly and calmly — 'Are you thinking about hurting yourself or ending your life?' — research supports direct language (Gould et al., 2005).

Listen without immediately problem-solving — 'That sounds incredibly hard. I'm glad you told me.' This is enough for now.

Do NOT promise confidentiality — Say: 'I care about you too much to keep this secret. I'm going to get you some help.'

Dazzi, T. et al. (2014). Does asking about suicide induce suicidal ideation? Psychological Medicine, 44, 3361–3363. | Gould et al. (2005). JAMA, 293(13), 1635–1643.

Safety Planning 2.0: Beyond the 'Contract for Safety'

Why contracts fail — No-harm contracts have no evidence base and create false security. Rudd et al. (2006) found they may actually reduce disclosure.

Safety planning is collaborative — Developed WITH the student, not handed to them. Collaboration increases ownership and follow-through.

Stanley-Brown Safety Planning Intervention — Six-component evidence-based protocol validated in multiple RCTs (Stanley & Brown, 2012; Bryan et al., 2017).

Six components — 1) Warning signs 2) Internal coping 3) Social distractions 4) Adults to contact 5) Professionals 6) Means restriction

Teacher's role — You may be listed as a trusted adult on a safety plan. Know what that means — availability, confidentiality limits, how to respond.

Stanley, B. & Brown, G.K. (2012). Safety planning intervention. Cognitive and Behavioral Practice, 19(2), 256–263. | Bryan, C.J. et al. (2017). J Consulting & Clinical Psychology, 85, 419–426.

When to Escalate: Teacher's Decision Tree

OBSERVE	ASK	REFER	STAY	DOCUMENT
Student discloses, warning signs appear, or baseline behaviour changes significantly	Ask directly about safety in private — calmly and without alarm	Contact counsellor or psychologist immediately — do not handle alone	Do not leave the student alone until clinical support arrives	Record exact words, time, context, and all actions taken

Emergency 911 if there is immediate danger to life | Canada Suicide Prevention: 1-833-456-4566

Gould et al. (2005). JAMA, 293(13). | Canadian Psychiatric Association (2016). School-Based Mental Health.

Legal & Ethical Considerations for Educators

Duty to report — All school staff are mandatory reporters in BC under the Child, Family and Community Service Act — this supersedes confidentiality.

When confidentiality must be broken — Imminent risk to self or others. Always tell the student before breaching: 'I have to tell someone to keep you safe.'

Working with minors — Consent typically from parents/guardians. Mature minors in BC can consent to some services independently.

Documentation and liability — Clear, factual documentation protects you legally. Vague notes or failure to document a concern is a professional liability.

The need-to-know principle — Share safety information with those who need it to protect the child — counsellor, admin, parents. Not as hallway conversation.

BC Child, Family and Community Service Act, RSBC 1996, c. 46, s.14.

Managing Acute Behavioural Escalation: Evidence-Based Principles

Prevention over reaction — Know the student's triggers, early warning signs, and typical escalation sequence BEFORE crisis — use this knowledge proactively.

Reduce demands during escalation — Lowering the volume of demands when a student is escalating is counter-intuitive but neurobiologically sound — high EF demand accelerates escalation.

Limit audience — Remove peers where safely possible. Social observation activates self-conscious emotion and prolongs escalation.

Prosodic and postural regulation — Calm, quiet voice; open body; eye-level positioning — these signal safety to threat-detection systems (Porges, 2011).

Offer constrained choice — 'Would you like to take a break in the hall or sit in the back?' — preserves autonomy and reduces perceived threat.

Porges, S.W. (2011). The Polyvagal Theory. Norton. | Delahooke, M. (2019). Beyond Behaviors. PESI Publishing.

MODULE 3

The Collaborative Toolkit

Integrated Evidence-Based Interventions

Today's Evidence-Based Toolkit

CPS

Collaborative & Proactive Solutions

MI

Motivational Interviewing

SFBT

Solution-Focused Brief Therapy

PACE

Playfulness, Acceptance, Curiosity, Empathy

TIC

Trauma-Informed Care Framework

NE

Narrative & Externalizing Approaches

Collaborative & Proactive Solutions (CPS): Core Philosophy

Developed by Dr. Ross Greene — Validated in schools, psychiatric units, and juvenile detention (Pollastri et al., 2013; Ollendick et al., 2016).

Plan A — Adult imposes will unilaterally — Maintains adult authority but produces compliance without skill-building, and frequently triggers escalation.

Plan B — Collaborative problem-solving — Adult and child share in generating solutions. Most effective for durable behaviour change.

Plan C — Drop the demand strategically — Used temporarily to reduce friction while building capacity for Plan B. Not surrender — a tactical choice.

Plan B is the evidence-based target — Increases buy-in, reduces power struggles, teaches missing lagging skills through the problem-solving process itself.

Pollastri, A.R. et al. (2013). Harvard Review of Psychiatry, 21(4), 188–200. | Greene, R.W. & Ablon, J.S. (2006). Treating Explosive Kids. Guilford Press.

The Plan B Conversation: Step-by-Step

Step 1 — Empathy — Gather the child's perspective FIRST. 'I've noticed you're refusing group work lately. What's going on?' Listen without solving. Ask: 'What else?'

Step 2 — Define the Problem — Add your concern without dismissing theirs. 'The thing is, group work is part of the curriculum and I need to find a way to include you.'

Step 3 — Invitation — 'I wonder if we can figure out a solution that works for both of us.' Brainstorm together — evaluate together.

Key rule: Empathy must be genuine and complete — If you move to Step 2 before truly understanding Step 1, the child will know — and the conversation collapses.

Timing is everything — Plan B is a proactive, planned conversation held during a calm moment — never reactive, never during crisis.

Greene, R.W. & Ablon, J.S. (2006). Treating Explosive Kids. Guilford Press. | Pollastri et al. (2013). Harvard Review of Psychiatry, 21(4), 188–200.

PRACTICE ACTIVITY

Plan B Role Play

Scenario:

Jordan (Age 12, Grade 7) refuses to submit any written work for 3 weeks. When pushed, he says 'I'm not doing it' and puts his head on the desk. He participates verbally but shuts down completely at the sight of a pencil or keyboard.

Task:

In pairs — one person plays teacher, one plays Jordan.
Teacher: use all three Plan B steps:
1. Empathy — gather Jordan's perspective fully before moving on
2. Define the Problem — add your concern without dismissing his
3. Invitation — generate solutions together

15 minutes, then group debrief

Motivational Interviewing (MI): Engaging the Reluctant Student

What is MI? — A collaborative, person-centred style that strengthens intrinsic motivation by exploring and resolving ambivalence (Miller & Rollnick, 2013).

OARS: The four core skills — Open questions, Affirmations, Reflections, Summaries — applicable in any brief conversation with a resistant student.

Rolling with Resistance — Never argue, confront, or persuade. Resistance is a signal to back off and reflect — not to push harder.

Change Talk vs. Sustain Talk — Listen for the student's own arguments for change (Change Talk) and reflect them. Avoid arguing against sustain talk.

MI Spirit — Partnership, Acceptance, Compassion, Evocation — MI is an attitude first, then a technique.

Miller, W.R. & Rollnick, S. (2013). Motivational Interviewing (3rd ed.). Guilford Press. | Lundahl, B. et al. (2010). Research on Social Work Practice, 20(2), 137–160.

Rolling with Resistance: What to Say Instead

- **INSTEAD OF pushing...**
- 'You need to come to school every day.'
- 'If you don't do this, you'll fail.'
- 'Other students manage — why can't you?'
- 'You're not even trying.'
- 'Your parents will hear about this.'

- **TRY reflecting instead...**
- 'School feels like a lot right now. What's the hardest part?'
- 'Sounds like you're worried about the future. Tell me more.'
- 'You're frustrated nobody gets how hard this actually is.'
- 'I hear you — this doesn't feel worth it. When did that start?'
- 'You're carrying a lot right now. What would help most?'

Brehm, S.S. & Brehm, J.W. (1981). Psychological Reactance. Academic Press. | Miller, W.R. & Rollnick, S. (2013). Motivational Interviewing. Guilford Press.

Solution-Focused Brief Therapy (SFBT): Core Techniques

Premise — Focus on what already works — not on analyzing problems. Build on existing strengths and exceptions (de Shazer et al., 2007).

The Miracle Question — 'If you woke up tomorrow and the problem was solved, what would be different?' Builds vision of change without requiring insight into causes.

Exception Finding — 'Tell me about a time when this problem wasn't happening.' Identifies strategies the student already uses — often unknowingly.

Scaling Questions — 'On a 1-10 scale, how bad is today? What would one step up look like?' Creates movement and makes change tangible.

Research base — Kim (2008) meta-analysis: SFBT produces significant improvements across school-based outcomes. Gingerich & Peterson (2013): 43/54 controlled studies showed positive effects.

Kim, J.S. (2008). Research on Social Work Practice, 18(4), 357–369. | Gingerich, W. & Peterson, L.J. (2013). Research on Social Work Practice, 23(3), 266–283.

Externalizing Language: Before & After

- **BEFORE (Person = Problem)**
- 'You're so aggressive.'
- 'Stop being defiant.'
- 'You're an anxious kid.'
- 'Why are you always so difficult?'
- 'You ruined the class.'
- 'You're failing because you don't try.'

- **AFTER (Externalizing)**
- 'Anger showed up big today. What set it off?'
- 'Sounds like The Resistance is talking loud. What's it worried about?'
- 'Worry seems to be working overtime today. What's it saying?'
- 'Something is making this really hard right now. What is it?'
- 'A tough moment happened. How do we repair together?'
- 'Something is getting in the way. Let's figure out what.'

White, M. & Epston, D. (1990). Narrative Means to Therapeutic Ends. Norton. | Madigan, S. (2019). Narrative Therapy (2nd ed.). APA Press.

1 in 5

Canadian children have a diagnosable mental health condition

Of these, fewer than 25% receive appropriate treatment. Schools are where most children are first identified — teachers are the most critical gatekeepers in the child mental health system.

Waddell, C. et al. (2005). BC Medical Journal, 47(4), 174–180. | MHCC (2012). Changing Directions, Changing Lives. Ottawa.

MODULE 4

Engaging the System

Families, Schools, and Cross-Sector Collaboration

Families as Partners, Not Problems

Reframe family dynamics — Parents of high-risk children have usually heard what is wrong. They need to hear what they can do, and to feel genuinely heard first.

The expertise exchange — Teachers know the child in one setting; parents know the child across all others. Both perspectives are essential and incomplete alone.

What families want from schools — To be heard first. To not be blamed. To have practical strategies. To see their child recognized as capable.

Alliance-building language — 'You know your child best. I want to learn from you, and share what I'm seeing from my end.' — this disarms defensiveness.

Parent-teacher alliance predicts outcomes — Webster-Stratton (2006) and Sanders et al. (2009): parent-teacher collaboration is a significant independent predictor of intervention success.

Webster-Stratton, C. (2006). The Incredible Years. Umbrella Press. | Sanders, M.R. et al. (2009). Triple P Positive Parenting Program. Journal of Family Psychology, 23(4), 467–477.

School-Home Collaboration for EF Support

Creating consistent, supportive environments (Dawson & Guare, 2010)

School Accommodations

- Extended time on tests (reduces WM bottleneck under time pressure)
- Preferential seating (near teacher, low-distraction zone)
- Task breakdown: written instructions, step-by-step checklists
- Frequent check-ins and self-monitoring prompts during work

Home Strategies

- Visual daily schedule posted in common areas; consistent routine
- Homework routine at same time and place every day
- Break large tasks into sub-goals; reward milestone completion
- Limit screens; protect 9–11 hours of sleep per night

PACE: A Relational Framework for Healing Connections

Developed by Dr. Dan Hughes (2007) — Originally for attachment-disordered children; broadly applicable across all high-risk youth and their caregivers.

PLAYFULNESS — Light, creative engagement that signals safety. Play activates the social engagement system and lowers threat detection.

ACCEPTANCE — Accepting the child's inner life — feelings, needs, wishes — without requiring them to change first. Not approval of behaviour.

CURIOSITY — 'I wonder what it's like to be you right now.' Non-judgmental exploration of the child's experience.

EMPATHY — Resonating with the child's emotional experience. 'That sounds really hard.' — naming and validating without amplifying.

Hughes, D. (2007). Attachment-Focused Family Therapy. Norton. | Pianta, R.C. et al. (2003). Journal of School Psychology, 41, 223–238.

Addressing Caregiver Burnout: What Parents Need from Schools

Name it without shame — 'Many parents of children like yours tell me they're running on empty. How are you doing?' — this gives permission to be honest.

Validate the exhaustion — Parenting a high-needs child is objectively harder. ACEs, dysregulation, and daily school calls produce chronic parental stress.

Identify parents' own triggers — Parents cannot regulate a dysregulated child if they are dysregulated themselves — the same EF principles apply to adults.

Provide psychoeducation — The same EF and neurodevelopment content from Module 1 helps parents understand their child — and respond differently.

Connect to community support — Parent groups, respite care, family counselling. Schools are not the only support — connect actively to what exists.

Bearss, K. et al. (2015). JAMA, 313(15), 1524–1533. | Miko, I. (2017). European Child & Adolescent Psychiatry, 26(3), 281–292.

Building Cross-Sector Safety Nets for High-Risk Youth

Why teams matter — No single professional has full context on a high-risk child. Teams prevent both gaps and duplication of effort.

Who should be at the table — Teacher + school counsellor + psychologist + family + community support worker + (as relevant) youth worker, probation, or mental health clinician.

Shared language is essential — Teams fail when professionals use different frameworks. Agree on shared goals, shared vocabulary, and decision rules at the outset.

Wraparound model — Child and family-centred planning with natural and professional supports. Evidence from Burns & Goldman (1999) and Bruns & Walker (2008).

Your role in the team — You provide the most frequent observational data in the child's life. Your documentation and communication are clinically irreplaceable.

Bums, B.J. & Goldman, S.K. (1999). Promising practices in wraparound. CMHS. | Bruns, E.J. & Walker, J.S. (2008). Research on Social Work Practice, 18, 132–142.

MODULE 5

Advanced Case Application

Complex Scenarios & Clinical Decision-Making

Case Study: Aiden, Age 9 — ASD + Trauma

Presentation: Aiden has ASD (Level 2) and a trauma history (witnessed domestic violence to age 6). He screams and hits when transitions are announced, strips off his shirt during sensory overload, and has injured two classmates this month. School is considering suspension.

Discussion Questions:

1. Which specific executive functions are most impaired?
2. How does ASD affect inhibitory control and cognitive flexibility separately from trauma?
3. Why is suspension a contraindicated intervention here?
4. What environmental modifications target the identified EF deficits?
5. What would a Plan B conversation with Aiden require given his communication profile?

Case Study: Maya, Age 15 — ADHD + ODD

Presentation: Maya has ADHD (combined type) and ODD. She is intellectually sharp, argues with every teacher, leaves her seat without asking, and told her math teacher last week: 'I don't need this — I'll never use it.' Three teachers have requested her removal.

Discussion Questions:

1. Map Maya's presentation onto specific EF deficits (use Barkley's model).
2. What is the function of her oppositional behaviour? What need does it serve?
3. Which MI techniques most apply? Where would you listen for change talk?
4. What is the Plan B conversation target, and what is Maya's likely unspoken concern?
5. What three classroom modifications would most directly address her EF profile?

Clinical Decision-Making: Selecting the Right Approach

First: Assess regulation and EF state — Is the child's PFC online? High arousal or threat-state = co-regulation first. No intervention works when EF is offline.

Use CPS when — There is a recurring, predictable problem. The child is calm. You have 10+ minutes. The problem has a collaborative solution.

Use MI when — The child is ambivalent or resistant. You want to strengthen intrinsic motivation. Even a 5-minute hallway conversation qualifies.

Use SFBT when — The child is stuck. You want to build hope and identify existing strengths and exceptions. Time is limited.

Use immediate safety protocol when — There is acute risk of harm to self or others. Safety supersedes collaboration until the child is safe.

Greene, R.W. (2016). Raising Human Beings. Scribner. | Barkley, R.A. (2012). Executive Functions. Guilford Press.

What If the Child Refuses to Talk?

Silence is information — Withdrawal and monosyllabic responses are communication — often indicating a threat-state where verbal processing is unavailable.

Side-by-side activities — Drawing, walking, building something together. Reduces social pressure of direct eye contact and verbal demands.

Parallel engagement — Sitting quietly alongside, working on your own task — non-threatening presence models regulation without demanding reciprocity.

Externalizing through drawing or writing — Give paper: 'Draw or write what today feels like.' No words required. The product is rich clinical material.

Patience as a neurobiological intervention — 'I'm not going anywhere. You don't have to talk.' — reduces threat and often produces the first word.

Perry, B.D. (2009). Examining child maltreatment through a neurodevelopmental lens. Journal of Loss and Trauma, 14, 240–255.

PBIS: School-Wide Systems That Support High-Risk Youth

Positive Behavioral Interventions and Supports — Three-tier prevention framework: universal (Tier 1), targeted (Tier 2), intensive (Tier 3) (Sugai & Horner, 2009).

Tier 1 — Universal supports — Consistent expectations, proactive relationship-building, positive recognition, trauma-informed and EF-informed school culture.

Tier 2 — Targeted supports — Check-in/Check-out (CICO), mentoring, small-group SEL, increased structured adult contact.

Tier 3 — Intensive supports — Individualized FBA-based behaviour support plans, multi-disciplinary teams, individualized safety planning.

Why it matters — High-risk children benefit most from clear, consistent, predictable environments. PBIS provides the environmental structure that scaffolds EF development.

Horner, R.H. et al. (2010). Journal of Positive Behavior Interventions, 12(3), 133–148. | Bradshaw, C.P. et al. (2012). School Psychology Review, 41(2), 149–164.

Co-Regulation: The Neuroscience of Calm Contagion

What is co-regulation? — The process by which a regulated adult's nervous system influences a dysregulated child's nervous system toward greater regulation

Social engagement system —prosodic voice, open body posture, and calm facial expression

Physiological synchrony is documented — Feldman (2007): caregiver-child cardiac and respiratory synchrony is measurable and correlates with relationship quality and child regulation.

Your nervous system is the tool — Slowed breathing, lowered voice, relaxed face — these are biological signals of safety, not theatrical performance.

You cannot co-regulate from depletion — Teacher self-regulation is a professional competency and a clinical prerequisite for effective work with dysregulated students.

Porges, S.W. (2011). The Polyvagal Theory. Norton. | Feldman, R. (2007). Current Directions in Psychological Science, 16(6), 340–345.

75%

of lifetime mental disorders begin before age 24

The median age of onset for most mental disorders is between 11–14 years. Schools are where most conditions are first observable — early identification dramatically alters long-term trajectory.

Kessler, R.C. et al. (2005). Archives of General Psychiatry, 62, 593–602.

MODULE 6

Closing & Sustainability

Taking Care of Yourself to Take Care of Others

Vicarious Trauma & Compassion Fatigue in Educators

What is vicarious trauma? — A cumulative transformation in the helper's inner world resulting from empathic engagement with traumatized people (Pearlman & Saakvitne, 1995).

Signs in teachers — Intrusive images, emotional numbing, dreading specific students, cynicism, hypervigilance, reduced empathy, sleep disruption.

Compassion fatigue vs. burnout — Burnout is job overload; compassion fatigue is the cost of caring deeply. Both can coexist and are clinically distinct.

It is not weakness — Vicarious trauma is an occupational hazard, not a personal failure. It is what happens when you care about people who are suffering.

Protective factors — Regular supervision and consultation, collegial support, professional training, clear role boundaries, reflective practice.

Pearlman, L.A. & Saakvitne, K.W. (1995). Trauma and the Therapist. Norton. | Brunsting et al. (2014). Exceptional Children, 80(3), 325–337.

Evidence-Based Self-Care for Educators Working with High-Risk Youth

- **Professional Strategies**
- Regular peer consultation — normalize talking about difficult students
- Clear professional role boundaries
- Ongoing professional development (like today)
- Supervision with a counsellor or psychologist
- Early recognition and naming of compassion fatigue

- **Personal Strategies**
- Physical activity — the most evidence-based stress regulator
- Mindfulness practice (Jennings et al., 2017)
- Social connection outside of work
- Creative expression and meaning-making
- Rest as a professional obligation, not a luxury

Jennings, P.A. & Greenberg, M.T. (2009). Review of Educational Research, 79(1), 491–525. | Jennings, P.A. et al. (2017). Mindfulness, 8, 46–58.

“The research is clear: what teachers do and how they relate to their students has a profound and lasting impact on student wellbeing — often greater than any specific therapeutic intervention.”

— Hamre & Pianta (2001), Child Development

Key Concepts: Rapid Recap

Paradigm shift — Behaviour signals lagging skills or unmet needs — not wilful defiance.

EF neuroscience — PFC matures through mid-20s; trauma, ADHD, poverty impair EF development measurably.

Lagging skills model — Identify the specific EF deficit — then scaffold it rather than punish around it.

Risk response — Ask directly, stay, refer, document. Never promise confidentiality.

CPS Plan B — Empathy → Define problem → Invitation. Proactive, collaborative, builds lagging skills.

MI — Roll with resistance. Evoke change talk. You are not the persuader — the student is.

PACE — Playfulness, Acceptance, Curiosity, Empathy — the relational foundation for all the rest.

What You Can Do Monday Morning

1. Pick one student and name the specific EF deficit most likely driving their behaviour.
2. Try one externalizing language shift — 'the Anger showed up' rather than 'you are angry.'
3. Attempt one Plan B conversation. Choose a calm moment. Use all three steps.
4. Make one positive call home to a parent of a high-risk student before any crisis occurs.
5. Do a 5-minute self-regulation check before school — notice your own nervous system state.

Choose ONE. Do it consistently. Mastery beats breadth every time.

Sensory Regulation in the Classroom: Practical Strategies

Sensory breaks — 5-minute movement breaks every 45–60 minutes improve attention and EF performance for all students.

Alternative seating — Standing desks, wobble chairs, floor cushions — proprioceptive input supports regulatory capacity.

Noise management — Fidget tools, noise-cancelling headphones, quiet corners — sensory sensitivity is neurobiological, not volitional.

Predictable transitions — Visual schedules, consistent transition sequences, advance warnings — reduce cognitive flexibility demands.

UDL principle — Sensory modifications that help struggling students through Universal Design for Learning benefit ALL students.

Ahn, R.R. et al. (2004). American Journal of Occupational Therapy, 58(3), 287–293. | CAST (2018). UDL Guidelines. Wakefield, MA.

Social-Emotional Learning (SEL): The Evidence Base

What is SEL? — Developing self-awareness, self-management, social awareness, relationship skills, and responsible decision-making.

Evidence base — CASEL meta-analysis (Durlak et al., 2011): 213 programs, 270,034 students — SEL improved academic achievement by 11 percentile points.

Behavioural outcomes — Significant reductions in aggression, conduct problems, and emotional distress across studies.

Teacher SEL matters — Teacher social-emotional competence predicts classroom emotional climate and student outcomes (Jennings & Greenberg, 2009).

SEL directly builds EF — Self-management and responsible decision-making are operationalizations of inhibitory control and planning — SEL IS EF training.

Durlak, J.A. et al. (2011). Child Development, 82(1), 405–432. | CASEL (2020). CASEL's SEL Framework. Chicago.

Cultural Humility in Working with High-Risk Youth

Cultural humility defined — An ongoing commitment to self-evaluation, redressing power imbalances, and advocating for others (Tervalon & Murray-Garcia, 1998).

Diagnostic bias — Children from racialized communities are over-identified for conduct disorders and under-identified for anxiety and internalizing conditions.

Indigenous youth — Historical and ongoing impacts of colonization are a critical context. Cultural connection and land-based learning have an emerging evidence base.

Family culture — Parenting norms, communication styles, and relationships with authority vary across cultures — differentiate cultural difference from pathology.

Your posture — 'I am still learning. Help me understand your family's experience and how I can best support your child.' This is the foundation.

Tervalon, M. & Murray-Garcia, J. (1998). Journal of Health Care for the Poor and Underserved, 9(2), 117–125. | Skiba et al. (2014). Urban Education, 49(6), 634–658.

School Refusal: A Clinical Lens for Educators

School refusal ≠ truancy — Truancy is volitional social avoidance. School refusal is driven by anxiety, distress, or neurobiological factors — a clinically distinct phenomenon.

Prevalence and peak points — Affects 1–5% of school-aged children; peaks at key transitions — Kindergarten, Grade 6, Grade 9 (Kearney, 2008).

Underlying drivers — Separation anxiety, social anxiety, specific phobia (evaluation, performance), depression, EF-based avoidance.

Avoidance compounds the problem — Each day at home reduces EF-based distress tolerance and increases the neural difficulty of returning — avoidance is self-reinforcing.

Teacher role in re-entry — Warm, private welcome. Reduced academic demand at re-entry. Private greetings. These lower the threat-detection threshold for return.

Kearney, C.A. (2008). Clinical Psychology Review, 28, 451–471. | Kearney, C.A. & Albano, A.M. (2004). Behavior Modification, 28(1), 147–161.

The Role of Psychologist Consultation: When and How

What school psychologists offer — Psychoeducational assessment, FBA/BSP, system-level consultation, brief intervention, team coordination.

When to consult — Persistent behaviour not responding to Tier 1–2 supports; suspected learning disability; safety concerns; complex dual diagnoses.

How to make referrals effective — Document what you've tried, what works, what doesn't, and specific behavioural examples with frequency and context. Data is clinical gold.

Consultation vs. referral — You can consult a psychologist for guidance on your own approach, even without a formal referral for the student.

You are part of the team — No assessment or intervention plan is complete without teacher input. Your observations are clinically indispensable.

Ysseldyke, J. et al. (2006). School Psychology: A Blueprint for Training and Practice III. NASP.

BC Mental Health Resources: What to Know and Share

Crisis lines — Canada Suicide Prevention: 1-833-456-4566 (24/7). BC Crisis Line: 310-6789 (no area code needed). Text 45645.

Kelty Mental Health Resource Centre — Free information and navigation for BC families and youth. keltymentalhealth.ca — high-quality, evidence-based.

BC Children's Hospital Mental Health — Specialized consultation and referral pathways for complex youth presentations.

BC Ministry of Education — Mental Health in Schools framework. gov.bc.ca/mentalhealth — policies and school-based resources.

Sunshine Coast Health Centre — Residential mental health and addiction treatment. Trauma, PTSD, and addiction programming. sunshinecoasthealthcentre.ca

BC Ministry of Education (2020). Mental Health in Schools: A Framework. Victoria, BC.

Individualized Behaviour Support: What Teachers Implement

Functional Behaviour Assessment (FBA) — Gold-standard assessment identifying the function of challenging behaviour: escape, attention, access, or sensory (Hanley et al., 2003).

Behaviour support plan components — 1) Antecedents to modify 2) Replacement skills to teach 3) Responses to behaviour 4) Team roles and responsibilities

Teachers implement — psychologists design — Your role: consistent, precise implementation and systematic data collection. Consistency IS the intervention.

Data collection is non-negotiable — Frequency, duration, intensity, antecedents, consequences. This data determines whether the plan is working.

Plans must be reviewed regularly — At minimum quarterly. High-risk youth change rapidly — plans that don't keep pace become counterproductive.

Hanley, G.P. et al. (2003). Journal of Applied Behavior Analysis, 36(2), 147–185. | Ingram, K. et al. (2005). Journal of Positive Behavior Interventions, 7(3), 133–144.

FINAL REFLECTION

Before You Leave Today...

On a card or your phone, write:

ONE THING that changed how I understand a challenging student:

_____

ONE THING I will try differently in the next 7 days:

_____

ONE PERSON I will share something from today with:

_____

Sunshine Coast Health Centre | Powell River, BC

Thank You

Your work with children matters more than you know.

Carissa Muth, Psy.D., R.Psych
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Workshop materials and reference list available on request.

References — Brain Development & Executive Function (1)

- Casey, B.J. et al. (2008). The adolescent brain. Developmental Science, 11(1), 101–108.
- Steinberg, L. (2010). A dual systems model of adolescent risk-taking. Developmental Psychobiology, 52(3), 216–224.
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