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On the Cover: Caroline McLaury, age 8, draws a picture while waiting for her mom. Caroline is the daughter of Jill McLaury of Hurricane and John McLaury of St. Albans. She is the granddaughter of Ron and Cecilia Scarbro of Athens, WV, and Charles and Cathy McLaury of Roscoe, Texas.

Editor
Susannah Grimm Poe, Ed.D.

Parenting Perspectives…
“Like a Pebble in a Pond…”
By Christal Barton

This morning as I dropped Nathan off for school, he was doing so well. He said good morning to the teachers as he walked patiently down the hallway, he read the signs and posters in Nicky's room as we dropped him off, and he hung up his backpack and put away his folder. Mickey Mouse Clubhouse plays in his classroom when he comes in in the morning, so it's difficult for him to focus on anything else. But he tried, and I was proud as he walked over to the carpet and sat, perhaps a little too close to the boy next to him. My heart wrenched when I saw the boy immediately get up and move to the other side of the carpet--this boy, bigger than the others sitting there but still a child, is my fear.

I have a chance of finding staff members who bully my child, and there are protocols and procedures in place to make sure it never happens again, but another child? That one is harder to handle, especially when Nathan can't tell me what's happening, can't stand up for himself, often doesn't even recognize he's been treated badly.

I took a breath and turned to walk away, trying to convince myself that what I had seen wasn't that bad, that the boy had moved simply because Nathan had invaded his personal space. And then I heard it--this small but firm voice. I turned back around to see the indignation on the little girl's face as she said "That was not very nice!" Then came a chorus of little voices. "yes, that was kind of mean" "You know, Nathan is working really hard, you should be nice to him." I saw the boy who had moved, first with a surprised look on his face, then chagrin.

Ah, so he HAD moved away from 'the weird kid'. And then, he looked thoughtful. As if he was wondering if maybe he had made the wrong choice.

I looked over at my baby, sitting tranquilly in the middle of this miracle, seemingly oblivious to it all. And I saw the tiny smile on his face--the only clue that he was completely aware of what had just occurred.

"Children are cruel" we often hear. I submit that children are kind, strong, and determined to do what is right up until the time they are taught otherwise.

Thank you, the room full of kindergarten students who stood up for a child who can not (does not?) stand up for himself.

Thank you, too, the boy who did a thoughtless thing, and then reconsidered his actions when the possible harm was pointed out to him.

Thank you, the family of one little blonde haired girl, for giving her the courage to stand up for what is right.

And thank you, Nathan, who by your very existence made the world just a little kinder today. That boy will carry this moment with him, as will all of the children who witnessed or participated in it. That moment will impact their lives. Such a tiny moment, like a pebble in a pond. You, my amazing child, just changed the world. Again.

Christal Barton and her husband John live in Milton with their three sons.
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Changes in Diagnostic Criteria Affect Families Dealing With Mental Health Concerns

A Centers for Disease Control and Prevention report issued this week found that between 13 and 20 percent of children in the U.S., or up to one out of every five kids, is living with a mental health disorder. The fifth edition of the Diagnostic and Statistical Manual (DSM-5) was released in May of this year, and it signals changes for many children already diagnosed with mental health disorders, especially those with autism and mood disorders.

Often touted as the psychiatrist’s “bible,” the DSM is published by the American Psychiatric Association and establishes the almost universal standard by which doctors classify, diagnose and ultimately treat mental disorders – making it an essential part of the psychiatric profession. This is the first major rewrite of the near-1,000-page guide in 20 years.

The DSM is utilized not only by clinicians, but researchers and health insurance companies as well. Even government officials take interest in the DSM’s criteria in order to determine grant funding, insurance coverage and new health care policies.

The DSM-5’s release brings some radical new changes, which have been met with mixed reactions from mental health professionals and family members. Some of the most highly debated changes include the elimination of Asperger’s disorder and the addition of a few new controversial conditions such as cannabis withdrawal, gambling addiction and disruptive mood dysregulation disorder (DMDD).

So what do these changes mean for those families currently dealing with mental health disorders?

Most of the transition from DSM-4 to DSM-5 will occur behind-the-scenes from the advantage point of parents and children who receive services. Psychologists and psychiatrists often do not even provide parents with a detailed elaboration of the specific subtype of the child's disorder, because the distinctions can be fairly technical.

But there are some major changes that parents will need to know, like the decision to group Asperger's syndrome and Pervasive Developmental Disorder, NOS, under the broader umbrella of autism spectrum disorder going forward. See more explanation on page 7.

Parents should also be aware that there is a new diagnostic category known as Social Communication Disorder that includes children who have difficulties communicating socially, but who do not display the repetitive behaviors that are often a hallmark of the autism spectrum.

The DSM-5 also introduces a new depressive disorder, called "Disruptive Mood Dysregulation Disorder," in order to help address concerns about potential over-diagnosis and over-treatment of bipolar disorder in children. From the mid-1990s to the early 2000s, the number of children diagnosed as bipolar increased almost 40-fold. The new diagnosis applies to kids up to 18 who show persistent irritability and frequent episodes of extreme behavioral problems. See page 9 for more information on DMDD.

The changes in DSM-5 affecting children are meant to make diagnosis clearer for professionals and should not alter their day-to-day treatment. But parents should ask about and be aware of their child's particular diagnosis, especially if it will impact insurance reimbursement for services, or determine the eligibility for special education services at school.
Attention deficit hyperactivity disorder is getting a revision, with the elimination of a previously required symptom and the changing of the required age of onset from age 7 to age 12.

Autism spectrum disorder: The criteria will incorporate several diagnoses from DSM-4 including autistic disorder, Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder (not otherwise specified), into the diagnosis of autism spectrum disorder for DSM-5 to help more accurately and consistently diagnose children with autism. (see page 7 for more information).

Obsessive compulsive disorder (OCD), once categorized under anxiety disorders, is now getting its own category of Obsessive-compulsive and related disorders. Along with OCD, this category includes Body Dysmorphic Disorder (BDD), Trichotillomania (TTM, or hair pulling) and a brand new disorder called Hoarding Disorder.

Binge eating disorder will be moved from DSM-4’s Appendix B: Criteria Sets and Axes Provided for Further Study to DSM-5 Section 2. The change is intended to better represent the symptoms and behaviors of people with this condition.

Disruptive mood dysregulation disorder will be included in DSM-5 to diagnose children who exhibit persistent irritability and frequent episodes of behavior outbursts three or more times a week for more than a year. The diagnosis is intended to address concerns about potential over-diagnosis and overtreatment of bipolar disorder in children.

Excoriation (skin-picking) disorder is new to DSM-5 and will be included in the Obsessive-Compulsive and Related Disorders chapter.

Hoarding disorder is new to DSM-5. Its addition to DSM is supported by extensive scientific research on this disorder. This disorder will help characterize people with persistent difficulty discarding or parting with possessions, regardless of their actual value. The behavior usually has harmful effects—emotional, physical, social, financial and even legal—for a hoarder and family members.

Mental Retardation, a term used in the DSM-4, is now “Intellectual Disability.”

Pedophilic disorder criteria will remain unchanged from DSM-4, but the disorder name will be revised from pedophilia to pedophilic disorder.

Personality disorders: DSM-5 will maintain the categorical model and criteria for the 10 personality disorders included in DSM-4 and will include the new trait-
specific methodology in a separate area of the DSM to encourage further study of how this could be used to diagnose personality disorders in clinical practice.

**Posttraumatic stress disorder (PTSD)** will be included in a new chapter in DSM-5 on Trauma- and Stressor-Related Disorders. DSM-5 pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. PTSD will also be more developmentally sensitive for children and adolescents. With the more controversial changes, the DSM-5 is also refining the criteria for post-traumatic stress disorders (PTSD), including a subtype for PTSD in preschool children.

**Removal of bereavement exclusion:** the exclusion criterion in DSM-4 applied to people experiencing depressive symptoms lasting less than two months following the death of a loved one has been removed and replaced by several notes within the text delineating the differences between grief and depression. This reflects the recognition that bereavement is a severe psychosocial stressor that can precipitate a major depressive episode beginning soon after the loss of a loved one.

**Specific learning disorder** broadens the DSM-4 criteria to represent distinct disorders which interfere with the acquisition and use of one or more of the following academic skills: oral language, reading, written language, or mathematics.

**Substance use disorder** will combine the DSM-4 categories of substance abuse and substance dependence. In this one overarching disorder, the criteria have not only been combined, but strengthened. Previous substance abuse criteria required only one symptom while the DSM-5’s mild substance use disorder requires two to three symptoms.

**Dependence’ to ‘addiction,’ cannabis withdrawal and gambling disorders**

The DSM’s chapter on substance abuse has also undergone changes, now being called the Substance Use Disorders chapter. The diagnostic criteria for these conditions have been expanded, but one of the biggest changes deals with the swapping of two seemingly similar words when describing these disorders: the term “dependence” is out and the term “addiction” is in. Now the DSM-5 just talks about addiction, in context, being about the compulsive nature of the disorder.”

For example, patients being prescribed pain medication may wind up hooked on the drug, but they are still taking the medication under the guidance of a physician. They aren’t necessarily seeking out the medication by themselves, but if they are taken off the drug they may still have psychological withdrawal. In this case, they aren’t dependent on the drug, but they are addicted, according to the new guidelines.
Autism Spectrum Disorder Now Combined Into Single Category

One of the most publicized changes in the DSM-5 involves grouping all of the subcategories of autism into a single category known as autism spectrum disorder (ASD). This move effectively eliminates previously separate diagnoses of autism— including autistic disorder, Asperger's disorder, childhood disintegrative disorder and pervasive development disorder “not otherwise specified” (PDD-NOS).

This merging of categories creates a “sliding scale” for autism, meaning individuals will be diagnosed somewhere along the autism spectrum, given the personal severity of their symptoms. Many parents and health care providers have speculated that this transformation may end up excluding some of those already diagnosed with an autism disorder, like Asperger’s or PDD-NOS. The diagnostic criteria for autism spectrum disorder has been modified based on the research literature and clinical experience in the 19 years since the DSM-4 was published in 1994.

Changes include:
• The diagnosis will be called Autism Spectrum Disorder (ASD), and there no longer will be subdiagnoses (Autistic Disorder, Asperger Syndrome, Pervasive Developmental Disorder Not Otherwise Specified, Disintegrative Disorder).
• In DSM-4, symptoms were divided into three areas (social reciprocity, communicative intent, restricted and repetitive behaviors). The new diagnostic criteria have been rearranged into two areas: 1) social communication/interaction, and 2) restricted and repetitive behaviors. The diagnosis will be based on symptoms, currently or by history, in these two areas.

Although symptoms must begin in early childhood, they may not be recognized fully until social demands exceed capacity. As in the DSM-4, symptoms must cause functional impairment. All of the following symptoms describing persistent deficits in social communication/interaction across contexts, not accounted for by general developmental delays, must be met:

• Problems reciprocating social or emotional interaction, including difficulty establishing or maintaining back-and-forth conversations and interactions, inability to initiate an interaction, and problems with shared attention or sharing of emotions and interests with others.
• Severe problems maintaining relationships — ranges from lack of interest in other people to difficulties in pretend play and engaging in age-appropriate social activities, and problems adjusting to different social expectations.
• Nonverbal communication problems such as abnormal eye contact, posture, facial expressions, tone of voice and gestures, as well as an inability to understand these.

Two of the four symptoms related to restricted and repetitive behavior need to be present:
• Stereotyped or repetitive speech, motor movements or use of objects.
• Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change.
• Highly restricted interests that are abnormal in intensity or focus.
• Hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of the
Autism Spectrum Disorder
Combined Into Single Category

Symptoms must be present in early childhood, but may not become fully manifested until social demands exceed capacities. Symptoms need to be functionally impairing and not better described by another DSM-5 diagnosis.

Symptom severity for each of the two areas of diagnostic criteria is now defined. It is based on the level of support required for those symptoms and reflects the impact of co-occurring specifiers such as intellectual disabilities, language impairment, medical diagnoses and other behavioral health diagnoses.

Rett Syndrome is classified as a discrete neurologic disorder, not a subdiagnosis under ASD, although patients with Rett syndrome may have ASD.

Because almost all children with DSM-4 confirmed autistic disorder or Asperger syndrome also meet diagnostic criteria under DSM-5, re-diagnosis is not necessary. Referral for reassessment should be based on clinical concern. Children given a PDD-NOS diagnosis who had few DSM-4 symptoms of autism or who were given the diagnosis as a “placeholder” might be considered for more specific diagnostic evaluation.

Patients may wish to continue to self identify as having Asperger syndrome, although the DSM-5 diagnostic category will be ASD.

Children with ASD also should be evaluated for a speech and language diagnosis in addition to the ASD to inform appropriate therapy.

The DSM-5 includes a new diagnostic category of social communication disorder that describes children with social difficulty and pragmatic language differences that impact comprehension, production and awareness in conversation that is not caused by delayed cognition or other language delays.

Over the past decade, the United States has seen a striking increase in the amount of autism diagnoses, with the Centers for Disease Control and Prevention estimating that one in 88 children suffers from an autism spectrum disorder. Epidemiological studies have found that the majority of children accounting for this incidence are those with PDD-NOS – a diagnosis given to those with communication issues and pattern behavior but who do not meet the full criteria for autism or another pervasive developmental disorder.
Disruptive Mood Dysregulation Disorder
“New” Diagnosis For Chronic Irritability

The DSM-5 is eliminating the diagnosis of pediatric bipolar disorder and creating a brand new category called disruptive mood dysregulation disorder (DMDD), described as intense outbursts and irritability beyond normal temper tantrums in young children.

DMDD occurs in children who have chronic irritability, as well as frequent episodes of temper outbursts several times a week for more than a year. It is a severe, ongoing irritability, lasting most of the day, every day. It can be contrasted to bipolar disorder, which is characterized by distinct episodes of mania and depression.

The establishment of this diagnosis was meant to reduce the number of misdiagnosis now occurring. In the last decade, more and more children as young as 2 years old have been diagnosed with bipolar disorder, leading to the prescription of powerful antipsychotic medication that can be quite intense for children at such a young age. According to the Agency for Healthcare Research and Quality, hospital stays for childhood bipolar disorder have increased by 434 percent from 1997 to 2010.

The idea that many children now suffering from these rages have been misdiagnosed with bipolar disorder, which means they’re not being properly or successfully treated—and as a result may be overmedicated with drugs carrying potential side effects from severe weight gain to diabetes.

However, treatments for DMDD are unclear at this point, experts agree, and trial studies are just now testing the effects of antidepressants and stimulants as a possibility.

Below is the diagnostic criteria for Disruptive Mood Dysregulation Disorder (DMDD):

A. Severe recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation.
B. The temper outbursts are manifest in the form of verbal rages or physical aggression towards people or property.
C. The temper outbursts are inconsistent with developmental level.
D. The temper outbursts occur, on average, three or more times per week.
E. Nearly every day, most of the day, the mood between temper outbursts is persistently irritable or angry.
F. The irritable or angry mood is observable by others (e.g., parents, teachers, peers).
G. The diagnosis should not be made for the first time before age 6 or after age 18.
H. The onset of these symptoms is before age 10 years.
I. There has never been a distinct period lasting more than one day during which abnormally elevated or expansive mood was present most of the day, and the abnormally elevated or expansive mood was accompanied by the onset or worsening, of three of the criteria of mania (such as grandiosity or inflated self-esteem, decreased need for sleep, pressured speech, flight of idea, distractibility, increase in goal directed activity, or excessive involvement in activities with a high potential for painful consequences.

The behaviors do not occur exclusively during an episode of Major Depressive Disorder and are not better accounted for by another mental disorder. The symptoms are not due to the effects of a drug or to a general medical or neurological condition.
How ADHD Has Changed in the DSM-5

Changes in the DSM-5 for the diagnosis of ADHD include a change in the age of symptom onset to by age 12 rather than by age six.

In addition, several symptoms now need to be present in more than one setting, rather than just some impairment in more than one setting, and new descriptions were added to show what symptoms might look like at older ages. For adults and adolescents age 17 or older, only 5 symptoms are needed instead of the 6 needed for younger children.

Here is the new criteria:

**People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:**

**Inattention:** Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
- Often has trouble holding attention on tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, sidetracked).
- Often has trouble organizing tasks and activities.
- Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
- Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- Is often easily distracted
- Is often forgetful in daily activities.

**Hyperactivity and Impulsivity:**
Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person’s developmental level:

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often "on the go" acting as if "driven by a motor".
- Often talks excessively.
- Often blurts out an answer before a question has been completed.
- Often has trouble waiting his/her turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

**In addition, the following conditions must be met:**

Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.

Several symptoms are present in two or more settings, (e.g., at home, school or work; with friends or relatives; in other activities). There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.

The symptoms do not happen only
Tips for Parents:

Helping Your Child Prepare for Change

Be clear. State, in a positive way, what the change is going to be. "Mom and Dad are going on a trip in two days. Before we leave, Aunt Lisa and Uncle Rich will come to stay until we get back!

Daddy and I will call you each night we are away right before bedtime. Then plan something special that you can do to prepare: Tomorrow we’ll go to the grocery and you can pick out your favorite ice cream treat to eat right before get in your pajamas while we are gone!"

Point out the good things about the change. For example, in the case of moving to a new home you could highlight that the child will have a new room she can help decorate or that there is a big swing on the tree in the back yard.

Remind the child of all the things that will be the same. Children don’t always understand that their whole lives won’t change just because one thing will be new or different. In the family is expecting a new baby, remind your child that his bed will still be his own and that he will still have special mommy time every Thursday.

Children also want to know that what they feel is normal and they are OK for feeling that way: "You may sometimes feel jealous or mad when mommy is cuddling with your new sister. It's OK to feel that way. If you feel bad, come tell mommy or daddy and we can help you"

Bottom line. In whatever way that works for you and your child, get the point across: you are loved, we are taking care of you, you are safe, you can talk to us if you are worried.

How ADHD Has Changed ...

during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Based on the types of symptoms, three kinds (presentations) of ADHD can occur: Combined Presentation: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months Predominantly Inattentive Presentation: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months Predominantly Hyperactive-Impulsive Presentation: if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months. Because symptoms can change over time, the presentation may change over time as well.

What Can I Do to Change my Child’s Behavior?

Children tend to continue a behavior when it is rewarded and stop a behavior when it is ignored. Consistency in your reaction to a behavior is important because rewarding and punishing the same behavior at different times confuses your child. When you think your child’s behavior might be a problem, you have three options:

- Decide that the behavior is not a problem because it's appropriate to the child's age and stage of development.
- Attempt to stop the behavior, either by ignoring it or by punishing it.
- Introduce a new behavior that you prefer and reinforce it by rewarding your child.

How do I stop misbehavior?

The best way to stop unwanted behavior is to ignore it. This way works best over a period of time. When you want the behavior to stop immediately, you can use the time-out method.

How do I use the time-out method?

Decide ahead of time the behaviors that will result in a time-out (usually tantrums, or aggressive or dangerous behavior). Choose a time-out place that is uninteresting for the child and not frightening, such as a chair, corner or playpen. When you're away from home, consider using a car or a nearby seating area as a time-out place.

When the unacceptable behavior occurs, tell the child the behavior is unacceptable and give a warning that you will put him or her in time-out if the behavior doesn't stop. Remain calm and don't look angry. If your child goes on misbehaving, calmly take him or her to the time-out area.

If possible, keep track of how long your child's been in time-out. Set a timer so your child will know when time-out is over. Time-out should be brief (generally 1 minute for each year of age), and should begin immediately after reaching the time-out place or after the child calms down. You should stay within sight or earshot of the child, but don't talk to him or her.

If the child leaves the time-out area, gently return him or her to the area and consider resetting the timer. When the time-out is over, let the child leave the time-out place. Don't discuss the bad behavior, but look for ways to reward and reinforce good behavior later on.

How do I encourage a new, desired behavior?

One way to encourage good behavior is to use a reward system. Children who learn that bad behavior is not tolerated and that good behavior is rewarded are learning skills that will last them a lifetime. This works best in children older than two years of age. It can take up to two months to work. Being patient and keeping a diary of behavior can be helpful to parents.

Choose one or two behaviors you would like to change (for example, bedtime habits, tooth brushing or picking up toys). Choose a reward your child would enjoy. Examples of good rewards are an extra bedtime story, delaying bedtime by half an hour, a preferred snack or, for older children, earning points toward a special toy, a privilege or a small amount of money.

Explain the desired behavior and the reward to the child. For example, "If you get into your pajamas and brush your teeth before this TV show is over, you can stay up a half hour later." Request the behavior only one time. If the child does what you ask, give the reward. You can help the child if necessary but don't get too involved. Because any attention from parents, even negative attention, is so rewarding to children, they may prefer to have parental attention.
What Can I Do to Change my Child’s Behavior?

instead of a reward at first. Transition statements, such as, "In five minutes, play time will be over," are helpful when you are teaching your child new behaviors.

This system helps you avoid power struggles with your child. However, your child is not punished if he or she chooses not to behave as you ask; he or she simply does not get the reward.

What are some good ways to reward my child?

Beat the Clock (good method for a dawdling child)
Ask the child to do a task. Set a timer. If the task is done before the timer rings, your child gets a reward. To decide the amount of time to give the child, figure out your child's "best time" to do that task and add 5 minutes.

The Good Behavior Game (good for teaching a new behavior)
Write a short list of good behaviors on a chart and mark the chart with a star each time you see the good behavior. After your child has earned a small number of stars (depending on the child's age), give him or her a reward.

Good Marks/Bad Marks (best method for difficult, highly active children)
In a short time (about an hour) put a mark on a chart or on your child's hand each time you see him or her performing a good behavior. For example, if you see your child playing quietly, solving a problem without fighting, picking up toys or reading a book, you would mark the chart. After a certain number of marks, give your child a reward. You can also make negative marks each time a bad behavior occurs. If you do this, only give your child a reward if there are more positive marks than negative marks.

Developing Quiet Time (often useful when you're making supper)

Ask your child to play quietly alone or with a sibling for a short time (maybe 30 minutes). Check on your child frequently (every 2 to 5 minutes, depending on the child's age) and give a reward or a token for each few minutes they were quiet or playing well. Gradually increase the intervals (go from checking your child's behavior every 2 to 5 minutes to checking every 30 minutes), but continue to give rewards for each time period your child was quiet or played well.

What else can I do to help my child behave well?

Make a short list of important rules and go over them with your child. Avoid power struggles, no-win situations and extremes. When you think you've overreacted, it's better to use common sense to solve the problem, even if you have to be inconsistent with your reward or punishment method. Avoid doing this often as it may confuse your child.

Accept your child's basic personality, whether it's shy, social, talkative or active. Basic personality can be changed a little, but not very much. Try to avoid situations that can make your child cranky, such as becoming overly stimulated, tired or bored. Don't criticize your child in front of other people.

Describe your child's behavior as bad, but don't label your child as bad. Praise your child often when he or she deserves it. Touch him or her affectionately and often. Children want and need attention from their parents.

Develop little routines and rituals, especially at bedtimes and meal times. Provide transition remarks (such as "In 5 minutes, we'll be eating dinner."). Allow your child choices whenever possible. For example, you can ask, "Do you want to wear your red pajamas or your blue pajamas to bed tonight?"
One Parent’s Perspective

“Change Is The Essence Of Life”

by Gloria Schaffer

“Change is the essence of life. Be willing to surrender what you are for what you could become.” — Reinhold Niebuhr

Reinhold Niebuhr was an American theologian who lived from 1892 to 1971. He has influenced a great many persons over the years with his writings, including many politicians. He has influenced perspectives and thoughts all over the world. What an incredible statement to make about anybody! Reinhold Niebuhr has also influenced me.

I first time I read something by Reinhold Niebuhr was when I read his Serenity Prayer in my 20’s. It reads as follows: “God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.” This prayer has always been a help to me, particularly when I left both of my abusive marriages. It speaks to changing the things we have the power to change, the things that need changing in our lives. I guess the part I grabbed onto was to ask God to “grant me the courage to change the things I could.”

One definition of change from http://www.Dictionary.reference.com is: “to make the form, nature, content, future course, etc., of (something) different from what it is or from what it would be if left alone.” I chose to do that twice in my life and in the lives of my children. Twice in our lives, we were in a family where I was married to my children’s father. Twice in our lives, those family situa-

lives were in danger. In times like those, one develops a strength to face the situation. One develops the strength to change the situation for the better. That is what happened within me. I could have stayed and remained in marriages and my children would have had a dad in their lives. That prospect was not a healthy one, as their dad was abusing me and them. So, I changed it, with The Lord’s help. I want to note here that I could not have done this without God’s help and direction.

Do I miss being married? Sometimes. Do I miss my children having their dad in our home? Sometimes. But when I weigh that against the health, peace, and love in our home now, the scales are tipped in our single—parent home direction. My children are flourishing. I am flourishing. I am not being ridiculed. I do not have to walk on eggshells every day, afraid that something I might say or do might “set him off.” I don’t have to worry that someone else is controlling my decisions, my money, my involvement with my family. I am free! I am changed!

The second time I read something that Reinhold Niebuhr had written was when I was taking my kids into daycare. There was a poster on the fridge that read, “Change is the essence of life. Be willing to surrender what you are for what you can become.” Wow! I had all sorts of thoughts when I read that!

One was, “change is hard,” and “change is not easy.” Another was, “I can become more than I am now? I wonder who that might be?” It was inspiring. I read it every
“People, Partnerships and Possibilities”
Planned for Charleston in September

The Bureau for Behavioral Health and Health Facilities and 29 conference partners for three days of exploring how People, Partnerships and Possibilities can enhance your life and the lives of the individuals you touch every day at West Virginia's first Integrated Behavioral Health Conference.

The goals of this conference is to:
- engage with other members of the behavioral health community,
- create partnerships throughout the state,
- be inspired by our speakers, and
- earn Continuing Education Credits (CEUs).

This conference will also provide a forum for those working in or reliant on provider systems in our state to explore the complex issues associated with building integrated care systems supporting individuals with substance use, mental health, intellectual and developmental disorders.

Internationally- and locally-recognized presenters will explore current trends in integrated health care, clinical supervision, and evidence based practices to increase engagement and outcomes in service provision. Participants will be able to choose from nearly 100 plenary and workshop sessions.

One Parent’s Perspective

day going into the daycare and I committed it to memory. I could become more than I was at that moment!

At that time, I was at the end of my second abusive marriage and was getting ready to move to a new house and start a new job (the one I have now!) I had enrolled my oldest (who was 12 at the time) in therapy and had in-home services in our home trying to help with all the turmoil we were experiencing. I was parenting 6 kids, ages 12, 10, 8, 5, 3, and 1. I was getting divorced (again), moving (again), and starting a new job (again.) These, as you may know, are some of the top stressors people can experience. My kids were mad at me because I was divorcing their dad/step-dad. I was facing loneliness, but freedom. I was overwhelmed. But change bid me to follow it, with the promise of a new life trailing behind it. I have taken steps to change several times in my life. I have changed my living circumstances, my name, my income, my weight, my parenting techniques, my walk with The Lord. Life is full of changes. It is how we face those changes that matters.

Change is not usually easy. It takes commitment on our part. It takes a realization of the need for change, and the determination to make it happen. But think of all that awaits you when you finally decide to cooperate with it! I wonder what you will become as you surrender who you are today!

Gloria Shaffer is Parent Coordinator of Region III in the FAST Project of Legal Aid of WV.
For Parents:

Writing Personalized Stories Can Help Your Child Manage Change

One of the best ways to help children deal with change is to write a simple story book that simply explains what is happening to the child. Stories can help children make sense of their environment, their emotions and their behavior. With children of any age, but particularly children who are quite young, picture books help make any kind of lesson one is trying to teach much more concrete for them. Too many words can simply get confusing for them, but a few sentences combined with a picture really allows them to take in and understand the message. You don't need to be a great artist or writer to make these books and they don't need to take a lot of time or cost much. The great thing about them is that you can really do them however you wish, in a very short amount of time.

You can make books from many different items. Most easy would be to use folded sheets of printer paper that are stapled or tied along the fold to look like a bound book. You can also make more finished books on your computer, using a word processing program with a booklet option or a publishing program. You can even go to a web service like Shutterfly and use your own text and photos and have the book professionally printed and bound. Some local chain stores, like CVS or Walmart, will offer same day pick up for these computer-designed books. A 3-ring binder and plastic inserts with 8.5" x 11" paper will also work, and would be easy to update and change for new events, or buy blank books and fill the pages in like a sketch pad or a scrap book. It doesn't matter what it looks like, but it should “speak” to your child and the fears or worries he or she has about an upcoming event. Often, your kids will love this book and want to see it and have you read it often, so make sure it’s sturdy and portable.

Don’t worry about being an artist! Use old photos of your child and the highlights of the upcoming change, For example if you are going to visit friends for a holiday, take pictures of those people you will be visiting, their home, yard, and the bed your child will be sleeping in. Also picture the familiar objects the child will take with him or her: a teddy bear, special clothes, a lovey for when they get overwhelmed. Explain the behavior you expect from them during this time of change. For example, you might write: If ___ was scared, he would take a deep breath hug his blanket (or whatever would calm the child). You can also leave a blank list of options for the child to fill out as you discuss the event. If you don’t have photos, make stick figures or cut pictures from magazines. Your kids don’t care as long as they are in the book and you are reading it to them.

The finished book can be used at any time to prepare the child for the upcoming change. Begin reading it as part of the bedtime routine, and remind the child of the event and the book throughout the days approaching the event. Remind your child to look at the book right before the event, and remind them as it occurs of how you expect them to react.
Change:
A Kid’s Guide to Understanding and Handling Change.

Change means that something different happens...

Sometime the different thing is good!
(like a new puppy)
Sometimes the different thing is bad.
(like getting a bee sting!)

Some changes we know are coming. These are called expected changes.
Like changing from shorts to long pants in the winter.

Or getting a long summer break from school.

Expected changes are easier because we know it is going to happen.
Then we can get ready for the change.

Sometimes we like the expected changes, and sometimes we do not like the expected changes.

Changes I Like:       Changes I Don’t Like:
Some changes we do not know will happen. They are surprises. They are called unexpected changes, like:

Your bus driver is someone new ...
Your favorite shirt is in the wash...

An unexpected change that **we like** is called a “welcome” change.

*What are some welcome changes for you?*

1.

2.

An **Unexpected change that we do not like** is called an “unwelcome” change.

Unexpected changes are harder because we did not know they were going to happen. We were not ready.
Unexpected and unwelcome changes often mean a person has to do something they do not want to do.

Sometimes people get very upset with the change and might want to say “no!”

But saying no to the change can make more trouble. Many times you don’t have a choice,

Everyone has to handle unexpected, unwelcome changes

No one likes it. No one wants to change. But there are always changes in life. Part of growing up is learning how to help you handle unexpected, unwelcome changes.
My tools to handle change:

You can ask:

“Are there any changes I should know about today?”

You can ask your parents and teachers if there are any changes. You do not have to wait and wonder if something unexpected happens.

If you know there will be a change, make a reminder note or picture and carry it with you. When you are nervous or confused about the change, check your note and feel better.

Self-talk: say something in your brain to help you feel better about the change. It might help to save them aloud or write them down so you can read them over and over again.

### My Schedule

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My tools to handle change:

I can talk to a grown-up if I am nervous or worried.

If I am having a really hard time handling the change, I will ask if I can take a break away from the situation.

I will go to a quiet place and look at a book or even exercise to help me feel calmer.

Here are other tools that I will use to accept change:

1.
2.
3.
Summit on WV Safe Schools Makes Ten Recommendations

Ten recommendations resulting from the Summit on West Virginia Safe Schools were unveiled by United States Attorney Booth Goodwin on June 11 during the West Virginia Department of Education Office of Healthy Schools 2013 KidStrong Conference held in at the Charleston Civic Center.

Goodwin convened the statewide Summit on Safe Schools in Feb 6, 2013, to bring together educators, law enforcement professionals, parents, mental health professionals, government officials and students to exchange ideas and develop practical steps to prevent and prepare for school violence.

U.S. Attorney Booth Goodwin said, “This report summarizes the Summit’s most critical lessons. It begins with an immediate agenda for West Virginia safe schools: ten things that we must get to work on right now if we want to make our schools safer,” Goodwin said.

“We owe it to our children and our educators to do everything in our power to keep our schools safe. Anything less is unacceptable,” Goodwin continued.

The report features an agenda of ten items for preparedness and response that should be implemented as soon as possible:

1. Establish a single, locked point of entry for every school, where a school official can see and identify would-be visitors before they enter.

2) Install classroom doors that lock quickly from inside the classroom – or keep doors locked all the time.

3) Install emergency buttons that sound a school-wide alarm and automatically call the police.

4) Explore the use of shatter-resistant materials on glass windows and door panels in schools (a requirement that the West Virginia School Building Authority recently adopted for all new schools built in the state).

5) Establish a Prevention Resource Officer Corps to place more law enforcement officers---including retired police officers and military veterans---in schools as prevention resource officers.

6) Bring together local police and educators to develop closer ties between law enforcement and schools.

7) Conduct active-shooter drills in every school at least annually, with full participation from law enforcement.

8) Develop a statewide program to identify potentially violent students early and intervene immediately.

9) Introduce a proven anti-bullying program in every school.

10) Implement a communication system to immediately disseminate information about violent or disruptive incidents to parents, other schools and child care facilities.

The report also features a section that focuses on preventing violence. The report’s prevention strategies include developing a concerted effort to address bullying; identifying and intervening with troubled children early; placing a greater emphasis on school climate; developing a system to comprehensively collect information about students with behavior issues; and expanding the number and role of school counselors and prevention resource officers.

The West Virginia Board of Education has identified a list of schools in the state with the greatest learning gaps among student groups. These schools will get additional support to meet the needs of their students.

Ninety-seven schools have been identified in 39 West Virginia counties. Elementary and middle schools were identified based on 2012 WESTEST 2 results. High schools were identified based on gaps in graduation rates. A list of all focus schools can be found at: http://wvde.state.wv.us/esea/priority-focus-schools.html.

The focus school designation is part of West Virginia's ESEA Flexibility Waiver, which includes waivers of certain provisions of the Elementary and Secondary Education Act (ESEA), also known as the No Child Left Behind Act.

"To provide support to focus schools, a Focus Assistance Support Team (FAST) will be created on the state, regional and county levels. The FAST teams will then conduct an assessment of student subgroup strengths and weaknesses to target during the three-year improvement timeline. If a focus school can decrease the gap between student subgroups for two consecutive years and show sufficient progress, it can be transitioned off the list.

In April, the West Virginia Board of Education also identified a list of 32 low performing schools across the state as priority schools.

Priority schools also are part of West Virginia's ESEA Flexibility. However, these schools were identified based on overall student performance. The schools are among the lowest 5 percent of Title I schools based on school-wide student achievement and a historical lack of progress over three years. All non-Title I schools meeting the same criteria have been identified and are included in the priority schools.

Under the priority schools designation, a diagnostic visit will be conducted to identify weaknesses within the school and then each school will be provided a road-map to success based on its specific needs. The West Virginia Department of Education and Regional Education Service Agencies (RESAs) will then work together with each school and county school system to provide professional development and technical assistance to improve the performance level of each school.

Schools named priority schools and their county are: Barbour, Philippi Middle, Junior Elementary; Berkeley, Burke Street Elementary; Braxton, Braxton County High; Cabell, Peyton Elementary, Enslow Middle; Fayette, Ansted Elementary, Collins Middle; Grant, Union Educational Complex; Hampshire, Hampshire Senior High; Kanawha, Mary C. Snow West Side Elementary, Watts Elementary, J E Robins Elementary; Lincoln, Lincoln County High, Midway Elementary; Logan, Buffalo Elementary, Man Senior High, Chapmanville Senior High; Mercer, Spanishburg School; Mingo, Gilbert Middle, Williamson Middle; McDowell, Southside K-8, Mount View High; Preston, Tunnelton-Denver Elementary; Summers, Summers County High School; Taylor, Anna Jarvis Elementary; Wayne, East Lynn Elementary, Wayne Middle; Webster, Webster County High, Glade Middle; and Wood, Jefferson Elementary, Franklin Elementary.

If after a three year period the priority school no longer fits the initial criteria for priority status and shows major improvements in student achievement, they can lose the status.
Mailing info

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**Mutual Self-Help Parent Support Group**

*Circle of Parents*

is a place where parents can connect with each other, learn from each other, and be sources of strength to each other.

Meeting times and locations:

**Westbrook Health Services, Parkersburg**
1st and 3rd Tuesday from 10 to 11:30 a.m.

**Disability Action Center**
2nd and 4th Wednesdays from 11:30 a.m. to 2 p.m.

**WVU Center for Excellence in Disabilities**
Morgantown
1st and 3rd Thursdays from 10-11:30 a.m.

Meetings are always free, confidential, anonymous, non-judgmental, and promote positive, non-abusive parenting.