Happy Thanksgiving

NOVEMBER 2020

WOODALL GNETS NEWSLETTER

The Woodall GNETS Program * 1822 Shepherd Drive, Columbus, Georgia 31906 * 706-748-3166 Office
A community of lifelong learners, responsible citizens, and champions of success!

Message from Mrs. L. Thornton - Director

To: Parent/Guardian

If you have any questions or concerns in regard to the Woodall GNETS Program, please do not hesitate to contact me via phone or email:

Phone: (706)748-3166 Office

E-Mail: Thornton.Lachrista.S@muscogee.k12.ga.us

Woodall GNETS Mission Statement

To create a climate of cooperation and socio-emotional competence through explicit modeling of behaviors and expectations for students and staff.

A community of lifelong learners, responsible citizens, and champions of success!

WOODALL GNETS PBIS FRAMEWORK

What is School-wide PBIS?

School-wide positive behavior intervention and supports (SW-PBIS) is a system of tools and strategies for defining, teaching, acknowledging appropriate behavior, and correcting inappropriate behavior. It is a framework for creating customized school systems that support student's outcomes and academic success.

SW-PBIS is for the whole school. It is preventative and changes the paradigm of focus from negative behaviors to positive expectations and interactions.

There are four main elements in SW-PBIS

1. Customized practices to support student behavior, such as defining and teaching appropriate behavior.
2. Systems of support for educators in the school; such as school-wide behavioral expectations, indicators, and coaching.
3. Data-based decision making, which is the corner stone of the behavior problem-solving process.
4. And, the combination of these enable school-wide outcomes which promote social proficiency and academic success.

Dr. Vytoris Sanford—Instructional Specialist

Notes from the Desk of:

Chauntell Beal— Behavioral Specialist

November Character Word of the Month
PATRIOTISM

Patriotism- Respectful devotion or love to one's country

Greeting,

We will start the Behavior Assessment System for our in person students. Please complete the forms and return them. The Behavior Assessment System for Children, Third Edition (BASC™-3) is a multimethod, multidimensional system used to evaluate the behavior and self-perceptions of children and young adults ages 2 through 25 years. The BASC-3 system includes the following components: • Behavioral and Emotional Screening System (BESS) • Teacher Rating Scales (TRS) • Parent Rating Scales (PRS) • Self-Report of Personality (SRP) • Structured Developmental History (SDH) • Student Observation System (SOS) • Behavior Intervention Guide • Behavioral and Emotional Skill Building Guide - part of the BASC-3 family of products • Flex Monitor • Parenting Relationship Questionnaire (PRQ™) Typically, emotional and behavioral difficulties have various facets. Consequently, these difficulties need to be assessed by a number of different viewpoints. BASC-3 components offer a comprehensive system for identifying, evaluating, monitoring and remediating behavioral and emotional problems in children and adolescents. Each component can be used individually or in whatever combination is best suited to the situation at hand.

Notes from the Desk of:

Dr. Vytoris Sandford—Instructional Specialist

A Parent's Role in Virtual Education

Because of the increased autonomy and self-motivation required to be successful in an online program, parent involvement is generally a key indicator of a successful virtual school experience. Studies show that there is a direct positive correlation between parent involvement and student success.

Encourage and Motivate

Being a positive encourager is possibly the most important role for the parent in a virtual school setting. Praise your child's successes. Just as you would display good work from a traditional school on the refrigerator and the walls, do the same for your student's online work. Surround them with examples of the positive things they are accomplishing.

When helping your child understand a concept or complete assignments, be encouraging without giving answers away. Coach your student and certainly work with them. If something becomes too difficult or they do not seem to understand, you or your child should contact the teacher and request additional assistance. Meanwhile, continue to be positive and encouraging with your child.

A community of lifelong learners, responsible citizens, and champions of success!

Childhood Engagement and Attachment: Specific Disorders

Dr. Leon Rodgers, EdD, MSW, MHDL
Forensic / Licensed Clinical Social Worker

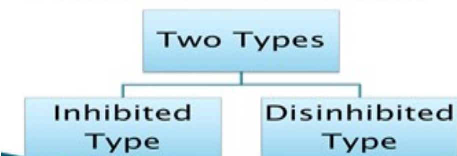
Disinhibited Social Engagement Disorder (DSED) is an emotional disorder which begins in childhood. It is classified as a stressor-related disorder in the newest guide to diagnosing mental disorders, i.e., the DSM-5. Social neglect during childhood (a lack of adequate care-giving) is a diagnostic requisite. DSED is similar to *Reactive Attachment Disorder* (RAD) but presents with externalizing behavior and disinhibition rather than internalizing and withdrawn behavior with depressive symptoms. Children who have experienced severe social neglect or deprivation before age two are at greatest risk to experience DSED. Similar to RAD, DSED symptoms can arise when children lack the basic emotional needs for comfort, stimulation and affection, or when repeated changes in caregivers prevent the child from being able to form and maintain stable and nurturing attachments, which, for example, can occur when a child experiences frequent foster or group home changes.

DSED involves a child engaging in overly familiar or culturally inappropriate behavior with unfamiliar adults. For example, the child may be willing to go off with an unfamiliar adult with minimal or no hesitation. These behaviors cause problems in the child's ability to relate to adults and peers. Moving the child to a normal caregiving environment can decrease symptoms. However, even after placement in a positive environment, some children continue to have symptoms through adolescence. Developmental delays—especially cognitive and language delays—may co-occur along with this disorder.

DSED is characterized by grossly abnormal social behaviour, occurring in the context of a history of grossly inadequate child care (e.g., severe neglect, institutional deprivation). The child approaches adults indiscriminately, lacks shyness to approach adults, will go away with unfamiliar adults, and exhibits overly familiar behavior towards strangers. DSED can only be diagnosed in children, and features of the disorder develop within the first 5 years of life. However, the disorder cannot be diagnosed before age one (or a mental age of less than 9 months), when the capacity for selective attachments may not be fully developed, or in the context of Autism spectrum disorders (ASD).

Cont'd...

RAD occurs in children who have experienced severe social neglect or deprivation during their first years of life. It can occur when children lack the basic emotional needs for comfort, stimulation and affection, or when repeated changes in caregivers prevent them from forming stable attachments. Children with RAD are emotionally withdrawn from their adult caregivers. They rarely turn to caregivers for comfort, support or protection or do not respond to comforting when they are distressed. During routine interactions with caregivers, they show little positive emotion and may show unexplained irritability, sadness, or may report feeling unsafe and/or alone. The problems appear before age five. Developmental delays—especially cognitive and language delays—often occur along with this disorder. Children with RAD often have trouble managing their emotions. They struggle to form meaningful connections with other people. Children with RAD rarely seek or show signs of comfort and may seem almost fearful of their caretakers, even in situations where the parent figures are quite loving and caring.



According to DSM-5, the essential feature of RAD is marked disturbance of social relatedness in most contexts that begin before age five, and which is preceded by grossly dysfunctional care. Children with RAD may present in two very different, even opposite-appearing subtypes: *RAD inhibited-withdrawn type* (those who withdraw from interpersonal encounter) and *RAD disinhibited-indiscriminate type* (those who show little reserve toward strangers and seem impulsive as well as non-selective in their pattern of relationship). In a real-time clinical or educational setting, children with inhibited withdrawn form of RAD may resemble children with ASD in their level of emotional detachment, and lack of reciprocity. Other signs of ASD such as repetitive stereotyped behavior and restricted range of interest are absent in RAD. Language delay is commonly present in RAD at time of placement removal from an adverse setting, but progressively improves, unlike the case of ASD. Children with RAD do not demonstrate the idiosyncratic language of ASD, such as echolalia or pronoun reversal.

Key to both types of attachment disorder is the absence of selective proximity-seeking: the child does not go to the familiar caregiver in time of distress and, thus, does not appear to use this person as a safe "home base" from which to explore outward. Children with the disinhibited form of RAD may literally meet strangers with open arms, thus appearing to devalue the special relationship with a parent figure (and often worrying them on the matter of safety in public). In contrast, children with the withdrawn, inhibited subtype of RAD are reluctant to engage with their parent figure, or they might comply mechanically and without feeling. Reunions after time apart may be emotionally charged but ambivalent; the child pulls away or avoids eye contact, which may shake the caregiver's faith in the possibility for growth in the fragile, nascent attachment.

A pediatric psychiatrist, child-development psychologist, or licensed clinical social worker can conduct a thorough, in-depth examination to diagnose DSED or RAD. In order to strengthen child-caregiver relationships, treatment may include psychotherapy for the child, family therapy, parenting training, and special education services.

Holiday Stories

Thanksgiving

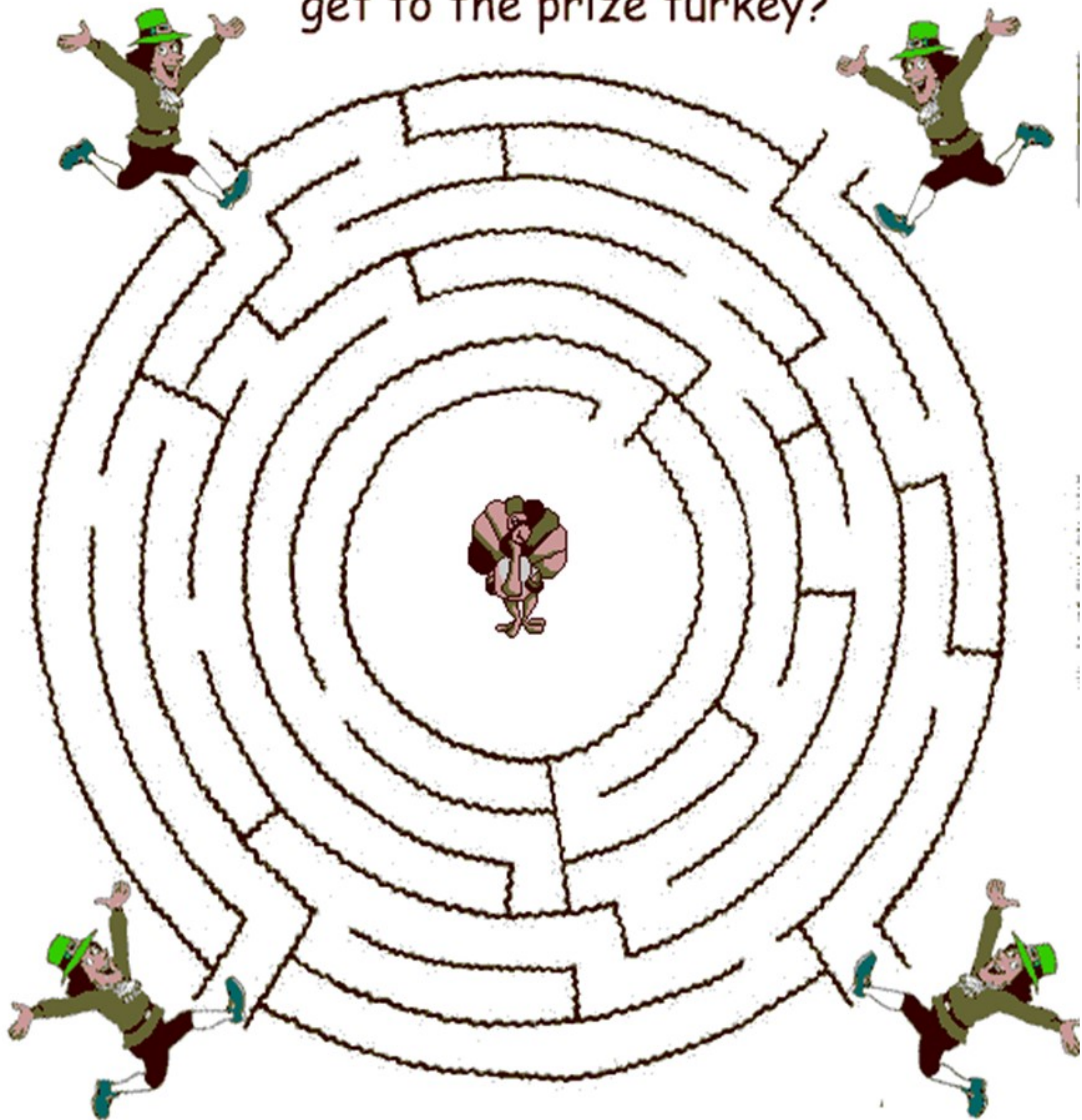
Story by Andrew Frinkle

Thanksgiving is the fourth Thursday in November. It is a day to celebrate harvest and all we are thankful for. It is a fall holiday.

Many countries have a harvest festival. The American Thanksgiving story goes back to early settlers known as Pilgrims. It had been a hard year for them. When their harvest was good, they wanted to celebrate.

The American Indians learned that the Pilgrims were celebrating, so they brought some food to the party, too. They brought things like deer meat, shellfish, and corn! Everyone was very thankful to have a good meal and great friends. What are you thankful for?

THANKSGIVING FUN ACTIVITY



November 11: Veterans Day

November 13: Progress Reports

November 23—27: Thanksgiving Break

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A G N I V I G S K N A H T G O
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1. Carve
2. Celebrate
3. Colonist
4. Cornucopia
5. Cranberry
6. Dessert
7. Farmer
8. Feast
9. Gather
10. Harvest
11. Holiday
12. November
13. Pilgrim
14. Platter
15. Pumpkin
16. Thanksgiving
17. Tradition
18. Turkey
19. Vegetable
20. Worship