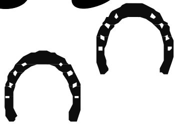
Hoofbeats



Formerly *KC Connections* and *Family Ties*

News from the **Attachment Disorder Network**

SERVING CHILDREN AND FAMILIES AFFECTED BY ATTACHMENT DISORDER MAR/APR 2000

Symptoms of RAD

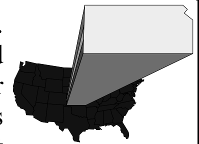
- ♦ *Poor peer relationships*
- ♦ *Poor eye contact*
- ♦ *Lack of cause and effect thinking*
- ♦ *Absence of guilt, no remorse*
- ♦ *Chronic, nonsensical lying*
- ♦ *Self-injurious behavior*
- ♦ *Vandalism and destructiveness*
- ♦ *Cruelty to animals and/or children*
- ♦ *Stealing/hoarding food*
- ♦ *Indiscriminate affection towards strangers*
- ♦ *Refusal to answer simple questions*
- ♦ *Provoking of anger in others on an almost continual basis*
- ♦ *Theft*
- ♦ *Firesetting*
- ♦ *Theatrical emotions*
- ♦ *Denial of accountability, always blaming others*
- ♦ *Learning disorders*
- ♦ *Toileting issues*
- ♦ *Lack of ability to give and receive affection*
- ♦ *Preoccupation with blood, fire, or gore*
- ♦ *Unusual speech patterns or problems —mumbles*

Notes from Nancy

Four years ago, amidst much trepidation, Kansas privatized its child welfare system. In a nutshell, our state foster care/adoption system works like this…

Someone believes a child may be abused or neglected and calls SRS, or Social and Rehabilitative Services. If the child is placed in state custody, the private *foster care* contractor assumes responsibility for placing the child in a home or facility. SRS continues its involvement. If parental rights are terminated, the private *adoption contractor* enters the picture. Of course, the child is likely still in foster care, so initially the foster care contractor is still involved. If adoption subsidies are to be negotiated, both SRS and the adoption contractor are a part of that negotiation.

For the first time since privatization 4 years ago, new contracts were just awarded for both the foster care and adoption contracts. Kansas is divided into 5 regions. Three of the regions retained the same agency for the foster care portion, while 2 regions will be serviced by a different agency. The state adoption contract was awarded to a single agency, and not the same one as in the past. This means that the primary foster care contractor in my county will change, requiring a shift in the hierarchy of who subcontracts with whom, a shift in licensure for many foster families, and still another link in an incredibly long chain of people responsible for



(Continued on page 2)

Attachment Disorder Network Mission Statement

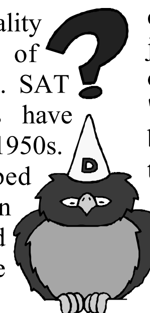
To recognize and promote healthy family attachments and to increase awareness and understanding of the critical importance of attachment to human development.

Reasons and Significance of Societal Mayhem and Severe Disturbances in the Population (Part 2)

Foster W. Cline, M.D.

Part 1 of this article appeared in the Jan/Feb 2000 newsletter...

The "Dumbing Down" of America



There is good evidence that the quality of the mean cubic millimeter of American protoplasm is decreasing. SAT (Scholastic Aptitude Test) scores have been steadily declining since the 1950s. Recently the SAT was "dumbed down". Since the "average score" on the SAT has always been 500, and because, by the 1994 the average score had dropped to 400, the mean was "dumbed down" to 400, so an actual score of 400 automatically becomes 500! The SAT Committee did this so the "average graduates could be meaningfully compared." But in fact, just the opposite is true. Recently the President of Stanford noted that all colleges now teach, "remedially, in the first year things that used to be taught in high school". In only two generations we have massively lowered our taste in movies, going from Casablanca to Dumber and Dumber. Even in television we have

(Continued on page 2)

Our Philosophy

We believe that a child's experiences and environment from the time of conception until 2-3 years of age establishes the child's frame of reference for all future interactions and relationships.

*** Pre-natal factors that affect attachment include: denial of pregnancy, dislike for the father of the child, substance abuse, inadequate diet and/or poor self-care, resentment, prematurity risk factors, and variable family support.*

*** Post-natal factors include: lack of parenting skills, various caregivers, ongoing substance abuse, "mechanical parenting," neglectful/abusive parental reactions, prematurity factors, and undetected or unrelieved pain in the child.*

We provide training on the recognition of Reactive Attachment Disorder and suggest resources and interventions to parents and professionals.

We provide support and alternative parenting methods for the beleaguered parents of these children.

(Notes, continued from page 1)

any given child. Some foster parents feel there are so many cooks in the kitchen that the children are getting burned.

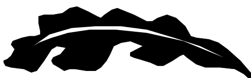
Earlier this month I had the opportunity to visit with Joyce Allegrucci, commissioner of SRS for the state of Kansas. Accompanying me was our private attorney who had been instrumental in accomplishing the private placement of our new Chinese daughter. Together, we expressed our concern over the profound discrepancies between county agencies in the definition of "abuse". The Commissioner agreed that was a problem. We discussed the fact that SRS staff does not understand attachment parenting, and has harassed families *because* of that lack of understanding. In fact, the Commissioner indicated she planned to arrange for a workshop on attachment disorder for state SRS staff. Our meeting closed with a request by Commissioner Allegrucci to meet again after the state legislature completes this session. I look forward to further dialogue.

The Basic Assumptions article on page 6 represents many, many hours of work last year by the ATTACh Board of Directors. It is available on the ATTACh website (www.attach.org) as well. To me, it represents an excellent view of what attachment therapy and attachment parenting is all about. Hopefully, this description of our core beliefs will help others understand that attachment work is NOT simply "holding" an unhappy or non-cooperative child.

For you local Kansas folks, we are asking for your feedback on support group meetings. Please see page 4 .

The last half of Dr. Foster Cline's article is as rousing and thought provoking as the first. If you didn't see Part 1, please contact Kathy Ryan for a copy of the Jan/Feb ***Hoofbeats***.

Watch for more details about our annual July 4th party. If we are in town, the party is on!

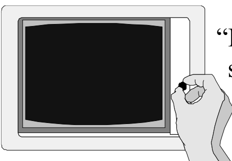


(Continued from page 1)

gone from the family viewing the Ed Sullivan Talent Show to Beeves and Butt Head.

These problems have societal implications in the cognitive domain:

Many young people entering adulthood are the vanguard of a vast number of Americans who suffer from the subtle effects of drugs in pregnancy, early abuse and neglect, and the breakup of the family. These Americans cannot meet the responsibilities required by society. Gergen (1990) notes in a U.S. News & World Report editorial:



"But there does appear to be something new in our midst. Americans are not only turning off, they are also tuning out. Since the early 1980's the three network evening news broadcasts at ABC, CBS and NBC have steadily lost millions of viewers and now draw less than half the audience shares of sitcoms like "Roseanne" and "The Cosby Show." Contrary to myth, many of these lost viewers are not migrating to PBS, CNN or other news alternatives; they are simply abandoning the airwaves. Gone as well are many potential readers of newspapers. Between 1970 and 1988, for example, the adult population increased by 36 percent, but the number of daily papers that were sold increased by only one percent. To hold audience, not to mention advertisers, many media organizations are scrambling downmarket, serving up huge helpings of fluff lightly sprinkled over with bits of news. The average network sound bite is down from 42 seconds in 1968 to nine seconds in 1988."

In 1966, 5 million of California's 11 million voted in the primary for governor. In 1990, 4.5 million of more than 21 million voted in the primary. These statistics are shocking. As a society, we are being shaken to our roots by monumental changes.

There is a pathetic and fruitless attempt at superficial answers. The decay indicated by the statistics here have been attributed to "a lack of crisis in American life"; "an age of indifference" or a decrease in "morality." While some of these ideas may be close to the truth, and others just plain silly, no one wants to face the obvious and very harsh reality. There is simply a decrease in quality of mean cubic millimeter of human protoplasm. Large masses of Americans simply engage in less thoughtful planning, are less intelligent, have less conscience and are less caring. All of these are indicators of basic ego strengths built on genetics, perinatal events, infantile and early childhood care.

Thus, even with an increasing population, the

(Continued on page 3)

(Continued from page 2)
total mass of American cerebral cortex is unable to support three weekly news magazines, unable to maintain focus on 45 seconds of one subject on the evening news and unable to even sustain daily newspapers that publish at the fifth-grade level.

The connection between ADD, learning disorders and behavioral disorders

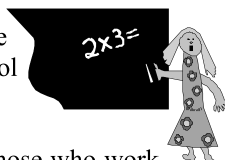
Professionals themselves often misunderstand the connection between Leaning Disorders of various types and behavior disorders. One is almost always seen as contributing or even causing the other. Typical of the writing of those in the educational field are the following observations:

"It is essential to identify a child's learning styles and learning problems early. For, if not early identified, the child's self esteem is lowered, he sees himself as a school or academic failure, and begins to seek self esteem in anti-social and disruptive behavior."

As in the above quote, generally it is true that those who collect funds from the government for education see early educational assessment as the answer to the violence in America.

On the other hand, those collecting federal dollars for therapeutic intervention see early behavioral assessment and family intervention as the answer to the school's difficulties with children who demonstrate learning problems:

"It is no wonder that children from a background of broken families, abuse and neglect are so filled with anxiety that they have trouble with school work. Until the child's home can be stabilized, the child's leaning at school will be compromised.



And across America those who work specifically with learning disorders end up "doing therapy" not learning exercises, and therapists end up often attempting to tutor the child on academics. The only thing everyone can agree on is that "learning disorders do not happen by themselves" and behavioral disorders almost always go hand in hand.

However, learning problems do not cause behavioral problems, and behavioral problems are not the reason for learning problems. The fact is that when infancy and early childhood are compromised, problems occur in both areas. Working on one area will not cure the other, and both are difficult to remediate unless the first year of life and early childhood experiences can be reworked. If such is possible, and in a few cases, it is, it is an expensive, time consuming, labor intensive intervention with maximum effort for generally minimal gains. For, using a computer analogy, the problem with the garbage on the screen (or with the child's behavior) is often not a "software" or educational problem, but a deeper problem with the child's hardware—the functioning of the brain itself. Unfortunately, massive amounts of federal money, attention, time, and programs will not fix the problem. As a matter of fact, such solutions often worsen the program by "enabling the dysfunction to be repeated in succeeding generations."

First year of life and violence in the culture

America's cognitive losses are mirrored by the rise of criminal problems: the loss of citizens' ability to delay gratification, inhibit impulses, and demonstrate concern for others along with the basic ability to show love, are all learned in the first year. A syndicated black columnist writes for the Miami Herald in January 1995 under the byline: "What's happening to young people? Why the impatience? Why threaten murder over a romantic rejection?"

But for many kids these days, every bump is a mountain they can't get over. I don't pretend to know why. Only that the world seems radically different now. That the children of the day seem ferociously impatient when their desires are denied. That they imbue every tiny setback with the full weight and passion of Shakespearean tragedy. And so every glancing wound becomes mortal, every real or imagined insult worth killing or dying for.

And so, you get these awful, screaming headlines about adolescents, babies, shooting, stabbing beating one another to death. Killing and dying over a boyfriend or a girlfriend, a patch of street or a strip of park. Or, sometimes, just because.

Thoughts concerning societal change

The answers necessary to address the fundamental problems facing society are both difficult and controversial. Therefore they may not be possible. All call for the prevention of problems rather than "reaching" the thought disabled and violent children after they are born or wander the streets unable to form lasting loving relationships or maintain meaningful employment. Almost two generations ago, long before America's problems on the streets mushroomed geometrically to its present horror, George Shaw noted, "Parentage is a very important profession; but no test of fitness for it is ever imposed in the interest of the children."

Should all who cannot pass a driver's test be forbidden to have children? Can anyone, anywhere, without the ability to pass a driver's test pass the test of raising a child for 17 years? Would any of those so concerned about robbing people of their right to have children, be willing, in reality, to have their own children raised by someone without the ability to pass a driver's test?

Should there be Norplant (mandatory birth control) for adults unable to complete a parenting course and/or seventh grade? Most would feel that someone who cannot master 7th grade materials is going to have a very hard time raising a child for 17 years!

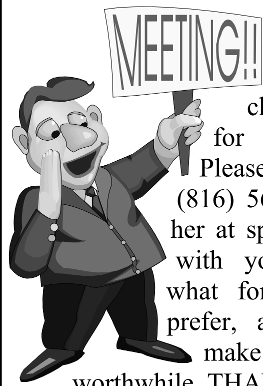
Should individuals on drugs be continually encouraged to have children? Many individuals on drugs are impulsive, and unable to care for themselves, let alone children. Should Norplant be mandatory for all for all adults found to be on drugs?

Many mothers have only one or two children on welfare. However, in my experience, the mothers who raise

(Continued on page 5)

Support Group Meetings

You may not have noticed (because you haven't been there!) that attendance at support group meetings has been dwindling. We *have* been meeting the first Wednesday of every month at the Gillis Home for Boys. Sally Popper has expressed a willingness to continue to facilitate these meetings, but we need your input. Would speakers or videotapes of speakers be helpful? If so, who would you like to hear? Would you prefer a location other than the Gillis Home? Is childcare essential for you to attend? Please call Sally at (816) 561-1905 or email her at spopper1@aol.com with your thoughts on what format you would prefer, and what would make your attendance worthwhile. THANKS!



Check out this book!

Single mom Carole Bilina of Chicago never expected to be reading about attachment disorder when she decided to read a recent Oprah's book club selection, *Map of the World* by Jane Hamilton (Anchor Books, 1994). But on page 350, the defense attorney questions a social worker about the social worker's knowledge of character-disturbed or unattached children. He asks her for a profile of such a child, a profile that a social worker could find in the Diagnostic and Statistical Manual of Mental Disorders or in the book *High Risk: Children Without a Conscience*. Part of the defense is that the child, a six-year-old boy named Robbie, is unattached. Although the social worker knows about attachment disorder, it had never occurred to her that Robbie fit the profile. Later in the trial, another social worker is called to the stand who describes the character-disturbed child and uses the term *Antisocial Personality Disorder* as a synonym.

Carole is the mom of 14-year-old Katie, who is scheduled to have therapy with Connell Watkins in March. Carol is curious about how author Jane Hamilton, who lives in Wisconsin, came to know about the attachment disorder.

Evergreen "Think Tank" Meeting

Comments from Sally Popper, PhD

I have just returned from two stimulating days at the Attachment Center at Evergreen, Colorado, where I met with about 25 other attachment therapists from around the country. Forrest Lien, clinical director of ACE, had offered to sponsor this "think tank" for therapists as a result of conversations at the last ATTACh conference. I think many of us were very appreciative to just have the opportunity to compare notes with other therapists doing the same kind of work. The conversations were buzzing from early until late. In the meetings, we shared information on what has proven effective or ineffective in our own practices. We learned about some promising therapies (for example, EMDR and neurofeedback) that may not have been developed for RAD children, but seem to work well with at least some of them. We talked about the need for social change to prevent abuse and neglect from occurring in the first place. We discussed the need for more opportunities to come together and be trained in specific skills, and we plan to hold more think tanks, as well as pre- or post-conference institutes for more formal training. We reviewed the Basic Assumptions formulated by the ATTACh Board and compiled our own list of recommendations for the Board. It was time well spent!

Check out the **new research results** by Robin Myeroff, PhD, on the effectiveness of attachment therapy…
http://www.attachmentcenter.org/research.htm

I Didn't Do It!

One afternoon a man came home from work to find total mayhem in his house. His three children were outside, still in their pajamas, playing in the mud with empty food boxes and wrappers strewn all around the front yard. The door of his wife's car was open, as was the front door to the house.

Proceeding into the entry, he found an even bigger mess. A lamp had been knocked over, and the throw rug was wadded against one wall. In the front room the TV was loudly blaring a cartoon channel, and the family room was strewn with toys and various items of clothing. In the kitchen, dishes filled the sink, breakfast food was spilled on the counter, dog food was spilled on the floor, a broken glass lay under the table, and a small pile of sand was spread by the back door.

He quickly headed up the stairs, stepping over toys and more piles of clothes, looking for his wife. He was worried she may be ill, or that something serious had happened. He found her lounging in the bedroom, still curled in the bed in her pajamas, reading a novel.

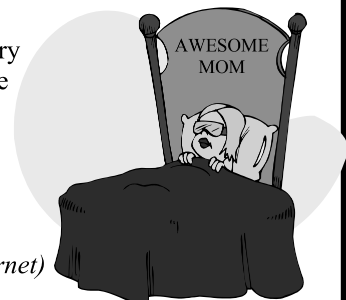
She looked up at him, smiled, and asked how his day went. He looked at her bewildered and asked, "What happened here today?"

She again smiled and answered, "You know every day when you come home from work and ask me what in the world I did today?"

"Yes," was his incredulous reply.

She answered, "Well, today, I didn't do it."

(From the internet)



(Continued from page 3)
violent youth have numerous children being handled as *someone else's* responsibility, either raised in foster homes, group homes, or being cared for by other's dollars in their own birth home. Should there be refusal of welfare payments to all who have children while on welfare?

Should a mother, or couple be allowed to continue to produce children for other people to care for? Is it possible to say, "one is enough?" Should parents who have one child being cared for or supported by the population be refused the right to produce other children until they are able to care for the first?

Should there be mandatory parent education classes in Junior High, Senior High and during pregnancy? Are such classes as important as history and math?

Should there be mandatory drug and alcohol testing during pregnancy? If the test is positive, should the mother be placed in residential care? There is no known way to reach children with fetal alcohol syndrome, a population that is growing each year.

Should there be tax rebates based on the parents attendance at parenting classes and enrolling their child in early education programs?

Should there be government support of private enterprise doing in-home stimulation and appropriate outreach to "at risk" children?

Should people be paid for not having children? Presently mothers are paid by the baby to produce them. Arguably, that program has worked! Mothers are paid not to have the father in the home. There are presently more broken families, and more out-of-wedlock pregnancies than ever before. Do people need to be paid for the opposite behavior?

As the culture disintegrates, becomes more co-dependent, and more encouraging of irresponsible behavior, it may be too late to ask these questions.

SALLY the SAGE

(SAGE: One renowned for judgment and wisdom.)

By Sally Popper, PhD

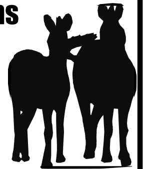
Dr. Bruce Perry is a leading researcher on the impact of trauma in early childhood. He runs the Child Trauma Academy at Baylor College of Medicine in Houston. I recommend his excellent web site—www.childtrauma.org—where you can find many articles for parents and for professionals. The focus is on the psychobiology of trauma. And lest you think that this doesn't include your child, consider that for a young child, losing parents is traumatic, something that feels to the child life-threatening and terrifying, since parents, however they behave, are still everything to the child. I will summarize a couple of Perry's major ideas, and hope it piques your interest enough to explore all the information on his web site.

Perry identifies two major ways that children react to trauma. The first is dissociation or freezing, both physically and mentally. Dissociation helps the child "not know" what happens when things are too terrible to know. The second way a child may react to trauma is with hyperarousal—experiencing a surge of energy that prepares the child to flee or protect him or herself. If dissociation is frequent and prolonged, the long term state of the child's brain, the habitual level of various neurotransmitters, and the way the child reacts to all sorts of experiences changes in the direction of dissociation. The child is likely to show chronic symptoms of withdrawal, physical complaints, anxiety, depression and dependence. If the child reacts to trauma with hyperarousal, and the trauma is prolonged, the child will become more habitually aroused with hyperactivity, increased muscle tone, higher body temperature, sleep disturbances, as well as difficulty regulating feelings and cardiovascular state. Thus, as Perry notes, "states become traits." Perry goes on to say, "The same remarkable qualities of the developing brain that allow the growing child to internalize and rapidly learn about the world ultimately betray the traumatized child. Their brains develop as if the entire world is chaotic, unpredictable, violent, frightening and devoid of nurturance—and unfortunately for most, the systems that our society has developed to help these children (the juvenile justice, foster care and mental health systems) often continue to fill their lives with neglect, unpredictability, fear, chaos, and most disturbing, more violence."

Check out our website!

www.radzebra.org

- **Meeting information**
- **Newsletter order forms**
- **Articles and Poems**
- **Symptom list**
- **Links**



Need more information?

Nancy Spoolstra, DVM
6500 W. 183rd St.
Stilwell, KS 66085
Phone 913-897-1900
FAX 913-897-4477
saanda@aol.com
www.radzebra.org

Gail Trenberth
PO Box 18475
Boulder, CO 80308
303-443-1446
GailADPN@aol.com

Kathy Ryan
10219 Howe Lane
Leawood, KS 66206
913-381-9026
lryan@qni.com

Sally Popper, PhD
6908 Valley Road
Kansas City, MO 64113
816-333-9106
Spopper1@aol.com

Dave Boehnke, LMSW
Director of Special Needs Adoption
Catholic Community Services, Inc.
2220 Central Avenue

ATTACh: BASIC ASSUMPTIONS

The primary goal of therapy with children and adults with attachment problems is to enable them to form healthy attachment relationships with their current and future families, and to resolve the dysfunctional feelings and behaviors developed in response to the early attachment breaks. Members of ATTACh represent a variety of treatment models about which there is a range of consensus. The following are basic assumptions about which there is general agreement.

What we believe about attachment

1. Unresolved issues about early traumatic experiences which have interfered with the formation of secure attachments may need to be explored and resolved so the child and/or family can be receptive to experiencing trust and the formation of sincere, secure, reciprocal relationships/ attachments.
2. Attachment difficulties can occur in any family constellation; such as birth, adoptive, foster, step, etc.
3. Attachment therapy involves family members as active, central participants in therapy. Parents and children are members of the treatment team. The family's emotional response to the therapy needs to be monitored, as well as the child's.
4. When exploring unresolved issues, treatment will take into account past and present family dynamics. If the relationship with birth parents has been terminated, they will be respected and held accountable for any hurt they inflicted. Treatment will actively differentiate the new parent relationships from the old ones. If relationships are still intact, they will also be respected and held accountable, taking into consideration circumstances out of their control which contributed to the attachment problems such as: chronic pain, severe illness, separation, death, parental depression, etc.

5. Healthy attachment relationships include trust, empathy, reciprocal behaviors, attunement, communication, touch, and both physical and emotional closeness. Attachment therapy emphasizes these aspects of relationships among all participants: parents and child, parent and parent, therapist and child, and therapist and parents.

What we believe about children

6. The child's primary attachment prenatally and during the first years of life provides the foundation for personality development. A break or trauma in a child's in-utero bond or early attachments often interferes with his/her ability to form subsequent attachments, and negatively influences the child's beliefs and behaviors about future relationships. Appropriate attachment therapy can ameliorate the effects of a break or strain in primary attachment.
7. Discovering the child's individual inner working model is important for therapeutic success. The inner working model influences the child's life. The child can be helped to change these negative life conclusions, and as a result change their response to events and relationships.
8. Each child is a unique individual and a variety of therapeutic techniques may be utilized based on the child's history and inner working model, and parental abilities and style.

What we believe about families

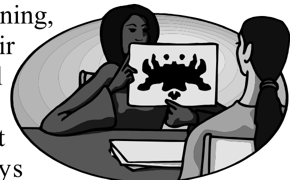
9. The therapist will support, not undermine, the authority and value of the parents during therapy sessions. If there are differences between the parent and the therapist, the therapist and parents will actively work to resolve them.
10. The bulk of the work in attachment therapy occurs at home, between the parents and the child. The therapist assists the parents in developing parenting styles and philosophies which support the development of healthy attachments. Consequences with empathy are a primary means of teaching the child, but all discipline is aimed toward nurturing the attachment relationship. The therapist serves as a consultant with the parent on techniques which include:

- Reversing the center of control in the home, as children in inappropriate control of their environments are at risk for physical and emotional trauma.
- Maintaining a positive, supportive, family atmosphere.
- Maintaining structure and limits.
- Increasing reciprocal, positive interactions between parent and child.
- Increasing the child's readiness to rely on the parent for safety, help, comforting and nurturing
- Helping the child make choices that are in his own best interest, and in the best interest of his family, and to accept the consequences of those choices.
- Helping parents become emotionally available for their child as healthy and safe individuals. This may include examining their own issues,such as the marital relationship, infertility, grief and loss, childhood trauma, etc.
- Helping families and children develop reasonable expectations of success.

11. Crucial to treatment progress is the parent's commitment to keeping the child in the family.
12. Parents deserve complete and unbiased information on a continuing basis and in a supportive manner.
13. Success belongs to the family, not to the therapist.

What we believe about therapists

14. A therapist has a responsibility to make parents aware of treatment options.
15. Supervision, peer supervision and therapy are all recommended options for support and continued skill development of the therapist.
16. Therapists should be aware of their own biases and issues that affect the manner in which they work.
17. Therapists should work only within their area of expertise, in keeping with their level of training, and under their professional code of ethics.



18. A therapist should always approach a family and child with respect and without blame.

How we do attachment therapy

19. Attachment therapy is hard work for everyone involved.
20. This difficult work must occur within a therapeutic atmosphere that conveys safety, protection and hope and provides empathy and comforting to all family members as the work proceeds.
21. The therapist needs to take an active and directive stance in working with the child and family on core issues that the child and family may initially find

(Continued on page 7)

(Continued from page 6)
difficult to address. Therapeutic interventions may be confrontational, intrusive, and challenging to the child.
22. The parents and therapist are in control of the session and of the child, in a nurturing, safe and empathic manner. The adults take the lead in attachment therapy but are always observing and responding to the feelings and needs of all family members.
23. Both the child and the family must have a developmentally appropriate understanding of the therapy process and goals.
24. Informed consent is an important element of treatment planning.
25. A child may be therapeutically held during the course of attachment therapy.
26. Children sometimes need medication; however inappropriate or over medication may thwart the therapeutic process.
27. In unique cases when family members choose not to attach, after careful work and evaluation, respect will be given to their choice and an alternative treatment plan will be established.
28. As attachment is on a continuum so is treatment. Interventions should be flexible and specific to the needs and emotional state of each member of the family.
29. A central therapeutic activity is for the child and family members to experience and then express their emotional responses (anger, sadness, fear, etc.) to past and present situations that are interfering with attachment.
30. Parent-child interactions that are central to establishing a healthy attachment, i.e. eye contact, physical contact, tone of voice, smiles, other non-verbal communication and gestures, are central to the interactions of therapy. These interactions may be exaggerated with the child to produce a therapeutic effect.
31. Holding as a therapeutic technique provides a multi-sensory experience that refines attunement, facilitates emotional reciprocity and honesty, enhances empathy responses, allows the child to experience vulnerability in a safe way, and reenacts the holding nurturing experience of infancy; all of which provide a corrective emotional experience.
32. The therapist may model and elicit various emotional states in order to facilitate the child's integration of cognition to emotion.
33. The therapist works with other significant persons in the child's life (psychiatrist, school, etc.) to establish a team effort to help this child and family reach their fullest potential.
34. Treatment is based on an understanding of the symptom complex and the child's and families' histories.
35. The parents and child participate actively in the therapy together, with all parties working to develop healthier patterns of interacting and communicating. They are supported, encouraged and educated. Strengths are recognized and developed.

What we believe about evaluation of attachment therapy

36. A review of goals and progress will be completed at the conclusion of therapy.
37. There is value in conducting long term follow-up and assessment of outcomes.
38. We support and encourage research to improve our ability to assess and treat children and families.

Adopted 10-19-99
by the ATTACh Board of Directors

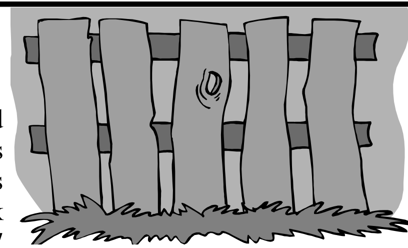
It is not giving children more that spoils them; it is giving them more to avoid confrontation.
John Gray, *Children Are From Heaven (Harper Collins)*

Calendar of Events

Monthly meetings are held at 7:00 PM the first Wednesday of every month at the Gillis Home for Boys, 8150 Wornall Road, KCMO. The next meeting date is April 5th

For the past 2 years we have had a July 4th Party at the Spoolstra's home. IF they are still in town (and they are planning on it…), the party is on! Mark your calendars now and watch for further details!

The Fence



There once was a little boy who had a bad temper. His father gave him a bag of nails and told him that every time he lost his temper, he must hammer a nail into the back of the fence. The first day the boy drove 37 nails into the fence. Over the next few weeks, as he learned to control his anger, the number of nails hammered daily gradually dwindled. He discovered it was easier to hold his temper than to drive those nails into the fence.

Finally the day came when the boy didn't lose his temper at all He told his father about it and the father suggested that the boy now pull out one nail for each day that he was able to hold his temper. The days passed and the young boy was finally able to tell his father that all the nails were gone. The father took his son by the hand and led him to the fence. He said, "You have done well, my son, but look at the holes in the fence. The fence will never be the same. When you say things in anger, they leave a scar just like this one. You can put a knife in a man and draw it out. It won't matter how many times you say I'm sorry; the wound is still there. A verbal wound is as bad as a physical one. Friends are a very rare jewel, indeed. They make you smile and encourage you to succeed. They lend an ear, they share a word of praise, and they always want to open their hearts to us."

(From the internet)

Attachment Disorder Network
10219 Howe Lane
Leawood, KS 66206

Attachment Disorder Network Membership Form

I would like a one-year membership in the **Attachment Disorder Network** for **$25**.
My **Individual Membership** includes:

- An informational packet on attachment disorder.
- A year's subscription to ADN's bi-monthly newsletter, ***Hoofbeats.***
- Access to on-line directory, lending library, past issues of newsletters and other member-only info.

Professional Membership for therapists and other practitioners for **$150** includes:

- Five copies of each issue of a year's subscription of ADN's bi-monthly newsletter, ***Hoofbeats.***
- Unlimited sample newsletters and recruitment materials.
- Detailed information about your practice on www.radzebra.org website with links to your website.
- Discounts on training/educational programs & materials (coming soon).

I learned about ADN through:

Name

Organization (if applicable)

Address

City, State, Zip

Phone Number E-mail address

Total Amount enclosed $______________________

I am: ☐ Adoptive Parent ☐ Counselor/Therapist ☐ Other
☐ Foster Parent ☐ Social Worker
☐ Bio Parent ☐ School Personnel

Please make checks/money orders payable to the
Attachment Disorder Network
And mail to: **P.O. Box 23508**
Overland Park, KS 66283
847-855-8676
Credit cards accepted through Paypal at
www.radzebra.org