

Transcript
What is Attachment Focused Therapy?
An Interview with Dr. Arthur Becker-Weidman

Recording:

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Dr. Bridget Nash:

Hello. I'm Dr. Bridget Nash and I'd like to welcome you to the Therapy Show, a podcast series that seeks to demystify mental health treatment. Today I'm honored to welcome Dr. Arthur Becker-Weidman, who is the director of the Center for Family Development in New York. He's an internationally acclaimed speaker and workshop leader and consults with therapists and organizations throughout the United States and internationally about the evaluation and treatment of attachment disorders, attachment-focused treatment, and prenatal exposure to alcohol. Dr. Becker-Weidman has achieved diplomat status in child psychology and forensic psychology from the American Board of Psychological Specialties and is a certified therapist, consultant, and trainer for the Attachment-Focused Treatment Institute and the Dyadic Developmental Psychotherapy Institute. Dr. Becker-Weidman is vice president on the board of directors of the Association for the Treatment and Training in the Attachment of Children and was founder and first president of the board of Dyadic Developmental Psychotherapy Institute. He is an adjunct clinical professor at the State University of New York at Buffalo, the Academy for Human Development in Singapore, and Medaille College in Buffalo. Dr. Becker-Weidman has published extensively in peer-reviewed professional journals and is the author and co editor of seven books including Attachment Parenting: Developing Connections and Healing Children and The Attachment Therapy Companion: Key Practices for Treating Children & Families. Dr. Becker-Weidman, welcome to the Therapy Show.

Dr. Arthur Becker-Weidman:

Thank you, Dr. Nash. It's a pleasure to be here and I look forward to our discussion.

Dr. Bridget Nash:

Can you start by telling us a little bit about your personal background and professional development that led you to your research in attachment-focused therapy?

Dr. Arthur Becker-Weidman:

It probably goes back to when I was in graduate school for my PhD and my dissertation. The research I did for that was primarily focused on looking at psychological differentiation, locus of control among compulsive adolescent substance abusers and their families. The children in the study were in residential treatment for drug abuse. It really struck me how the relationship between the child and the primary caregiver seem to be really important for understanding how these difficulties developed and as importantly how to address them. And over time, I published some material about adolescent substance abusers, their families, looking at different elements. It was probably in about 1998 that I first started focusing on attachment specifically and adoption issues. So those were two kind of related fields, adoption and attachment concerns.

Dr. Bridget Nash:

So how would you briefly explain attachment-focused therapy to a non-professional?

Dr. Arthur Becker-Weidman:

One of the phrases I like to use with parents, especially early in treatment when we're just beginning to talk about the methods and approaches that tend to be most effective when you have a child who has experienced complex trauma, which is chronic early maltreatment that occurred within a caregiving relationship, disorders of attachment trauma, is it's about connections, not compliance. In other words, attachment-focused treatment really focuses primarily on the relationship between people. And in a parent-child situation, the focus is not on compliance. It's on developing a healthier, better connection.

Let me just be clear here, Dr. Nash. I am not saying compliance isn't important. What I'm really saying is that the way you get true compliance is through developing a meaningful deep emotional connection between the child and the parent. And if you don't mind my sharing a personal story, what describes this I think, my older daughter, when she was applying to graduate school in psychology to be a clinical psychologist, as you now, you write an essay, why do you want to be a psychologist? And she wrote about how her mom and dad are both in the mental health field and growing up we always talked about things and this is one of her interests. And then she shared a little vignette that I think captures what I'm trying to describe here about connections, not compliance.

She wrote about being maybe four years old and running down the hallway yelling, screaming, "No! No! Not another discussion. Just put me in timeout." What that captured is with all of our kids, if we were not happy with something that they did, we'd say, "Come here. We have to have a discussion." And so what I think that illustrates is for her, if we were unhappy with her, unhappy with something she did, that for her would be more painful than just putting her in timeout or physical discipline. In other words, the relationship we had was emotionally significant, deep and meaningful, and our displeasure or unhappiness caused her real discomfort and that's how you get real compliance.

Dr. Arthur Becker-Weidman:

You can make anybody do anything if you're using a force, but when you turn your back they may not continue with what you'd like them to. But if there's a real deep emotional connection the child or the other person, in a couple, for example, values the relationship, values your approval, that's what we'll make sure that things continue in a positive way whether you're looking or not looking.

Dr. Bridget Nash:

Thank you for that example. I think that would make sense to most people listening. When and how did you realize that an attachment-focused approach would be an effective form of therapeutic intervention?

Dr. Arthur Becker-Weidman:

Probably I began considering that back in 1998 and began writing about attachment, reading a lot of early writings about attachment, John Bowlby for example, Mary Main, other people. Then I began putting together the basic elements of attachment-focused treatment, specifically dyadic developmental psychotherapy. And I guess the first publication about that would have occurred probably in about 2002, and then I did my research looking at attachment-focused treatment for families where there are disorders of attachment and trauma and comparing dyadic developmental psychotherapy with what you might think of as usual care. But the preliminary findings came out in 2005. And then the comprehensive multi-year study was published, I believe, that was 2006. And that study really demonstrated very briefly, not going to bore you, but very briefly, we looked at about 64 families who came to our clinic, and as part of the comprehensive evaluation that we always do before treatment begins, there were a variety of tests and questionnaires administered including the child behavior checklist.

About half of the families continued in treatment with us and got dyadic developmental psychotherapy. And about half the families got other forms of treatment elsewhere, often because of geographic issues. Maybe they couldn't travel that far, what have you. And they got, I called it usual care individual therapy for the child play therapy, family therapy, residential treatment, those kinds of things. The two groups were no different during the evaluation on important dimensions like age and gender and their scores on the child behavior checklist.

One year after treatment began, the children that got dyadic developmental psychotherapy showed notable statistically significant reductions in all of the scales of the child behavior checklist, and all of the scales moved from what we call the clinical range to the normal range. The children who got other forms of treatment that I mentioned, there was no change. All of their scores stayed in the clinical range. And then four years later we contacted everybody again. Four years after treatment ended, for children who got dyadic developmental psychotherapy, their scores continued in the normal range. The children in that usual care group, actually most of them continue getting treatment during that whole four year period. And what we saw is that four years later, their scores in several key areas like attention problems, aggressive behavior, thought problems, and a few other areas actually got worse.

And so, what that really demonstrated as you know, but it's very important for families to know, there is no such thing as counseling and that's what you want for your child. There are different forms of treatment for different conditions. You can have the most competent therapist delivering outstanding treatment, but if it's not the right treatment for the underlying condition, they're not going to get better. An example I use with families, when you go to your doctor with a cough, you don't want your doctor to give you cough drops. You want your doctor to tell you, do you have an allergy, do you have the flu, do you have lung cancer? Why are you coughing? And that's what gets treated, the cause, not the symptom.

Dr. Bridget Nash:

That makes a lot of sense. And since you brought up dyadic developmental psychotherapy, can you tell us what it is?

Dr. Arthur Becker-Weidman:

Yes. So attachment-focused treatment is a broad umbrella. Under that umbrella, there are different approaches, and dyadic developmental psychotherapy is one such approach. Dyadic because the focus is on relationship. So very rarely do we see a child individually, for example, because if attachment is a relationship issue, right? Attachment develops between two people. A parent bonds with their child, the child develops an attachment to their parents. A couple have an attachment with each other. So if there are difficulties in the relationship, it just seems obvious to me you want a treatment that focuses on the relationship. I call it DDP, dyadic developmental psychotherapy. That's what DDP focuses on, the relationship between two or more people.

Dr. Bridget Nash:

So, can you talk about why people with attachment trauma develop both co-morbid mental illness or even addictions, and what can we do to help them?

Dr. Arthur Becker-Weidman:

Well, first thing, like so many things, the way you view something affects how you feel and what you do. So I would just give again a very simple example. As you know, sometimes children, teenagers, adults

will self-harm. They'll cut themselves. And when you see it that way, that, oh, this is a problem, they shouldn't do that, you focus on stopping the behavior. And as you know, and I'm sure most parents know, it's very hard to stop a behavior. However, if you look at the behavior not as a problem but as a response to the problem, well in that case, if cutting is a response to some problem, then what we might think about is can we substitute a healthier, more pro-social way of addressing whatever is the underlying problem. So again, I think addiction, all kinds of other difficulties can be the individual's response to this problem, a problem in relationships, a problem caused by early trauma and that's what we want to address, the underlying cause and help them develop a healthier response to those upsetting and disturbing events.

Dr. Bridget Nash:

What is the relationship between attachment trauma and suicide?

Dr. Arthur Becker-Weidman:

It's an interesting one and complicated. What I'm going to talk about comes from the adverse childhood experiences studies done years ago, and _____, was the principal investigator. And what I'm going to be talking about now was published in 2001 in the journal of the American Medical association. And what they looked at was adverse childhood experiences and the lifetime risk of an adult attempting suicide. So they looked at a variety of adverse childhood experiences, emotional abuse, physical abuse, sexual abuse, living at a home with a battered mother, drug abuse in the home, a mentally ill family member, and the parents separated or divorced. And I think I might've mentioned previously, many people think, well, physical abuse is horrible, and emotional abuse and neglect, well, it's not good. It's certainly much better, much less damaging than physical abuse.

And what the adverse childhood studies showed is that's actually not true. You're lifetime risk of attempting suicide as an adult if you've been physically abused is close to 7.5% or 8%. If you've experienced emotional abuse, it's over 14%. You're nearly twice as likely to attempt suicide if you were emotionally abused compared to being physically abused. Same thing if you lived in a home with a battered mother. So you weren't touched, maybe you weren't neglected. The only thing going on is that the woman was being abused in one way or another by her partner. When you grow up, your lifetime risk of attempting suicide is 9%, again, higher than if you had been physically abused. It just shows that these negative early experiences do have a significant effect on the likelihood of an adult later attempting suicide.

Dr. Bridget Nash:

And this highlights the importance of early intervention and treatment.

Dr. Arthur Becker-Weidman:

Exactly. So for example, around here and probably nationally, most battered women's shelters provide services to the children. Trauma related services because I think they're recognizing it's not only the woman who's been victimized, but even the children, as I say, maybe weren't touched and had food and all those kinds of things, they still are significantly affected and experienced significant psychological and emotional trauma.

Dr. Bridget Nash:

That makes a lot of sense as well. What about mental illness? Do you see a relationship between attachment traumas and mental illness? Co-morbid?

Dr. Arthur Becker-Weidman:

There may be some loose connection between those, but attachment is a completely different domain than mental health issues or mental health diagnoses. So basically there are four patterns of attachment, but there are many, many, many mental health issues. About 60% of the population has a healthy and secure pattern of attachment. About 35% have one of the two insecure patterns. And let me be clear, insecure does not mean a mental health issue. One of the insecure patterns among adults is called the preoccupied pattern, and the other insecure is called the dismissing or dismissive pattern. These people have families, jobs, relationships, all of those things. It's just the way they manage them is different than someone with a healthy and secure pattern. And only about 5% of the general population have what's called a disorganized pattern of attachment, which is the pattern most likely to sort of create all kinds of difficulties early and later in life.

An example of the preoccupied pattern, and we all know people like this, these are people who kind of can't let go of things. This might be the person, good friend of yours, you're going to meet them for lunch and they show up 15 minutes late. They say, "Oh, I'm really sorry. There was traffic." You say, "That's okay, don't worry about it. I had stuff to do. Glad you're here." And they can't let go of that. They keep saying, "Oh, I'm so sorry. I should have left earlier. I know there's traffic on Main Street. I should have taken that into account." You say, "It's fine. Don't worry about it." "No, no, no, no. I'm going to pay for lunch." They're preoccupied.

The person with a dismissive pattern doesn't really value emotions and relationships very much. I guess if I were going to stereotype, you might think of a physicist, mathematician, engineer type as opposed to a social worker, psychologist, psychiatrist type. But again, they're not mental health diagnoses. So four patterns of attachment, dozens and dozens of mental health diagnoses in the DSM-5. So they're different domains.

Dr. Bridget Nash:

I'm glad you clarified that. What's the average length of treatment for somebody working with an attachment-focused therapeutic intervention?

Dr. Arthur Becker-Weidman:

It varies. With children, what I usually find is about one month of treatment for every year old is the child. So for an eight-year-old, you might be looking at anywhere from 10 months to 18 months. Usually we begin treatment weekly. Then as time goes along we will meet less and less frequently, and toward the end we might only be meeting monthly. I always tell parents, because that is an important question, the schedule of meetings will be determined by you. So if we need to meet more frequently because things aren't going well, we will. And when we get to the point where you know, we find, hey, things are going well, not much to talk about today, then we'd meet less frequently.

And when are we done? We're done when you say things are good enough. It's not for me to tell you you're done, we're not done. It's when you feel that the family is good enough, and of course if something pops up later, often a key developmental milestones, families will come back for. What I hear universally from parents when they come back is "Oh, we need a bit of a tuneup" and they'll come in for a couple of sessions. Now with couples or adults, then the treatment tends to be quicker I would say. Usually within several months, six months, there's enough progress that they wind up feeling things are good enough at that point.

Dr. Bridget Nash:

I like that how you're seeing that the parents and the family is the expert on what they need.

Dr. Arthur Becker-Weidman:

There was a family I saw. They were guardians of their great niece when she was I think about five years old. They came to see me when she was about 16. Lots of problems. They came from the far eastern part of New York state, so they probably drove about three hours to come to my office. And when she graduated high school, her senior year in particular, things were going really well. She was on a couple of clubs, had a lot of friends, got into local community college. And from my point of view, we're done, everything was fine.

But remember I'd end each session with "Great. Sounds like things are going well. Do you want to schedule another appointment or should we just kind of leave things open and you'll call me?" And for about a year, the end of every session, the dad would say, "Oh no, no, let's come back next month." Things were really going fine. They'd come in. They'd report how wonderful things were going, and then they'd want to come back a month later. For whatever reason, they found it helpful. And it's again their family. They're the ones to tell me, "Okay, now we don't need to come back with any regularity."

Dr. Bridget Nash:

You mentioned before about couples' work. We think of this work with families, parents, children, but it's interesting that you mentioned couples because I think a person who wasn't treated as a child, it could manifest in their relationship. Is that correct?

Dr. Arthur Becker-Weidman:

Absolutely. Without treatment, you don't grow out of them. In fact, what some of my research showed, particularly when I looked at developmental functioning, I measured that with the Vineland Adaptive Behavior Scales, what we found was over time, those who were not treated, the gap between their developmental age is measured by this psychometric instrument and their chronological age actually increased. So yeah, you don't grow out of it. If anything, things tend to get worse as you get older without treatment.

Dr. Bridget Nash:

What skills, habits and tactics can people adopt either during their sessions or in between sessions to improve the effectiveness of attachment-focused therapy?

Dr. Arthur Becker-Weidman:

I fairly regularly give the parents or the family what I call homework to do between sessions because I don't want people to experience you come to my office for an hour and a half or two hours once a week, twice a month, and that's treatment. No, treatment actually has to continue with children at home because if you think about it, so I see the family a couple of hours a month. They live together, so obviously their relationship is more important than mine with them. So I would give them suggestions, assignments, homework to do. There's a little girl I see with her mom. The girl has a lot of difficulty with impulse control, has difficulty trusting adults for a variety of reasons. So a lot of what we do in the office and then I have them do at home are games and activities that involve compliance, but in a fun way.

For example, *Mother May I* is a game. *Red Light, Green Light* would be a game. There's a game I have them do where the child has to copy what the parent does and periodically I yell, "Freeze!" and the child has to stop. The mom keeps moving and then I say, "Go." And so the mom and the girl, they do these activities probably every day in between sessions. And then their written assignments, I might have

them do drawing in between sessions. So, the idea is to really get across treatment this interest. Here in my office, that's where, particularly for the parents, I'm going to coach you and help you figure out what you want to do at home.

Dr. Bridget Nash:

I think that's really important to reframe homework as something fun. I mean that's incredible.

Dr. Arthur Becker-Weidman:

I like short phrases. In some ways, I'm simple and it keeps me remembering stuff, but over the years what I've boiled parenting down to is this very simple formula. It goes like this. First, you do it for the child and make it enjoyable. Then you do it with the child and make it fun. And then finally they can do it independently and the it can be anything. For example, I don't know if you have children or not, but if you can imagine your toddler when they first grow teeth, you don't hand them a toothbrush and toothpaste and say, "Get in the bathroom and brush your teeth." You do it for them. You're not angry about it. You're not upset. In fact, you probably make it fun. In fact, you probably get them a toothbrush with their character and you'd do it for them and you make it enjoyable.

And at some point, your toddler grabs the toothbrush and says, "Me do it." And they do it and it's not a good job. Again, you don't yell at them, tell them it's terrible. You say, "Oh, that's wonderful. You've done such a great job. Let me do finishing touches." And then at some point you realize, oh, they're doing a fine job all by themselves and now they can do it independently. And that applies to pretty much anything. And this sort of reminds me that when you have a child who is developmentally younger than their chronological age, you want to treat them where they are developmentally, not chronologically. So if you have a 10-year-old who acts and functions more like a six-year-old, you want to interact with them like a six-year-old and help them develop the skills to act in a chronologically, more age-appropriate manner.

And again, that often involves not expecting them to... If you expect a six-year-old to do what a 10-year-old should be able to do, no one's going to be happy. So you may have to take a couple steps back and do stuff. So for example, a common complaint I hear from parents is "I tell her to go brush your teeth. She goes in the bathroom, comes out, says she did it, but she didn't. And I have to go in and feel her toothbrush and check that out. It's always a big battle." Again, that's not conducive for developing a good relationship.

So, I encourage parents to think when their child doesn't do something, not that they won't do it because if I asked you to do something and you want to do it, I'm going to be annoyed at you. If on the other hand, I think, "Oh well she can't do it," then what I'm going to do is I'm going to want to help. I'm going to want to do it with you. So I encourage parents in the example I was relating, after breakfast, you go in the bathroom with your child and both of you brush your teeth the same time and make it fun, make it enjoyable. So that's how that fits in.

Dr. Bridget Nash:

I really like that, meeting them where they are.

Dr. Arthur Becker-Weidman:

Exactly. I tell parents with teenagers for example, even if you're positive, your kid is sort of yanking your chain, you still do better assuming they can't do it, not they won't because if they can't do it, you're going to try to help them. And that's a connecting experience. And if they're really just trying to agitate

you as you do it with them, eventually they're going to say, "I can do it. Don't worry about it." And they will. So you can't lose assuming the other person can't do it rather than thinking they won't do it.

Dr. Bridget Nash:

So, what are some of the most common obstacles or missteps that prevent patients from seeing the full benefits of attachment-focused therapy?

Dr. Arthur Becker-Weidman:

One would be not doing the exercises at home that we've talked about in this session. If they're really thinking it's just what happens in my office that's going to slow things down. Another barrier might be the parents' own early history, maybe early trauma, maybe disorders of attachment. That's one of the reasons in the assessment that I do before we begin treatment I have parents complete what's called the parent stress index to get a better picture of again, what are their stressors, what's going on, what obstacles might there be so that I know how to help them with that and how to work with them.

The way the treatment works model-wise, first we do this comprehensive assessment. We look at attachment and health issues, sensory issues, executive function in three sessions and a bunch of tests and questionnaires. And then once we begin treatment, if attachment-focused treatment, dyadic developmental psychotherapy is appropriate, the first several meetings are just with the parents about attachment, facilitating parenting and here's where we might begin to address some of the potential barriers, some of their expectations that, "Oh, you're going to fix everything. I don't have to do anything." Well, that's not really the case and helping them figure out what they need to do at home.

Dr. Bridget Nash:

And this is so important for people to understand that treating a child is not just one patient. It's the whole family.

Dr. Arthur Becker-Weidman:

Exactly. Because again, attachment is a relationship process. And so if there's a problem in the relationship, you treat the relationship, not the person. And to treat the relationship you need the people involved in the relationship present. Might be more obvious to people if I say I wouldn't want to do marriage therapy with only one part of the couple. It'd be hard to do that. You need both there because marriage therapy focuses on the relationship.

Dr. Bridget Nash:

Can you share any point examples of where attachment-focused therapy had a major impact in someone's life?

Dr. Arthur Becker-Weidman:

I can think of a couple. One, I remember I worked with this family. I think the boy was 12 or 13 when they came to me. Really a pretty difficult history, physical abuse, sexual abuse, a lot of neglect. He'd been in, I can't even count how many foster homes and treatment programs before he came to his family. I worked with the parents for several years. He eventually graduated high school, joined one of the branches of the armed service, went into the military police, air police arm of that. And I think he stayed in the service for maybe five or six years or stationed different places. At this point, he's I guess in his late 20s or 30s became a state trooper. So from his early history to this just it really struck me. And for me it was a good example of when we ended treatment, if things weren't perfect, they were okay,

but the trajectory of his development was changed such that he continued to make progress and do better and better and better over time. So that would be one example that really stands out.

Another one is a little girl that I saw who had been adopted from South America, a really talented gymnast. But a lot of her difficulties interfered with her being as good as she could be. Eventually, we got to the point where she could really focus on her gymnastics. The difficulty she had with her mother, with her coach really disappeared. Actually we began doing a bit of what I would describe maybe as sports psychology, helping her visualize what she wanted to do, helping her visualize more positive things rather than visualizing her early negative experiences in the orphanage in South America. And again, this little kid who, she's probably about 12, she's in gymnastics camps in groups all over the country with much older kids. That'll be another example of for me how helpful and impressive this approach can be and the kind of change that it can generate, particularly when you've got parents who are actively involved.

Dr. Bridget Nash:

And when we think about even intergenerationally this will not only affect the trajectory of her life, but also her children and onward and onward.

Dr. Arthur Becker-Weidman:

Oh yeah. I work with a lot of social workers and case workers who work for departments of social service here in the area, and it's pretty common when I talk to older case workers that they'll talk about now nearing retirement that they are seeing the grandchildren of the kids that they first saw when they first became a case worker. So without appropriate interventions, as I said, people don't grow out of this. And how do you learn to be a parent? How do you learn to be a father or a husband or a man? It's by that person who raised you and that's what you sort of channel. So if the person raising you has their own trauma that's been unresolved, that will be passed on. And if it's not resolved with you, that will be passed on to the next generation.

Dr. Bridget Nash:

Is there anybody that attachment focus is not appropriate for?

Dr. Arthur Becker-Weidman:

Well, certainly I wouldn't consider this approach in high conflict divorce. I wouldn't consider this approach with high conflict custody matters. It's not an approach I think I would use with someone who has a severe mental illness, schizophrenia, a psychotic disorder, maybe even a severe mood disorder. Now, people can have both. They could have bipolar disorder and a disorder of attachment, but then you have to realize the attachment-focused treatment can help with the relationship issues. But the mental illness, the bipolar disorder has to be treated in a different way by a psychiatrist with medication or another therapist. If I see an adult who has early trauma and disorders of attachment and an addiction, they need to get good substance abuse or alcohol treatment either before or concurrently with getting attachment-focused treatment. And again, this is why that early assessment is so important to really get a handle on what's going on with this person. People are complex and quite often the problems are complex, which means that the solutions or the interventions may have to be multimodal or multidimensional.

Dr. Bridget Nash:

So, Dr. Becker-Weidman, what are you most excited about in mental health treatment today?

Dr. Arthur Becker-Weidman:

Probably improving benefits and improving, maybe that's the wrong word, the loosening up of certain restrictions. It wasn't that long ago that most insurance companies limited mental health benefits to 20 visits a year and required you to call in after every three to five visits to get approval for the next set. And most companies, I think I've realized that was really a waste of resources. And most insurance companies certainly in New York don't require constant call in to a case manager to get approval. And at least in New York now, mental health and medical benefits have to match. So if there's no limit on your medical benefits, there's no limit on the mental health benefits provided it's medically necessary.

Dr. Bridget Nash:

That's really good. Parity is so important between mental health and physical health. So if you had a magic wand and could improve one thing about mental health treatment today, what would it be?

Dr. Arthur Becker-Weidman:

No deductibles. There are a number of families I see that have good health insurance after they've met their \$1,000, \$3,000 or even \$6,000 deductible, which is a real barrier for many, many families. Some people can't afford that. A lot can't. So I think that would be important. No deductibles for mental health because unresolved mental health issues can lead to significant medical and health issues. And for audience, I'd encourage them to Google the ACE studies, adverse childhood experiences studies done many years ago. What they looked at, there were about 18 behaviors they identified as adverse childhood experiences: being abused as a kid, neglected, having a family member in prison, being raised in a single parent home, et cetera. They had 18 of these.

And when they looked at the medical records for a health plan in Southern California, what they found with the more ACEs, adverse childhood experiences, in your background, the more likely you were to develop drug addiction or alcoholism, not surprising, smoke cigarettes, not surprising, develop depression or anxiety, not surprising. But what's surprising is the more ACEs in your background, controlling for everything else, blood pressure, height, weight, all of those things, smoking history, the more ACEs in your background, the more likely you were to develop COPD, chronic obstructive pulmonary disease, certain forms of cancer and other medical issues. So not addressing early trauma has major public health implications down the road. So that would be one thing. I think no deductibles make it easier and make copays... Or copays I think are fine. They just need to be reasonable so that they don't become a barrier to people seeking treatment.

Dr. Bridget Nash:

And I also think it affects society as a whole because having those barriers taken away helps people in community as well.

Dr. Arthur Becker-Weidman:

Absolutely. Besides the medical issues I just mentioned. If you go to a prison and interview the inmates there, an extremely high proportion of them have experienced chronic early maltreatment within their family, the family they grew up in. Again, untreated things don't turn out well either from a physical health point of view, mental health point of view, or a criminal justice point of view.

Dr. Bridget Nash:

So how can my audience learn more about your work, either online or in print?

Dr. Arthur Becker-Weidman:

Well they can certainly go to my website, www.centerforfamilydevelopment.com. For parents, a probably good resource book that I wrote is Attachment Parenting and I edited that with a colleague, and that would be probably a particularly useful book for them to read. It's got chapters on why you might want to get into neuropsychological evaluation, on the play therapy at home, art therapy, things like that. That probably would be a good book for them to take a look at.

Dr. Bridget Nash:

And links to your books and your work and your website will all be in the show notes and on therapyshow.com. So, Dr. Becker-Weidman, on behalf of myself, my listeners, and all of the people you have helped through your work, I want to thank you for your contributions to mental health treatment and for taking the time out of your busy schedule to help me and my audience better understand the fields of attachment-focused therapy.

Dr. Arthur Becker-Weidman:

Well, thank you very much. I appreciate the opportunity, and I've enjoyed our time together, and I do hope this has been helpful for your audience. You have a good day and a good rest of your week.

Dr. Bridget Nash:

Be sure to check out my website, therapyshow.com, which has many resources about mental health including a whole page dedicated to attachment-focused therapy. There you will also find how to submit questions, stories, or insights you have about the mental health system or suggestions about who else I could interview and how I can improve the show. I'd like to close by reminding our listeners to please subscribe, share, and review this podcast so you, someone you love and people around the world can gain more benefit from therapy. There's no need to suffer in silence. Get the help that you need to create the life that you want.