Frederick Bush (00:00):

This kind of approach is adaptable to a single intervention, say in a urgent care setting or clinic setting, as well as it can be used in a more extended version that aimed at reducing a range of symptoms and problems. And part of what we're getting at here is not only the problems themselves but the vulnerability to recurrence that by identifying these contributors and addressing these contributors that you are not only helping to address the immediate problem itself. But those factors that might contribute to persistence or recurrence because we know problems can reemerge under different stresses or down the line.

(00:57):

But if patients have a sense of what they've learned or used and that should be one other thing that I do want to say about this, that part of the idea is it is working with the patient for them to use this approach with themselves. That these are things that they can carry with them, that they can think about. Let's say somebody has somatic preoccupations from various sources under stress and they get better and then they suddenly notice like, "Oh, I'm starting to get fearful about my health again. What might be going on now? Well, there's increased tensions with my boss or with my partner.

(01:43):

And I remember I learned that this could be a trigger of these kinds of fears about my body or I would displace them onto my body when I was worried about this interpersonal conflict." We want patients to have and develop these kinds of tools to carry with them as they lead the therapy.

Dr. Laura Roberts (02:17):

Hi, I'm Dr. Laura Roberts, editor-in-chief for the books portfolio of the American Psychiatric Association and welcome to the APA Books podcast. So, welcome back to Psychiatry Unbound, I am very pleased to welcome to our show Frederick Bush who put together problem focused psycho psychodynamic psychotherapy in 2022 for us. And this is a wonderful book and very accessible and interesting I think for people really across careers and across different kinds of practice settings. And so, I'm really excited to talk with you today Fred, welcome and-

Frederick Bush (02:59):

Thank you.

Dr. Laura Roberts (03:00):

Yeah, so you and I have talked about this wonderful book before but I would love for you to share with our listeners what made you want to put away the nights and weekends and everything to dedicate to this particular book. It was a heroic effort that you led yourself and so I'd love to hear a little bit about why the world needed this particular book.

Frederick Bush (03:25):

Well, I've been working on psychodynamic approaches to specific disorders for many years. Some with my colleague Barbara Millwright and some with others. And the idea of those is for one thing, as you said, to make psychodynamic psychotherapy more accessible. I put a lot of focus on clarifying concepts and making these the usual psychoanalytic terms more user-friendly because I think it's a great approach. And I think sometimes it's hard for people to work with it or follow it because it tends to be written about and sometimes even talk and taught in very complex language.

(04:17):

And then what we had found was that using it as an approach to specific problems had a value to it that wasn't part of typical traditional psychodynamic psychotherapy that follows what the patient brings up session and session. And not that there isn't an important role for that but this really helped to address the specific issues that people brought into therapy like panic or depression. And then the third part is that I then felt we needed a more general problem focus approach because obviously people don't just come in with panic or depression. They come in with panic, depression, other issues, behavioral problems, relationship difficulties.

(05:12):

And that a more generalized focus approach would be of value for clinicians to use just for whoever came in to see them and talk about how to adapt this treatment approach for these purposes.

Dr. Laura Roberts (05:31):

Yeah, that's great. So, can you give an example that you hope a listener would say, "Oh, I just had a patient last week who said that and I wish I'd had that book so I would know how to strategize the therapeutic care of this patient." So, what would be an example of a presenting problem that a patient might bring?

Frederick Bush (05:50):

Well, certainly someone who might come in with panic attacks, that would be obviously a common presentation or anxiety. There's a lot of anxiety about [inaudible 00:06:10], for example, people reemerging from COVID and some of the fears that they've had of that. So, a lot of times what we've found in our panic studies is that patients who have panic or anxiety may also struggle with their issues with assertiveness and we think that has to do with conflicts around anger. So, for instance, seeing a patient who was both fearful of reemerging from COVID and had had a serious case.

(06:47):

And felt that others in the medical community or others who had not experienced the same issues with COVID that she did had become, were dismissive of her. And the same thing with her friends about joining people socially that she felt like a lot of people who were done with COVID and didn't care and weren't really empathic to what she was struggling with. So, she was both very fearful about recurrence and then she was fearful about how people would respond to her and angry also about it.

(07:37):

And these were both blocking her from getting back out into the world. So, one aspect had to do with looking at her fears of getting a severe case of COVID like she did the first time. Working with understanding the trauma that she went through originally and that that made her particularly fearful of getting back out into the world but that people weren't experiencing the same problems with COVID that she was in terms of what she experienced originally. They weren't getting as ill, that would tend to have mild cases and that her worries about recurrence of that traumatic experience which included feeling not well taken care of. Because at the time doctors were very busy and not available to give people the full response that they needed.

(08:40):

She felt she was sent home prematurely after seeing them so we were able to work on those fears. And then it turned out that part of her anger, hurt about getting back out into the world had to do with the experience of her parents who she felt were very unresponsive to her growing up or harsh or uncaring

about what things that she struggled with. And she was anticipating that people were going to respond the same way. And what was helpful to her was both an understanding of the fears of the COVID related to the initial trauma.

(09:29):

And it turned out she actually got COVID and had a very mild case and that actually did help with her fears although she was frustrated to get it. And then she actually began to confront some people about their attitude, about their lack of recognition, about her experience. And that helped her to feel better and safer because she would be able to talk to them about, "Hey, I need you to be a little bit more careful with me with regard to this." And so, it very much helped her to understand that she would just assume that people would respond negatively to that or in a hostile manner like she anticipated from her early upbringing.

(10:18):

And in fact, when people responded differently to that that helped her to feel safer and to become less fearful generally.

Dr. Laura Roberts (10:28):

Great, thank you. So, one of the things that I've observed in working a lot with trainees and psychiatry is how excited they are about adopting psychotherapy techniques in their clinical practice. But psychoanalytic and psychodynamic approaches feel big and overwhelming and time consuming, which of course is hard for trainees given all the demands on their time. I think your book is nice in that it shows how you can incorporate some of these techniques, approaches, ideas, conceptual framing in pretty routine practice of a psychiatrist.

(11:12):

And I wondered, was that your intention and do you think that's true? And what would you hope trainees would pick up from this book? Am I on the right track here?

Frederick Bush (11:23):

Yes, yes, I absolutely, I think this approach is usable by trainees. I think it can be used by people who work primarily in other kinds of approaches. And I think it can be used actually by psychodynamic psychotherapists who tend to use a more traditional approach for settings where they really would like to focus or address a particular problem. For instance, your clinic settings or public health settings where unfortunately, psychodynamic approaches are not always used in part because people don't think of them in that way.

(12:07):

And when I do talk to trainees, they're very excited to hear about the way these concepts are described because they've been put in ways that are unclear or they don't really get them. I talk about self and other representations and the models that people use in terms of their expectations from others which may be unconscious. Looking at the specific triggers of problems and emotions that might trigger them, give them a more coherent sense about what we mean by conflict and defense. The internal fantasies and feelings that people struggle with and how to apply them to particular problems.

(12:59):

And I think that that comes across in a way where it feels much more readily comprehensible and understandable. The specific techniques are more clearly spelled out than would usually be the case in a psychodynamic psychotherapy text. So, I think it gives them a sense of excitement that they can learn

about and use these techniques in their own work, in their practices. Whereas, previously they may have felt like, "Oh, it's just too much or it's very hard to comprehend."

Dr. Laura Roberts (13:40):

Yeah, so I think one of the myth busting that the book does is that you can incorporate some of these big ideas into even a single interaction with a patient. And that you can do some work in a time sensitive way, which I think is really a surprise to people. I think that's another strength or a surprise of the book is that you help illustrate how you might adopt and apply these principles in a time sensitive way in a variety of practice settings. Are there other things you're hoping that you can convey to either practicing psychiatrists or psychiatrists in training or psychologists around this problem focused emphasis that you have?

Frederick Bush (14:30):

Yeah, I think that was actually mentioned, had been mentioning an example of problem focused approaches have been used by psychoanalyst going back for some time. But they tend to be derided by analysts as being that they're not getting into as much depth and that they're not extensive enough. And one of the things that I would say is that this can be used for aspects of behavioral change. In fact, the prior book that I have written with American Psychiatric Press is Psychodynamic Approaches to Behavioral Change which isn't usually thought about as something that psychoanalytic approaches are useful for.

(15:25):

And it goes along with similar structure, the idea of a behavioral problem and looking at the dynamics of that problem, the self and other representations, the conflicts defenses, when does the problem occur? What is the patient experiencing before and after to address a way to change behavior? And that is not something psychodynamic theorists and clinicians have tended to frown on that. So, the problem focused approach, I've actually found in many instances to be more effective than the traditional approach.

(16:07):

And it came out of this work and research that we did but as I say, I think a lot of psychoanalyst have used them but there hasn't been anything spelled out about here are the steps to doing that. I gave the example that Freud in at one point there's a famous meeting that occurred with Gustav Mahler the composer. And Muller had a problem in his relationship with his wife and he had a problem that occurred with his potency. Conflicts with the wife I think partly had to do with that that she had her own interest that she wanted to pursue and he wasn't too tolerant of that.

[NEW_PARAGRAPH]And there was a lot of conflict that they were having, he was quite a bit older than her. And Freud went on a four-hour walk with Mahler, it's a famous four-hour walk around the city of Leiden in which they discussed these issues. And Freud interpreted, made a specific interpretation, first investigating about the problems and a specific interpretation that related to these issues. And in fact, the reports are that after this meeting, Mahler's potency improved and the relationship improved. And that was a four-hour meeting but Freud didn't have an idea like, "Oh, I'm going to put him in analysis and we need to have several follow up meetings to see how things are going."

(17:53):

So, this is the kind of thing that I'm suggesting but because this was generally frowned upon, there hasn't been any systematic organized way in which traditional psychodynamic, psychotherapy has been converted to addressing problems. And that's what this book spells out and that's as I see general

psychiatrist or for people who do traditional psychodynamic, psychotherapy. Giving courses to analysts on how to modify their technique in order to address specific problems. Just to give an example of how that would work, for instance, let's say you're talking about panic attacks in the typical traditional approach.

(18:49):

You might talk about the patient's panic attacks at the beginning but you might not come back to them if they go on to other topics. And in a focus therapy, you come back to the panic and you look at what you've learned that might help them to understand panic better in that session. And that can be hard for analysts to do but that's what we have found to be useful. One example is that I had someone who come into me and they had a brilliant psychoanalysis that was well known. And they had made a lot of progress in their therapy but they still had their panic attacks, they had a lot of self-understanding.

(19:37):

But none of it had been applied to the panic itself so they didn't really have any conception. And by attaching these understandings to their panic attacks at that specific problem, they were able to get some relief from that.

Dr. Laura Roberts (19:55):

Yeah, that's great, wonderful. Let's see, how can I put it? It's a challenge to adapt existing practices, right? When you're thinking about changing traditional approaches, you encounter some challenges in that process. Can I just ask, how did you arrive at this yourself? What challenges did you have to confront or work through in order to come up with this idea?

Frederick Bush (20:25):

Well, that's a good question and also how do you work with challenges? And it's different for different groups but this started way back many years ago. In fact, our first original manual, Dr. Bill Rod and I did with Arnold Cooper and Ted Shapiro was published in 1997 by American Psychiatric Press. But it came on, developed slowly with me and with other therapists that what we started to notice was that as we were after writing this manual and then using it, we noticed that we were more active.

(21:25):

That we tended to use more psychoeducation, not a formal sit-down psychoeducation but talking with patients about ways of understanding how their minds worked. How to look at problems, how to understand, how experienced their problems were affected by their past. To understand something about that the mind can be in conflict about certain issues that they defend themselves in certain ways. So, that aspect of psychoeducation and starting to use that focused approach in my own practice and finding it to be more effective.

(22:09):

I would go to do different kinds of consultations, let's say in a classroom setting and the people would tell me about a case and I would say, "Well, what exactly are you working on?" People would lose, they would lose track of what exactly the problem was that was being addressed with the patient. And I also have found that patients appreciate when you identify a specific problem and you monitor with them how they're responding to it. So, I think that does take some time to do that but I think other things can be grasped more readily the idea of monitoring a problem and seeing what is experienced before or it is onset, for instance, with panic, what are the circumstances that trigger the panic?

(23:15):

A lot of times it can have to do with the separation or a conflict and this gets people interested in the pattern. They think, "Oh, well wait, maybe there's a pattern to these problems. Maybe they occur under certain circumstances." And that goes for both patients and therapists to start to say, "Oh, well, maybe if I work with this problem in these specific ways and help to build a formulation around it, then I can understand it better and the patient can understand it better." So, I think some of it is quite readily graspable and can be quickly used and others, it takes time to build up a way of doing it.

(24:08):

Certainly, working with psychoanalyst in some instances has been challenging because they're not used to focusing on a particular problem. But I think after going over some different cases and how to use it, that does help them to find better ways to employ these techniques.

Dr. Laura Roberts (24:31):

As you're talking, it's also reminding me of a general medical literature about the chief complaint. I'm not sure if you've seen some of this literature but it's basically communication studies and studies of the doctor-patient relationship in medicine more broadly. Where if no matter how much good you do for the patient or how much you arrive at together that's beneficial, treating pneumonia or treating, having a hip replaced. If you don't respond specifically to the chief complaint that the patient brought to the encounter, they don't feel heard, cared for in the same way as the person who actually addresses the chief complaint.

(25:14):

I know it's not exactly the same but it's reminding me about of how people do appreciate when you focus on a problem and it's the problem that they've identified, right?

Frederick Bush (25:27):

Yeah, and I think that's certainly one thing about psychoanalytic treatments that first of all, that they have become more collaborative. They have tended to move from a model of the analyst is the authority and they're telling the patient what's going on in their unconscious to more of a mutual investigation. And I think in this effort, the idea is to collaborate with the patient in identifying the problems that they have. The first chapter of the book, I believe it's the first chapter, it is talking about identifying the problems, making a problem list which can, let's say, might include in talking about an anxiety, an assertiveness could include some sort of substance use is not uncommon.

(26:36):

And I think that as you work with that the patient really appreciates that you're recognizing the problem that you're working actively on it. The other is that, as I say, in a traditional psychodynamic, psychotherapy, which again, I think can be very valuable that you can lose track of what you're working on with the patient. And every now and then, the patient might say, "Well, hey, well, what about this, this and this? I've been talking about this has been really helpful. I'm talking about my past and I'm getting some things up my chest but what about this problem I have with my partner? And that has really changed."

(27:19):

Or they might say, "Well, I understand this problem better but what do I do now?" That's a very common thing. This approach works on, okay, well, here are the problems and here's what you're trying to do with the patient. For instance, the patient who was having trouble with feeling like, "Oh, people aren't going to respond to me about my COVID fears." "Well, we would talk about in this, what about

talking to people or trying to talk to people?" "Oh no, they won't listen." "Well, why do you believe they won't listen?" Well, maybe we can understand why you think that.

(28:07):

And then to actually get out there and experiment and what happens can often happen is that when she did try to do it, she got a different response than she thought she would get, which can then reinforce making that kind of change. So, I do think that there's a real value, we talked about the therapeutic alliance. Well, people are going to feel more of an alliance if they feel like you're working on things. And also, it provides a way to monitor how you're doing. "Hey, how are things going?" "Oh, well, this is actually better than it was. I'm getting out more now. I'm feeling a little less threatened about confronting the people or addressing an issue with my partner than I did before."

(29:00):

That shows that you're making some progress in ways that aren't always assessed in a psychotherapeutic treatment.

Dr. Laura Roberts (29:11):

Can you share with our listeners a particular challenge that you encountered in actually developing the book itself?

Frederick Bush (29:19):

One problem that in terms of a challenge of the book is what do you do, how do you do a problem? A focus treatment when you're looking at a series of problems? So, it was easier in writing the depression book, attending the depression symptoms or picking a specific behavioral problem or a panic attack to do that. So, that made it hard at first, so what I was able to come up with was this idea of having a problem list so you can designate problems A,B,C, and D. And it's not like you would say you would tend to focus on a particular problem, A, B, C, or D in a given session.

(30:17):

Not that this is cookbook and not say, "Hey, today we're doing A, today we're doing B or we're, no, no, we're not switching from problem B to A, we're just doing B today." But that you could monitor how you're doing according to dealing with each of the various problems. And then what turned out to be interesting, which has been understood from psychoanalytic standpoint but has not been necessarily used in this way. Is how different dynamics can contribute to or similar dynamics can contribute to different problems.

(31:06):

So, let's say someone has, as in the example I gave before, panic attacks, where part of what they struggle with is that their anger can readily disrupt relationships which is part of our formulation for panic. And they're fearful about asserting themselves with others because they have difficulties, that feeling safe doing that because they worry that the relationship is going to end or that will be over. The dynamics in and around conflicts with anger or their sense of the threat that they feel in relationships being easily disrupted are both related to dissimilar dynamic.

(31:54):

So, that way you can say like, "Oh, okay, well this helps problem A [inaudible 00:32:00] and problem B on assertiveness. And they also help depressive symptoms because a lot of what can happen is that people can get depressed because they're having trouble addressing their issues or their anger can end up becoming self-directed. They can end up attacking themselves, you are the problem. So, that shows

how you can use your identification of dynamics to address more than one problem at a time or interconnect them and help the patient to understand that. Help the patient to understand they're interrelated so that did help address that particular challenge.

Sanya Virani (32:52):

Hi everyone, I'm Sanya Virani and I am the host of Finding Our Voice, fresh perspectives in psychiatry. Now, this podcast actually addresses current issues as they pertain to psychiatry but we have a special focus on amplifying the viewpoints and opinions of our younger groups. Who are they? President and fellow members and early career psychiatrists. Finding Our Voice is available wherever you get your podcast from.

Frederick Bush (33:19):

I think one of the things that the book emphasizes that there's a lot of interest in trauma these days and for good reason. There's unfortunately a lot of trauma that's going around now or that people have experienced including in recent years. And it's been understood that it's hard to treat trauma, that it's a difficult problem to treat. So, one of the elements of this problem focused treatment is that it keeps in mind and talks about where problems may derive from traumatic events.

(34:11):

And it looks at psychodynamic contributors to problems around post-traumatic symptoms. For instance, patients often don't connect the symptoms they're having with the traumatic event, even though it may be triggered by various circumstances. Even for instance, the veteran that returns from being in a conflict zone may have all kinds of anxiety or irritability but not recognize how if this was stirred up or affected by the war situation. It may be dissociated or in denial because it's so threatening or disturbing. Or of course, abuse, early abuse situations that lead people to be vulnerable to subsequent trauma are not always identified or explored in other treatments.

(35:12):

But this treatment would attempt to understand how subsequent traumas are affected by early [inaudible 00:35:21]. For instance, the patient I talked about who had, how her particular reactions to COVID and the traumatic experience of getting COVID. And feeling her life was at risk were affected by her early experiences in terms of what she anticipated from others. And other areas of dynamic interests that are relevant to trauma but have not always and themselves been clearly explained.

(35:56):

For instance, a tendency to repeat traumatic experiences because people are often not aware of them or experienced situations as if they're in the traumatic event, as if the traumatic event is still occurring or maybe trying unconsciously to have a different outcome. An outcome in which it turns out to be more under their control or they're not so vulnerable but not be registering that they're doing this. So, I do want to highlight that that considering how prominent these issues are that there is a chapter in the book that focuses specifically on those issues.

Dr. Laura Roberts (36:43):

So, how important is it for the therapist and the patient to define the problem together, the problem that is the focus of the therapy?

Frederick Bush (36:56):

Well, I think that part's very important and I think, again, it's often overlooked because again, they can say, the therapist can be thinking, "Okay, well, I know what the problem is so I'm going to work on the problem." But if the patient hasn't identified that as the problem, then they may not be understanding what they need to work on or what they want to work on. They may not be understanding how to address it. So, I think that piece is very important.

Dr. Laura Roberts (37:36):

Yeah, there's so much care on each page of your books, so I really want to thank you for that.

Frederick Bush (37:42):

Oh, yeah, no, I appreciate that and I appreciate your support for the books so.

Producer V/O (38:06):

Psychiatry Unbound is hosted by Dr. Laura Roberts and produced by Iain Martin. Our original music is by Willow Roberts and our executive producer is Tim Marney. This podcast is made possible by the generous support of Stanford University. We are a production of American Psychiatric Association Publishing. Be sure to visit psychiatry online.org/podcast. To join the conversation access show notes and a transcript and discover new content or subscribe to us on your favorite podcast platform. Thank you for listening.

Producer V/O (38:35):

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