

Geir Nielsen & Karin Barth

**Short-Term Anxiety  
Provoking  
Psychotherapy**

*Handbook of Short-Term  
Dynamic Psychotherapy*

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**Geir Nielsen and Karin Barth**

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# Short-Term Anxiety-Provoking Psychotherapy

## INTRODUCTION

Short-Term Anxiety-Provoking Psychotherapy (STAPP) is a focal, goal-oriented, psychodynamic psychotherapy. It was first developed by Peter Sifneos in the late 1950s and has been systematically presented in two of his books: *Short-Term Psychotherapy and Emotional Crisis* (1972) and *Short-Term Dynamic Psychotherapy: Evaluation and Technique* (1979, 1987).

Based on psychoanalytic principles, STAPP aims to resolve pathological psychic conflicts and help those suffering from them to learn new ways of being in their interpersonal relationships. The criteria for undergoing STAPP have been developed for more than three decades and tested extensively. Combined with systematically described technical principles of intervention, this makes STAPP one of the best defined approaches to brief dynamic psychotherapy hitherto presented. Although introduced long before the concept of manualized therapies (Luborsky, 1984) arrived on the psychotherapeutic scene, the principles of STAPP can easily be transformed into manualized forms (Svartberg, 1989).

STAPP is offered only to individuals who have considerable amounts of ego strength but, while facing new life situations and as a result of being unable to overcome their emotional sufferings, have developed circumscribed

psychiatric symptoms or difficulties in their interpersonal relations (Sifneos, 1972).

The main features of the STAPP approach are brevity, emotional reeducation, problem solving, and limited goals. It is presupposed that the patient is able to cooperate in a therapeutic alliance, and that he or she is able to benefit from an essentially interpretive, insight-oriented technique. Therapy is conducted as weekly, face-to-face interviews. The number of interviews is not specified in advance, nor is there a termination date set. Typically, the number of sessions is tailored according to each individual's needs and treatment progress, although the total number of sessions ideally should not exceed twenty.

The outcome of STAPP is evaluated according to symptomatic, adaptational, and psychodynamic criteria. Positive outcome findings have been reported from several follow-up studies, with deep and enduring changes still observed many years after therapy had ended (Sifneos, 1987).

In this chapter we outline the main characteristics of STAPP, its historical background, criteria for selection of patients, the underlying theoretical assumptions, principles of technique, and some outcome findings.

Unlike the majority of approaches described in this handbook, STAPP is not here described by its developer. Therefore, in order to be as fair as

possible to the essence of STAPP, we have chosen to stay as close as possible to Peter Sifneos's own formulations. This notwithstanding, some inaccuracies and distortions of the genuine STAPP approach may come through; any such errors should be considered entirely our responsibility.

### **ORIGINS AND DEVELOPMENT: A CLINICAL ANECDOTE**

Sifneos (1972) has dated the beginning of STAPP to the year 1956, when he met a twenty-seven-year-old man, a student, who came to Massachusetts General Hospital in Boston requesting treatment for severe anxiety, mainly phobic symptoms, and a variety of somatic complaints. The symptoms, some of which the patient had suffered from since childhood, intensified and became acute shortly after the young man had decided to get married. The wedding day was already agreed upon, and would come three months later. However, barely the thought of being a center of attention during the wedding ceremony would make the patient extremely tense and uncomfortable. These feelings had rapidly generalized to other situations wherein he was exposed to enclosures of some sort or to crowds of people, such as riding public transportation or even in private cars. The patient's discomfort had become so intense that he had to walk to school.

His somatic complaints, for which no organic basis had been found, included stomach pains, trembling sensations, transient impotence, breathing

difficulties, perspiration attacks, and occasional diarrhea.

The patient saw his symptoms as interfering severely with his wedding plans, and he arrived at Massachusetts General Hospital with the hope of finding someone who could help him get rid of his symptoms within the time that remained before the wedding.

The psychiatric admission team concluded that it was unrealistic to attain the patient's goals within the time available. One of the evaluating psychiatrists stipulated a treatment length of at least three years.

Stopping the narrative here for a moment, we have to remember that the dominating attitude among psychoanalytically oriented therapists at that time was that long-term psychotherapy was the treatment of choice for all patients suffering from neurotic difficulties. As Bruce Sloane and Fred Staples ironically comment, "For if little psychotherapy was good, more was better, and most was best" (1979, pp. 1-2). It was also strongly believed that attempts at deeper changes should be avoided and that interpretations should be kept at a relatively superficial level—that is, avoiding dreams, transference, and childhood origins of neurosis (Malan, 1963).

Hence, when Sifneos, contrary to the conclusion reached by the admission team, decided to accept the patient for short-term psychotherapy, he challenged the clinical wisdom of the day. The actual therapy was offered



on a once-a-week basis, with the first session scheduled exactly seven weeks before the patient was going to marry.

Sifneos's psychodynamic formulation of his patient's difficulties pointed to unresolved oedipal conflicts. Choosing these as the targets for therapeutic exploration, active confrontations, and early transference interpretations (within the context of a rapidly established working alliance), Sifneos was able to treat his patient successfully in six interviews before the wedding. During the course of this short treatment period, it was possible to have a dynamically rich therapy. The patient gained a substantial amount of insight into the relationship between his current symptoms and his sexual wishes for his mother during childhood, the feelings caused by his father's death (when he was four), and later wishes for his stepfather's death.

By the end of therapy, the symptoms had diminished significantly. Although he felt a little apprehensive, all went according to schedule at his wedding. He became once again able to use public transportation and had overcome most of his somatic complaints. In a follow-up interview several years later, he was judged clinically as completely recovered from his neurotic problems and exhibited no symptoms.

Encouraged by the remarkable results obtained with this patient, Sifneos decided to identify the curative mechanisms and to explore the limits

of this kind of therapy. In his retrospective analysis of the case he came to the conclusion that a main change factor had been his helping the young man to face unpleasant emotional conflicts underlying his symptoms. Thus, therapy had certainly been more anxiety provoking than anxiety suppressing. Under the special conditions of having a patient highly motivated for self-understanding, a rapidly established working alliance, and the transference, Sifneos had been able to use anxiety-provoking questions and confrontations to induce a (benign) emotional crisis in his patient. The crisis in turn mobilized the man's problem-solving capacities and contributed to a new defense mechanism configuration. Following this focal dynamic change, the patient was able to abandon his phobias as well as his physical symptoms.

Having completed this first successful case, Sifneos and his co-workers eagerly sought patients with problems amenable to the same kind of anxiety-provoking technique. Over a period of four years they treated fifty new patients, many of whom were seen in follow-up interviews one to two years after therapy had ended. Systematic follow-up evaluations of twenty-one patients, using specified criteria for improvement and adequate research methodology, indicated that all had benefited considerably from their treatment.

Since then, Sifneos has been continually attempting to further develop, evaluate, and refine his treatment model. Most of his work has been done at

the Beth Israel Hospital in Boston, with which Sifneos has been associated since 1968. The STAPP model has also been clinically tested and researched in several other settings throughout North America and Western Europe (Sifneos, 1987). Thus, current applications of the model can be said to rest on a firm clinical base.

### **SELECTION OF PATIENTS**

The successful application of STAPP requires a careful preselection of patients. Therefore, all prospective candidates should undergo a thorough clinical evaluation, particularly with regard to ego functioning and motivation for change.

Sifneos (1987) has recently summarized the most common types of presenting complaints of patients accepted for STAPP: anxiety, or anxiety in conjunction with other symptoms (for example, physical symptoms without an organic basis), phobias with obsessive thoughts, grief reactions, mild depression, and interpersonal difficulties.

Looking closer at the list, we see that the items are all complaints frequently encountered in typical neurotic patients. This underscores the fact that STAPP is a therapy that should be offered only to patients within the neurotic range of the psychiatric spectrum. Excluded from the beginning are patients with psychotic symptoms, major affective disorders, alcoholism or

heavy drug abuse, suicidal tendencies and acting out, and severe (pregenital) character pathology (such as severe schizoid, borderline, or narcissistic personality disorders).

However, no patient should be selected for STAPP (or probably for any form of brief dynamic psychotherapy) on the basis of a presenting complaint or psychiatric diagnosis only. These are rough criteria that can serve no more than preliminary screening purposes. The final selection has to be made on the basis of identifiable ego resources and specified personality assets. For a good STAPP patient, this would mean that the evaluating clinician will give an affirmative answer to the following main questions:

1. Can the patient circumscribe his or her chief complaint or assign top priority to one out of several difficulties?
2. Did the patient have at least one meaningful relationship with another person during his or her childhood?
3. Can the patient interact flexibly with the evaluator, that is, experience and freely express feelings during the interview?
4. Does the patient give evidence of psychological sophistication?
5. Does the patient show adequate motivation for change and not only for symptom relief?

Lack of space allows us to give only a rough operationalization of the

criteria. The interested reader should therefore consult the more thorough definitions available in Sifneos's recent works (such as Sifneos, 1987). However, for the present readers to be able to grasp the criteria and their theoretical rationale, a few elaborating comments have to be made.

All five questions should be answered from clinical information obtained through the evaluation interview, and the answers should be yes or no. Of course, there are cases for which neither alternative seems to fit very well. However, the evaluator should still stick to the dichotomized (forced-choice) response format.

For question 1 to be answered in the affirmative, the patient must, first, be able to specify a chief symptom or difficulty and, second, assign that symptom priority over a period of time. If the patient voices more than one complaint, the evaluator should ask which one problem he or she wants to solve. A patient who is experiencing a variety of difficulties obviously faces a dilemma. Solving this dilemma, that is, being able to choose, is indicative of ego strength. It is evidence of the patient's being able to face the reality that not all difficulties can be solved in a limited period of time. Thus, this criterion also indicates tolerance for frustration and demonstrates the ego's capacity for delay. All things considered, this criterion is one of the quickest ways to differentiate patients who will do well with this sort of therapy from those who will require longer-term assistance (Flegenheimer, 1982).

Identifying a chief complaint is only part of the game. It is also implied in this criterion that the complaint can be meaningfully understood as a manifestation of an underlying circumscribed problem. Complaint denotes the patient's subjective distress and discomfort. A circumscribed problem is formulated by the evaluator, based on the patient's life history; it is a psychodynamic hypothesis that can explain the patient's main difficulty on the basis of underlying psychological conflicts. These conflicts ("specific internal predispositions," or SIP), of which the patient is at most vaguely aware, must be clarified, since they will become the basis of the therapeutic focus—the main targets of the therapist's technical maneuvers (Sifneos, 1979). In a "pure" STAPP the ideal focus is on an underlying problem most often rooted in oedipal/triangular conflicts. Patients with core problems at a preoedipal level are not considered appropriate candidates for STAPP.

A meaningful relationship, as elicited in question 2, is a relationship described in terms of trust, mutuality, and sharing. For a yes score on this question, the patient must be able to recall and to give examples from childhood of personally meaningful and stable give-and-take interactions with a key person. Vague, general statements of friendships, positive attention, or admiration should never pass as sufficient evidence. On the other hand, examples of the patient's having been willing to sacrifice for the benefit of someone else, that is, examples of altruism, should be considered particularly good measures.

Patients who fail according to the second criterion are usually seen as socially and emotionally immature individuals, often suffering from bad object representations. Most of them have little ability to withstand anxiety, and they often seek therapy primarily as a source of emotional gratification.

The third criterion is partly related to the second, as they both address the patient's ability to relate to and interact with others. Needless to say, for this criterion to be of any value, it is presupposed that the evaluator possesses sufficient relational capacity and interpersonal skills. A patient who is unable to express feelings such as fear, sadness, or anger during the interview in most cases suffers from strong emotional blockades that preclude being helped by a strongly transference utilizing and interpretive short-term therapy like STAPP.

Not only must the patient demonstrate a capacity for emotional expressiveness; he or she must also be able to show some emotional flexibility— being able to express different kinds of feelings as the topics and the nature of the interaction change. The patient's emotional interaction with the evaluator often predicts later transference patterns.

Psychological sophistication (question 4) is a somewhat difficult item to assess, and its definition has undergone many changes over the years. Originally, this criterion was a simple equivalent to above average

intelligence. Efforts were made to assess sophistication not by psychological tests but by obtaining evidence of superior academic achievement or work performance (Sifneos, 1969). It soon turned out, however, that the original construct was too cognitive a conception of intelligent adaptation. In our own work, we therefore prefer the term problem-solving capacity (Barth, Nielsen, Havik, et al., 1988).

As this criterion is now used, it also requires that the patient give some evidence of psychological mindedness, being open to understanding phenomena in psychological terms and willing to investigate the possibility that his or her symptoms may be related to intrapsychic conditions. A certain readiness for such understanding is, of course, necessary when the therapy purports to provide insight in a short period of time. Most often excluded by this criterion are patients who habitually externalize their problems.

The final criterion, as represented by question 5 (motivation for change), was originally formulated as motivation for psychotherapy. As data accumulated, it became more and more clear, however, that the critical factor was not motivation for psychotherapy as such, but rather an intent, or willingness, on the part of the patient to make concentrated efforts toward fundamental psychological change. Thus, motivation for change should not be confused with simple wishes for symptom relief.



Since motivation for change is probably the single most important selection criterion, it is divided into seven subcategories by which motivation is assessed:

1. Can the patient recognize that the symptoms are psychological in origin?
2. Is the patient honest in reporting about himself or herself?
3. Is the patient willing to participate actively in the evaluation?
4. Does the patient demonstrate interest in and curiosity about himself or herself?
5. Does the patient show openness to new ideas introduced by the evaluator?
6. Are the patient's expectations of the results of the treatment realistic?
7. Is the patient willing to make reasonable and tangible sacrifices (such as paying a reasonable fee and seeing the therapist at a mutually convenient time)?

All these subquestions refer to what may be observed in the interview situation, and again the scores are simply yes or no. To score a positive answer to the main question 5, at least five of the subcriteria must have been fulfilled.

Clinical judgment, by definition, always implies some uncertainty, and the assessment of selection criteria is both difficult and impressionistic. This notwithstanding, there is growing evidence from controlled studies that experienced clinicians achieve acceptable interscorer reliability and agreement with the selection criteria for STAPP (Heiberg, 1976-1977; Husby, 1983; Barth, Nielsen, Havik, et al., 1988). Yet since none of the reliability coefficients is perfect (in the Bergen studies varying between  $r = .88$  and  $r = .68$ ), it must be realized that important as these criteria may be, "they should not be looked upon too rigidly but used only as guidelines" (Sifneos, 1969, p. 293).

## GOALS OF TREATMENT

Virtually all brief therapies stress the need to select among issues and to concentrate upon a chief one (Small, 1979). Focalization, which David Malan defines as "the ability of therapist and patient together to find a focus quickly which is acceptable to both of them" (1963, p. 213), is therefore considered a cardinal feature of psychotherapies that are short by design.

With a limited amount of time, it is unproductive to have the therapeutic issues float freely, changing from session to session, all according to the patient's momentary preoccupations. Although free associating can be a very useful approach in long-term treatment, in short-term cases it hinders

optimal progress.

However, focalization as such does not guarantee that the therapy will turn out successfully. It is equally important that one select an appropriate focus. Although some authors (for example, Wolberg, 1965) suggest that specific symptoms can be identified as targets for concentrated therapeutic intervention, most dynamically oriented therapists question the value of that approach.

In STAPP, the focus should always be a psychodynamic one. Furthermore, experienced therapists agree that the focuses that respond best to STAPP are unresolved oedipal conflicts; but loss, separation issues, and grief may also be acceptable ones. The prototype STAPP candidate is a patient struggling with conflicts of a triangular, more than dyadic, nature.

For the therapist, identifying a focus implies two somewhat different tasks. First, the therapist must arrive at a psychodynamic formulation that crystallizes the specific conflicts to be resolved. Second, the therapist must be able to translate these theoretically based formulations into words that the patient will understand and accept as a meaningful focus for collaborative work. To proceed with other anxiety-provoking strategies before a mutually agreed upon focus has been established diminishes the probability of success drastically. Or, put in a more positive way: "Mutual agreement about the focus

constitutes the therapeutic contract, which establishes limits to therapeutic work and lays the foundation for the therapeutic alliance. In addition, the contract serves the purpose of making the patient take an active responsibility in treatment" (Bauer & Kobos, 1987, p. 58).

In focalization, STAPP differs from most other forms of short-term dynamic therapies, including the Intensive Brief Psychotherapy of Malan (1963) and the Intensive Short-Term Dynamic Psychotherapy developed by Habib Davanloo (1986). While Malan and Davanloo introduce the focus gradually through interpretation, the STAPP therapist makes it part of the therapeutic contract by specific evaluation procedures in the first session. Through this highly anxiety-provoking maneuver the emotional tone is set from the first hour of treatment. In several other respects, the models of Sifneos, Malan, and Davanloo share important features.

It is clearly an exaggeration for John Garske and Andrew Molteni (1985) to write that prospective STAPP candidates are "forced" to admit and agree that their symptoms are really manifestations of more central processes. But it is considered an absolute requirement for the patient at least to indicate a willingness to explore such possibilities.

For the patient to agree upon a focus is also to agree upon a fundamental treatment goal: to resolve psychic conflicts by the means of

exposing oneself to, and with the therapist's help examine, the areas of emotional difficulty that one tends to avoid. With gradually heightening awareness of conflictual feelings and their historical roots in childhood, and with the aid of the corrective emotional experiences (Alexander & French, 1946) of the therapeutic relationship, the patient will also be able to enjoy more satisfying interpersonal relationships in his or her "real" life.

### **THEORY OF CHANGE**

Thus far, no one has elaborated a comprehensive theory of change for STAPP in particular. From what has been said in previous sections, however, the reader will probably have concluded that STAPP is basically anchored in classical (not orthodox!) psychoanalysis and psychoanalytic ego psychology. Assumptions about the causes of psychopathology and interpersonal conflicts are closely connected with assumptions about their resolution. Together the two sets of assumptions constitute the rationale behind the therapist's activity.

In principle, the STAPP theory of change is rather simple and parsimonious. The main operating mechanism is supposed to be the patient's learning to solve an emotional core problem, as it is being evoked in the transference by the therapist's anxiety-provoking technique. Learning to solve an emotional conflict gives rise to self-understanding and a feeling of

well-being. Further, it leads to the development of new attitudes, which in turn facilitate improved personal and interpersonal functioning (Sifneos, 1969).

Basically, it is supposed that every symptom holds a psychodynamic meaning, hidden from the patient's conscious awareness, and that anxiety may be used as a motivating force for the patient to explore that meaning. In turn, the new cognitive and intellectual insights that emerge will help the patient to change his or her maladaptive behavior. Or, to put it in slightly different terms: by learning to recognize maladaptive reaction patterns, unmasking their historical source and meaning, and having corrective emotional experiences with the therapist, the patient achieves more inner freedom and ego autonomy. Being freed from longstanding parataxic distortions, the patient is enabled to adopt more flexible, self-directive, and mature ways of relating to other people. Thus, according to STAPP theory, lasting behavioral and symptomatic improvement is thought always to arise from the patient's having attained significant psychodynamic change and a new "internalized dialogue," which makes him or her more resistant to specific internal and external stressors.

Looking at therapy as a particular form of experiential learning and problem solving, Sifneos (1972) compares the role of the STAPP therapist to that of "an unemotionally involved teacher" or mentor, an analogy neither

original nor unique among psychoanalytically oriented therapists. Even Freud in his early writings (for example, Freud, 1905/1953) described his approach to treatment as a special form of "after-education," and later Franz Alexander and Thomas French (1946) alluded to learning concepts in their pioneering efforts to shorten psychotherapy.

Interesting, but rarely attended to, is the fact that the learning concept of STAPP may serve as a bridge to recent developments in behavioral psychotherapy, especially with regard to so-called exposure treatment (Marks, 1981). The essence of that approach, which is considered a particularly efficient therapy for phobias, has been cogently outlined this way:

In order to help this type of individual, it is necessary to change the avoidance behavior into some type of approach behavior. . . . [If] the client can be encouraged and supported to actually approach the situations he or she has avoided, there is an opportunity to secure positive change. If the client enters the previously anxiety-avoiding situation and the expected negative consequences are not forthcoming, a reduction in anxiety may ensue. (Garfield, 1989, p. 33)

Compare this with the following two brief statements by Sifneos as they pertain to STAPP: "[The therapist uses] anxiety-provoking questions to stimulate the patient to look into the areas of conflict which he tended to avoid" (Sifneos, 1969, p. 393), and "Past emotional conflicts and difficulties become reactivated and the patient reexperiences, as one may say 'alive' during the psychotherapeutic interview, the painful aspect of his past

emotional difficulties" (Sifneos, 1965, pp. 128-129). As the reader will easily see, the exposure component is here no less present than in the behavioral approach. Probably the main difference between the two approaches is that in the latter, exposure is ensured in relation to external fears or situations, while in STAPP the feared "situation" is an intrapsychic one, such as forbidden wishes, fantasies, or feelings. However, an effective agent of change in both forms of therapy is the patient's encounter with experiences usually avoided. In our opinion, such similarities in operating mechanisms should motivate therapists toward exploring the possible gains of integrative therapeutic efforts (see Nielsen & Havik, 1989).

## TECHNIQUES AND CASE EXAMPLE

### **Formulating the Therapeutic Contract**

The therapeutic contract formulation represents a transition from assessment to therapy proper. The contract constitutes a mutual agreement about the thematic focus of treatment and also about the limitations of the therapeutic venture. Sifneos maintains that "the therapeutic contract serves the purpose of making the patient take an active responsibility in the development of his psychotherapeutic work and sharing the difficulty which will be encountered as an equal partner, not as one dependent on the evaluator" (1979, p. 55). Preferably the contract should be formulated toward



the end of the evaluation interview, in connection with the therapist's summary of his or her impression of the patient's problems. At the latest the contract should be completed at the beginning of the first regular session.

Here is an example from an interview with a thirty-four-year-old female school counselor:

Therapist: If I understand you right, . . . you say that the pain in your muscles and joints of your hand and your tendonitis in your elbow have something to do with your tendency to force yourself beyond your own limits. You suggested that your pain might have something to do with your being too nice a person, too easy to get along with. It is very easy for you to say yes, and you take too big a share of what should have been joint liabilities. This happens more often between you and your female friends and between you and your mother. *(The patient is listening attentively and nods her head.)*

For the last couple of months you have managed to diminish this tendency somewhat in relation to your mother. But that makes you feel guilty and also mobilizes some anxiety. *(The patient sighs in confirmation.)*

You mentioned particularly that you used to have more difficulties with women than with men in this respect, which corresponds with your feeling that it is generally easier for you to get along with men than with women. Remember your own words: "There is something delicate here." *(The patient nods.)* You also said that you hope that therapy will help you to discover new connections in your life which may help you to say yes and no more according to your limits and your wishes. And I do agree. Let us therefore concentrate on finding out together what it is you call delicate in your relation with men on the one hand, and between you and women on the other, and maybe especially between you and your mother and father.

Patient: Yes, fine. When can I see you again?

The therapist has given a summary at the end of the evaluation interview. Using the patient's own words and formulations, she outlined the essence of the dynamic hypothesis that would guide her work. The patient obviously accepts the therapist's formulations and seems to be eager to get started on their joint venture.

Sifneos claims that in presenting his dynamic hypothesis and the contract, the evaluator must "be able to substantiate his impression by solid evidence in the form of specific examples of events, fantasies, and memories given to him by the patient and amassed during the course of the whole evaluation" (1979, p. 50).

### **Establishing a Good Working Alliance**

The example above strongly indicates that a fairly good *working alliance* between therapist and patient is already emerging. The patient herself has already done some of the "work" of putting her complaints into an interpersonal framework. But she has not yet managed to grasp the full dynamic meaning of what she is telling.

Building a good working alliance is a fundamental technical challenge for every STAPP therapist. The therapist tries to nourish the alliance both directly and indirectly, through verbal and nonverbal means. In the case just mentioned, the evaluator echoes the patient's formulations, thus enabling her

to feel herself recognized and understood. Most probably the patient perceives the evaluator as an attentive and interested other, who acknowledges and confirms her own thinking. In short, the patient is being approached as an equal partner, expected to contribute actively to the joint therapeutic work.

The working alliance is also strengthened by the therapist's active support whenever the patient is working hard within the therapeutic (oedipal) focus. Here is another example from the same patient's evaluation interview:

Therapist: What about your father?

Patient: He was such an extravert, an easygoing kind of person. He was an attorney, working for the county administration. He loved to talk to people. . . . Yes, very extravert. When he was mad at something or someone, he got it out of his system immediately, then, he could go on again. Mostly he was very good tempered and very cheerful. . . . Yes— (*tears well up*).

Therapist: What did you especially appreciate with him?

Patient: Well, I guess— yes, it was that he always found the time— (*silently crying*).

Therapist: That meant a lot to you?

Patient: Yes (*crying hard, searching for her handkerchief*).

Therapist: This is difficult for you, thinking of your father.

Patient: (*Sobbing*) I am thinking of when I used to visit him at his office. He used to close the office and go with me for a walk in the shopping areas downtown.

Therapist: That sounds nice. When you visited him, he seems to have treated you as a very important person, and he gave you all his attention. What more did the two of you like to do together?

Patient: He liked to boss me around (*smiles through her tears*). He liked to go fishing, and I had to be his assistant, or if he was to do some practical work at our country place, you know . . . I used to protest, to make him stop bossing me around, but it was nice that he wanted to have me around and not my brothers.

Therapist: I understand that your father is now dead. When did he die?

Patient: Ten years ago (*still crying*).

Therapist: I see, ten years ago, but it is still hard for you to talk about him, knowing that he is not around you any longer.

Patient: Yes (*sobs*), it is very painful, grievous. But I am astounded that I should cry like this now.

Therapist: I see. It sounds as if you were very close to your father, and that you do have some very nice memories.

Patient: Oh, yes (*smiles and goes on telling about some nice, sunny memories from childhood*).

## **Transference Issues**

Another technical consideration to be made early is the use of the transference. Usually, positive transference feelings predominate in the early phases of STAPP, and it is recommended that the therapist deal with them immediately, not waiting for the transference to appear as a resistance to be

interpreted later (Sifneos, 1979, p. 78).

In the following passage the evaluator is summing up, preparing for the contract formulation:

Therapist: So, here we are. You agreed to come and talk to me at a most inconvenient hour of the day for you and despite my being a woman, when you wanted to see a male therapist. Could this have anything to do with your problem—that is, saying yes and being nice, though you didn't really want to do just that, but something else?

Patient: Yes, yes, I guess you are right.

Therapist: So we are right in the middle of it?

Patient: Yes (*tears in her eyes*). You might say I thought that if I did this, I mean, came down for this interview, I could get accepted for therapy now, without having to wait for another half a year.

Therapist: Perhaps that was exactly the way it used to happen between you and your father? You did something for him, were a nice girl, so that you could have his attention, and then make an arrangement with him and come before your brothers?

Patient: Um, it sounds awful the way you put it! I haven't thought of it that way, but yes, I guess so, it was important for me to get his attention, as it has been to get yours.

In this example the patient recognizes the therapist's early transference interpretation, thus starting on her therapeutic work immediately. This is often the case with properly selected STAPP patients. However, a patient may also choose to test the therapist, like our school counselor did in her first

regular session:

Patient: I have been thinking about my situation. Somehow I feel that I have done it again—been too compliant. I mean, in spite of right now having too many duties, I mean, I knew that those weeks coming up would demand too much of me. They always do, when my husband goes away on his business trips. I should have postponed the start of my therapy . . . I feel I haven't got the time right now . . . All the same . . . Well, then I started to think of a friend of mine who went psychotic during her therapy with Dr. X [a woman], so—

Therapist: In a sense I think you are saying that you do not trust me as a woman, and therefore not as your therapist either? Perhaps you are afraid that I will mess it all up and leave you confused, or withdraw, like your mother used to do?

Patient: Well, we all got very frightened, you know. My friend almost managed to kill herself.

Therapist: Oh, yes, I understand that, it certainly must have made a strong impression on you. But I also hear you say that you *do not trust me*. I am just like all the other women, your mother and the rest, not to be trusted with important stuff. Your mind is so replete with important stuff that you are ready to withdraw and give it all up. It is too dangerous to look into, or to be trusted to a woman.

Patient: Um . . . Well, it is somewhat confusing, but I see your point. And, well, I recall my first thoughts about going to a female therapist, as I told you when we first met. . . But, but, when I think of our last session . . . You were very warm and understanding . . . helping me, but also very direct and strong. You kept your track, didn't give up or withdraw. It is all quite confusing.

Therapist: So in one way you recall me behaving more like your father, giving you time, listening, and so forth, and not allowing you to muddle about, talk me out of the track of what you really meant was important. On the other hand, I am also a woman, whom you don't know if you dare to trust, and who makes your life more complicated.

Patient: Um, yes, I am afraid you are right again. (*The patient then talks about a memory that had come to her mind shortly after the evaluation interview.*)

Sifneos (1979) maintains that early transference moves like these can be difficult to handle, since the working alliance has not as yet become consolidated. Our patient showed a reaction common to many STAPP patients. She came in touch with emotionally significant material, which provoked so much anxiety that she even considered dropping out of therapy. But the material obviously also stimulated the patient's curiosity, thus serving as an important driving force for further explorative work.

Like Malan (1976), Sifneos claims that the therapist's interpretations should focus particularly on therapist-parent connections, the so-called past-transference links. This provides the patient with significant insight. It also contributes to the *corrective emotional experience*. Together, these two important treatment factors facilitate the resolution of the patient's past and present interpersonal conflicts (Sifneos, 1979, p. 80).

Sifneos (1979, 1987) also discusses countertransference issues. In his opinion there are few countertransference problems in a typical STAPP. Of course, there may be episodes of, for example, dislike of the patient. But "the therapeutic alliance and the common problem-solving goals have an overriding influence on these difficulties and become instrumental in producing a positive result," he argues (Sifneos, 1979, p. 92). Looking over

our own clinical experience, we agree that the countertransference feelings that come up are most often positive, and that they can be relatively easily resolved or handled.

### **Didactic Interventions, Anxiety-Provoking Questions, and Patient Responsibility**

A successfully conducted STAPP may often contain a didactic component. For example, the therapist takes an active, didactic role when telling the patient what to expect from treatment, when outlining the rules to be followed, and when summarizing examples of new learning and better problem solving evidenced by the patient's behavior during treatment.

Sometimes didactic and interpretive interventions can be combined, as in the following sequence (from the sixth interview). The patient opens the dialogue:

Patient: This is very hard. I feel reluctant. I let all thoughts just come. It is kind of new and unfamiliar. I become insecure. . . . I am wondering if I am saying what you expect of me. You are kind of anonymous. You are receiving without saying yes or no. I want a response from you.

Therapist: Now try listening to your own words. What does it remind you of?

Patient: Well, you know at home we always got a reaction, from either mum or dad. Yes, and my oldest brother especially. He was even more closely supervised. I managed to get permission to stay out later than my brothers had managed at the same age. I don't think I ever took correction from my mother, though. But I do remember that she once tried to correct me, but I didn't listen, though I knew she was right. It was always my father's opinion



that was of most significance to me.

Therapist: You seem to carry the idea that I expect something special from you, that I should guide and correct you like you were guided back home. Remember that you are just as good a judge of what is important to talk about as I am. What is going on between us is of course important, so if you have more thoughts about why I should guide you, you can continue on that subject. However, if you find it more important to talk about why your father's opinion was of greater importance to you than your mother's, you can choose that.

The patient returns to the same topic in a later session, demonstrating that she has been working on it and that she wants to cooperate. Although it costs her quite a lot, she is providing much meaningful material.

Patient: Now I can understand my own clients' frustration when they expect to be guided on what to do. With you, I have had to learn what it is like to have to find out for myself what I want to do, or think, or feel. It all has to come from myself, from my inside, so to speak. I also have to sense how it is when I am trying to resist when it is uncomfortable . . . And that is uncomfortable, too.

You know, last time you asked for an example of me rebelling against my mother. I could feel my frustration toward her, but I couldn't remember any concrete situation. But as soon as I got outside your door, I remembered one: I went out to our country place with some friends, though my mother had forbidden me. Instead of arguing with her, I deceived her. They [the parents] found out, of course. Well, nothing really happened, but it was not that—it was that on remembering this incident, I found that I still avoid direct confrontations with her. I evade conflicts. That was humiliating to discover, so I continue to beat about the bush (sighs), I—

Therapist: Can you give me an example of you going around and not standing up for yourself in relation to your mother?

Patient: Well, it was a couple of days ago. She asked me to give her a hug. She

complained that it was so long since she had one. I felt so bad . . . it felt so artificial. I should have managed it better. . . . I do wish I could have said, "I don't feel like giving you a hug right now."

Therapist: How do you understand that?

Patient: Um, it is somewhat complicated. . . . I remember how nice it was to lie between mum and dad in their bed, mother holding my hand and playing with my foot, and father fondling my hair, which I loved him to do. Somehow I decided very early that I should never be like my mother. She couldn't even cope with her children. She started to cry when things became difficult for her. Somehow I consciously decided to become better than her.

Therapist: Better than your mother? How?

Patient: Well, I remember our skiing trips high up in the mountains. We had to climb the hillsides. They were steep, you know. The girls started to cry and refused to go any further. I felt contempt for them: Why couldn't they pull themselves together and go on?

Therapist: You felt contempt for your mother, too?

Patient: It was somehow important to be the best. You know, I picked up sports, sports my father was interested in. But I never was interested in the stuff my mother was good at, cooking and sewing, for example.

Therapist: You were afraid of not being able to knock your mother out in that area, too?

Patient: Um (blushing), I haven't thought of it that way . . . I got the thought the other night that my nice, pleasing behavior has something to do with my competition with the other girls. When I compete I can even exceed the limits of what I can cope with. I am using my brothers' measures.

Therapist: What do you mean? Please give an example.

Patient: Well, one week after I had given birth to my first child, I still had stitches and couldn't sit, but I started immediately to see my clients again. Well, it was completely crazy when I think of it today.

Therapist: How do you explain your behavior? Why did you do such a thing, and why was it so terribly important to reach that mountain peak? Why was it important to be the best, better than your mother?

Patient: I don't know.

Therapist: Oh, come on, now you are beating about the bush again.

Patient: I think I wanted recognition from my father. . . . Yes, that was very important, that he acknowledged me, that he showed his love for me. (*She goes on giving examples of what she used to do to please her father.*)

The therapist actively urges the patient to be specific and to avoid vagueness. She is continuously asking for examples and encouraging her to verbalize her own understanding of the situation. Thus, the therapist is also making anxiety-provoking clarifications and confrontations, relying on the working alliance and on the patient's motivation for change. These therapeutic efforts are immediately rewarded. Significant information keeps flowing. All along the way, the patient is encouraged to take responsibility for her actions and feelings.

### **Therapist Activity**

As the examples show, the STAPP therapist is actively challenging the patient by questions, confrontations, clarifications, or transference

interpretations. Activity is also exemplified by the therapist's forcing the patient to stay within the chosen treatment (oedipal) focus, by avoiding complex pregenital characterological issues, and by supporting the patient's attempts at more adaptive problem solving.

Sifneos strongly maintains that for the therapist to be able to handle the transference issues and the anxiety-provoking confrontations and clarifications, he or she has to be sensitive and convey that "instead of being a threat with his challenges, competitive postures, and strong resistances, he is eager to help the patient deal with the anxieties which he experiences" (1979, p. 94).

Furthermore, the therapist must actively help the patient to take full responsibility for himself or herself and to learn to choose the best way out of a variety of tempting neurotic maladaptive options. By continuously reformulating the material presented by the patient into interpretations, particularly of past-transference links, the therapist uncovers new connections, thus providing the patient with new insights and better possibilities for effective problem solving.

### **Dealing with Defenses**

Traditional psychoanalytic technique calls for always dealing with the defenses first; in contrast, the STAPP approach permits the therapist to

confront and interpret the underlying impulse or wish rather directly. Such head-on maneuvers are possible because the STAPP therapist, having provided a trusting environment by using the therapeutic alliance and positive transference, can afford to be selective and to concentrate on the specific areas wherein most of the patient's dynamic conflicts exist. Sensitive paying attention to verbal and nonverbal clues, the therapist proceeds to elicit and, if necessary, to push hard for painful associations, fantasies, or wishes. Having succeeded in reducing resistances through questions, anxiety-provoking confrontations, and clarifications, the therapist is usually rewarded with the sudden emergence of a fantasy, dream, or memory, "which pops, so to speak, out of the patient's unconscious and which confirms in a relevant and triumphant way the truth of his interpretations" (Sifneos, 1979, p. 95).

Here is an example of how our patient's defenses and resistance were challenged in the tenth session:

Patient: There is something I have found somewhat problematic for some time. . . . I have decided to talk about it today. I feel as if I am holding myself back when I am having sex with my husband.

Therapist: Yes? Go on.

Patient: I feel as if my mother is listening . . . I think she can hear us. You see, she has her own bedroom just above ours. I know I should say "so what," but it doesn't help me. I am still feeling uncomfortable.

Therapist: Uncomfortable? Please try to explain.

Patient: Um . . . I am thinking of my Danish boyfriend. With him it was quite different. I was much more free, much more alive. I did live more freely in Denmark. There I was not so regular and noble, not daddy's little girl!

Therapist: How did you feel, living like that?

Patient: (*Giggles*) Oh, it was great! (*Becoming serious again*) But I remember I started to get some anxiety from time to time.

Therapist: Anxiety? In what connections?

Patient: Um, I don't know, just anxiety.

Therapist: Oh, come on, don't hide yourself!

Patient: Well, somehow I rebelled against being my father's nice little girl . . . or was it during those periods I had those dreams. I dreamt very often that I was dead and everyone was standing around the coffin talking about me. I still have many dreams like that. . . . I dreamt the other night that my husband died. But this time I got so furious—how could he leave me alone, to sort everything out?

Therapist: What are you trying to tell me?

Patient: Trying to tell you? I don't know. You asked me . . . what was it again?

Therapist: Yes, what was it? What are you trying to tell me?

Patient: (*With tears in her eyes*) I had the impression that I had to be obedient toward daddy all the time. Conform to his rules, or else he should turn away from me. He wouldn't be fond of me any more (*silently crying*) . . . wouldn't love me any more.

Therapist: Do you say that your anxiety has something to do with rebelling against

your father, on the one hand, and with challenging your mother on the other? How do you explain that?

Patient: Strange to think that I dared to invite my Danish boyfriend home! Somehow I should show my father—show him that I wasn't that little girl of his any longer. On the other hand, they weren't there any more, my feelings for my boyfriend. He had become more indifferent to me. But those weeks at home . . . I was quite . . . enticing. But it was always mum who was most openly critical toward my boyfriends. (*A long silence, tears in her eyes.*)

Therapist: Well, go on . . . what bothers you?

Patient: I am thinking of my father. . . . He got his first heart attack just a few weeks after my boyfriend had left. I . . . I have been . . . I haven't been able to drop the thought that it was my fault—that I had provoked him, so that he got the heart attack (*crying hard*).

Therapist: Are you telling me that you were deliberately making your father jealous?

Patient: (*Mumbles.*)

Therapist: What do you say? Yes or no? Were you deliberately making your father jealous?

Patient: Well, I am afraid that was just what it was (*still crying*).

Therapist: But how do you want me to understand why you should make your father jealous? And how do you explain the immensely strong feelings between the two of you, feelings that you believe could have killed your father?

Patient: I don't know. But it was terrible thinking that he could have died. It got me stuck in the old groove again. I became the nice girl again. I didn't go back to Denmark where I had planned to continue my studies. Instead I stayed with my parents and got myself a job (*crying*).

Therapist: I understand that you are fond of your father and that thinking of having hurt him is difficult. (*Patient sobs.*) But how do you explain that your feelings . . . his feelings . . . almost killed him? Why did you have to make him jealous?

Patient: I don't know . . .

Therapist: Oh, come on, of course you know! Just tell me!

Patient: I don't know what you are hinting at. You tell me! (*Somewhat irritated.*)

Therapist: It is not my business to tell you. You are the one who knows how it was, how you were feeling. A minute ago, you told me that you had a wonderful time not being daddy's little girl in Denmark. In spite of that you had some periods of anxiety. You felt free and brought your boyfriend home so that your father should see, you said. And you also said that you were astounded at yourself daring to bring your boyfriend with you. You said that although your feelings for your boyfriend had vanished, you were behaving in an enticing way. You were the one who said that you were afraid that you had provoked your father so that he got a heart attack. The very first time that we talked about you and your father, you used the word delicate to describe your relationship, do you remember?

Patient: Um . . . yes, I was very proud of him, I loved to walk beside him in town, letting the others see what an elegant, smart man he was.

Therapist: Well, go on.

Patient: I remember another dream I had after he had died. In the dream he was dead, but I could very clearly and vividly feel the smell of his clothes. I could feel that smell very strongly. . . . It was very nice. I stood there remembering how he used to smell when I hugged him . . . and then suddenly he was alive again, standing there close to me. You know, smells have always meant a lot to me when I am in love {blushing}. Yes, um, it is almost like a love story. . . . After his illness he was very much changed. He became more dependent and helpless. He wanted me to nurse him. My mother didn't do it well enough. It had to be me. He was often sitting at the window waiting for me for hours. I



remember I used to have rather mixed feelings about that. I was proud that he preferred me to my mother, but somehow it was too much, too, and that made me feel awkward. I felt that I had been naughty. I had to be his very nice little girl again to make it up. It was a difficult time, with mother's jealousy and all that. . . . I was happy when I could leave for another job two years later. My husband-to-be persuaded me to come to his place and work. Thinking of it now, I might say that I ran off. I couldn't handle it any longer. His feelings toward me, my feelings . . . it was a mess.

Therapist: Do you see any connection between this and your present difficulties, that is, to feel free and uninhibited when you and your husband make love?

Patient: What do you mean? Oh, yes, that I feel my mother can hear us . . . Well, yes, that . . . I don't know (*cries*).

Therapist: Come on, don't be evasive.

Patient: Well, um, I guess I feel somehow I shouldn't make love . . . mother is somehow against it, I imagine. . . . I mean, it is all screwy.

Therapist: Go on.

Patient: Um, you want me to say that I think I make love with my father, when I am with my husband?

Therapist: I do not want you to say anything in particular. But you have agreed to talk about what you remember, what you feel, what you are thinking of. Don't talk it away. Well, do you think that your sensitivity for your mother's opinion and for her disapproval is because you think that you are making love with your father? Yes or no?

Patient: (*Cries*) I . . . well, there are something there . . . but not quite . . . well, yes, it must be . . . it is crazy. . . .

*(The hour ends here.)*

The therapist was pressing the patient incessantly, but at the same time she was carefully listening for the immediate effects of her confrontations and interpretations. All along she relied on the positive transference and the rapidly established working alliance. The therapist actively summarized the evidence that had accumulated and fed it back to the patient. The patient came up with two memories: in the first she is proudly walking at her father's side, and in the second (the dream) her father is called back to life by her strong memory of his smell. She even uses the phrase "like a love story" to characterize their relationship.

In preparing for the next (eleventh) session, the therapist was wondering whether the patient would fall back into her habit of receding from confrontations, "juggling." To arrest such tendencies, Sifneos (1979,1987) claims that it is a good measure, if not an imperative one, to take notes during the sessions, so that the therapist can confront the patient with his or her own words when necessary.

But let us now meet our patient in the eleventh session. She starts out by telling that it has been a difficult week, with a lot of tension, and so on. She continues as follows:

Patient: Once again I have been thinking of my father, and came to think about his funeral. My husband couldn't come to the funeral, but came a few days later. We went out to the cemetery together and sat down. There we had our first real conversation. I remember quite vividly that after that I wanted to

become pregnant. We made love together, as we never had done before. I felt so open and receptive towards him and very much alive.

Therapist: It sounds as if you are telling me that your father used to be between you and your husband.

Patient: Um, yes. I am afraid you are right. . . . But still the period after my father's death was a very difficult one for me. I often felt so lonely. . . . You know, even after I was married, I went to my father with my problems.

Therapist: What kind of problems?

Patient: Well, ordinary, everyday practical ones, like asking for help with the lighting in the yard, which I couldn't get to work, and so forth. I never talked to my husband about such problems. I was the organizer of all these things in the house . . . well, with my father's help. I also recall that father and mother competed to write most often to me, just as they had done when I was living abroad. I had to be careful, being equally attentive to both of them! (*She goes on talking about her love and affection for her father. She smiles and compares her situation with her own daughters' feelings for their father.* )

They, my father and mother, had talked about mother coming to live with me. I should take care of her when he died. Well, that I didn't know until she actually moved in with us. I felt it an unpleasant duty, and also felt terribly guilty for not being happy to help my mother, taking on the daughterly duty, you know. Why me? Why not my brothers? Just the thought that I am so negative towards her makes me feel guilty. But the other night I got the idea that this negative feeling, the feeling of an unpleasant duty, that I always have to do something for my mother . . . to be nice to her . . . to do all sorts of things for her, has something to do with my feeling that I have to make up for what I felt for my father, loving him more than her. . . . Strange, you know, the other night . . . my mother has a cold and had to be in bed. Earlier I would have felt that I should stay at home and nurse her, be with her all the time, and be frustrated. This time, however, I could choose to go to see her or not. I didn't have to do it. I felt free to go or not to go, so I saw her in the morning and went to my job as usual, without a bad conscience. I served her dinner, all right, and later in the evening I popped in because I wanted

to—I didn't have to. In spite of her cold we did have such a nice time together. I can't remember having had it so nice with her, just the two of us.

*(The patient goes on to talk about her former relationship with her mother, and about her balancing between mother and father.)*

The patient confirmed that she understood the dynamics and that she had taken responsibility for her feelings and actions. She had begun to work continuously with memories and fantasies that emerged; she also had new experiences with her mother. It turned out that the tenth session was the height of this therapy. Quite often after a STAPP treatment, the patient points to one particular hour as a peak experience or as a turning point.

During the next five hours our patient worked with her grief over her father's death, which she had not been able to do properly in the past. She also came up with additional memories connected to her oedipal problem—for example, a memory from her puberty, when she proudly showed her first bra to her father and he rejected her and ridiculed her. She also recalled an early memory when she was expelled from her parents' bedroom, because her older brother came home with a baby that her parents had to take care of, and the baby had to sleep in the parents' bedroom, where she used to lie.

## **Termination**

In most STAPP cases termination is initiated quite naturally and

logically when the patient has solved his or her focal (oedipal) problem. It is the patient just as often as the therapist who raises the termination issue. The therapist should look for concrete evidence of change, according to criteria specified for each individual patient at the beginning of treatment. For example, for the patient we have been following in this chapter, the solid evidence of change was her becoming able to perceive her father in a more realistic way—that is, not overridealizing him; to have greater acceptance for her mother and for herself as a woman; to be less competitive toward women in general; and to achieve a better sexual relationship with her husband—that is, a relationship with more reciprocity. She was also expected to feel less jealous of her own children and to have less pain in her hands and arms. Finally, it seemed realistic to expect some anxiety reduction.

For the last couple of sessions the patient worked hard on her relationship with her parents. On the one hand she struggled to keep the nice, smooth picture of her handsome and gallant father. But at the same time she forced herself to see other dimensions of him, for example, his tendency to boss and dominate the rest of his family. The patient more and more allowed herself to see how she had let him control her life, making both small and large decisions for her, even including her occupation and husband. Such discoveries aroused her anger, but she eventually managed to handle her ambivalent feelings.

As for her mother, she stated:

Patient: I have noticed lately that my mother is trying to understand me and my life situation. For example, she can understand that I am often coming tired from work. The other day she had made some stuffed cabbage for me and my family. . . . She knows I love that, but I rarely have time to prepare it. Somehow I can see now that she has a lot of consideration for me, not just demanding things from me, as I felt before. She is well meaning, but can't manage all the things she wants to do. It is as if I finally hear her saying that even if we disagree about a lot of things, she does love me all the same!

In the sixteenth session she talked about herself, her marriage, and her relations with others in her life.

Patient: I am now enjoying more positive feelings about being a woman. Sex is more joyful nowadays. I haven't got mother with me in bed any longer (*laughs*). I can allow sexual thoughts to come through to my mind and enjoy my fantasies. I haven't had any of my anxiety dreams for a long time. . . .

I do have it much better with myself nowadays, but it gives me a sour taste thinking of how I exploited the fact that I was the only girl and the youngest one at home. Think of my jealousy towards my brothers, and even, as a grown-up, towards my own children . . . and, of course, my mother! Every minute I was working hard to be at the center of attention, to get proof of being loved, of being the preferred one. . . .

In relation to my husband I have been shifting my position from at times being a little girl demanding him to be my father, and at times being an adult, competing with him. I did the digging in the garden and the painting, etc., in the house, while he had to do the laundry. Although he had to be the best of men, I had to be better than him. At times, I have put him on a pedestal, as I did with my father. But not any longer! . . .

I had to confront my daughter's teacher. I mean she didn't perform her job properly. But this time I managed to talk to her in a grown-up way. Not like last

year, when I was scolding her for her incompetence. This time I could listen to her version, too, and we came to an understanding. That was quite satisfying. She took my point, and we could sort it all out to be best for my girl. . . .

I am going to take a year off from my job and start studying again, just for pleasure.

The patient's physical symptoms had vanished, as had her anxiety. There were many indications that her oedipal problem had been resolved, so in spite of her general wish to continue therapy, before the nineteenth session she decided the time had come for her to stand on her own feet.

Sifneos claims that STAPP patients recognize clearly when their problem has been solved. But they might delay the ending for a while. However, "soon (they) realize that it is useless to prolong a situation which seems to be rapidly coming to an end" (1979, p. 156). Sifneos also maintains that this tendency has to do with the positive transference feelings for their therapists and with the strength of the therapeutic alliance, the two basic pillars of the STAPP technique.

To recapitulate, there are ten main technical ingredients of STAPP (Svartberg, 1989).

1. The therapist is generally active and somewhat directive.
2. Transference manifestations are handled early. It is particularly important to identify and interpret "parent-therapist"

connections, that is, the past-transference links.

3. The therapist tries actively to keep the patient within the therapeutic focus—in most cases, the oedipal triangle. Preenatal issues and characterological disturbances are systematically avoided.
4. The therapist encourages, and even presses, the patient to specify and to exemplify as concretely as possible his or her statements and verbalizations.
5. The therapist puts effort into having the patient take responsibility for his or her own wishes, feelings, fantasies, and actions.
6. The therapist frequently uses questions and statements such as Why? Why do you think so? How do you explain that? What do *you* think? What are *you* trying to tell me now? Don't run away from *your* problem! It is not my business to answer your questions! What are *your* feelings about this?
7. The therapist continuously applies pressure to the patient's focal defenses (the infantile triangle).
8. The therapist actively supports the patient when she or he is working hard within the focus.
9. The therapist and patient work hard to get a chronological overview of important events in the patient's life. The patterns observed are redundantly recapitulated for the patient.



10. The therapist recapitulates the information the patient is producing, particularly in periods of strong resistance.

## **APPLICATION AND MODIFICATIONS**

Although some therapists attempt to discover an infallible technique applicable to most, if not all, patients, the "pure" STAPP approach should be seen (at least at this point) as having utility for a relatively small and carefully specified population. Having its roots in classical psychoanalysis with regard to assumptions about the cause of psychopathology and related interpersonal conflict, the STAPP model suggests that the primary curative factor will be insight into this conflict. For a treatment that is straightforward and intentionally anxiety-provoking, it is essential that the therapist stick to clear cut and conservative selection criteria. For this reason, some observers have characterized prototypic STAPP candidates as ripe plums (Peake, Bordin, & Archer, 1988). Fairly often candidates are well-educated young adults struggling with problems in the developmental phase of intimacy versus isolation, that is, conflicts usually expressed in difficulty with heterosexual or peer relationships (Burke, White, & Havens, 1979). Working on such problems within the transference relationship often reactivates more basic (oedipal) conflicts that can be effectively resolved through interpretations of the past-transference link.

In an outpatient sample in Boston 26 percent (47 out of 182 patients)

were found to fulfill the criteria for STAPP (Sifneos, 1973). Similarly, for the patients in the Bergen Project on Brief Dynamic Psychotherapy (Barth, Nielsen, Havik, et al., 1988), STAPP could be recommended in 10 out of 44 cases (23 percent). However, with a typical inpatient sample at the University Psychiatric Clinic in Oslo, Astrid Heiberg (1975) reported that less than 10 percent fulfilled the STAPP criteria.

For us, as for our colleagues in Oslo (see Husby, 1985), it has been a challenge to investigate the possibility of offering some form of short-term dynamic psychotherapy also to patients who fall short of satisfying the selection criteria for STAPP. If it is possible to document any substantial therapeutic gain in such cases, the potential utility of shorter forms of treatment within the mental health service system will increase significantly.

In order to reach more patients, we decided to free ourselves from the strictly dichotomous response format of Sifneos's evaluation form. This was done by adding a number of subquestions, thus contributing to a more differentiated picture of ego resources than yielded by the original form (see Dahl et al., 1978; Husby, 1983; Barth, Nielsen, Havik, et al., 1988). For example, we expanded questions 1 and 3 as follows:

1. Is the chief complaint well circumscribed? *Subquestion:* If not, reasonably circumscribed?

3. Can the patient interact flexibly with the evaluator? *Subquestion: If not, is there any evidence of trust and contact?*

Using the modified evaluation form we were able to differentiate three groups of patients. The first group had a yes score on all main questions; these were excellent STAPP candidates. The second group had, as a minimum, a positive score on all five subquestions, in addition to showing motivation for change. Such patients, who often had some dependency problems or more maladaptive defenses, were assumed to benefit from a less anxiety-provoking approach, like Malan's (1963) Brief Intensive Psychotherapy (BIP). Finally, patients with a no score on one or more of the resource items and/or insufficient motivation for change were offered treatment according to a brief integrative psychodynamic approach (Nielsen et al., 1984; Nielsen & Havik, 1989).

While both STAPP and Malan's BIP are essentially interpretive forms of therapy, our integrative model uses a wider scope of strategies and procedures—such as supportive, behavioral, and cognitive coping techniques (Marmor & Woods, 1980; Wachtel, 1985). Such active interventions, which may even include hypnosis, are used as adjuncts to the usual psychodynamic techniques. In the integrative model, transference still represents a key consideration. However, there is less concern than in STAPP and BIP with internal conflict per se, and greater emphasis on actual events that may have affected the patient's self-esteem, interaction with others, and anticipation of

the quality of his or her personal environment (Chrzanowski, 1977). Insight is slightly deemphasized as a critical change factor, while the mechanisms of corrective emotional experience, gradual exposure to fear-arousing fantasies and situations, and the provision of coping experiences and mastery experiences hold more central positions.

Theoretically, the integrative model is rooted in interpersonal psychoanalysis and represents a way of thinking that some authors prefer to call cyclical psychodynamics (see Goldfried & Wachtel, 1987).

With the modifications described above, we have found Sifneos's evaluation form to be a clinically reliable instrument, which may assist the therapist in the selection of the right form of treatment for patients of varying ego resources and motivation for change (Barth, Nielsen, Havik, et al., 1988). Systematic outcome studies (Barth, Nielsen, Haver, et al., 1988) have taught us that the modifications here described allow us to make short-term dynamic psychotherapy a treatment of choice for a large number of patients encountered in our everyday clinical practice.

## **EMPIRICAL SUPPORT**

With well-defined inclusion criteria, relatively homogeneous groups of patients, narrow treatment focuses, specified technical operations, and clearly defined parameters for measuring change (Sifneos, Apfel, Bassuk,

Fishman, & Gill, 1980), the STAPP approach provides favorable conditions for pursuing good outcome research. Over the years, a number of well-designed follow-up studies have been carried out in various centers in North America and Europe. In most of these studies, outcome has been evaluated according to both symptomatic and dynamic criteria for improvement, as well as criteria for improved adaptive functioning (such as interpersonal relations with key persons in the patient's environment, problem solving, and work or academic performance).

With his group at Beth Israel Hospital in Boston, Sifneos has pursued a large number of systematic case studies of outcome and two controlled group studies. The most recent study (Sifneos, 1987) included fifty patients (thirty-six experimental and fourteen waiting list controls). All patients had been clinically judged as suffering from unresolved oedipal conflicts, and all fulfilled the inclusion criteria for STAPP. At the end of their waiting period, the data showed, eleven out of fourteen control patients were rated as "unchanged," while three had some symptomatic improvement and were rated as "little better." In contrast, at the end of therapy thirty out of the thirty-six experimental patients were rated as either "recovered" or much better," according to criteria that included both symptomatic and dynamic change. Only three patients were rated as "unchanged." By the time the control patients had also finished their therapies, thus increasing the total number of treated patients, the ratings of either "recovered" or "much better"

applied to eighty-six percent of the sample.

In Norway, three recent outcome studies (Husby et al., 1985a, 1985b; H0glend et al., 1988; Barth, Nielsen, Haver, et al., 1988) have yielded results very similar to those reported by Sifneos. Two of the studies (by the Husby and Barth teams) included long-term follow-up interviews. The follow-up findings contained strong evidence that improvement observed at the end of therapy was being maintained several years after therapy had ended. For most of the patients, therapeutic gain had even increased during the follow-up period. Worth mentioning is also the fact that clinically rated improvement in the patients was cross-validated through findings with psychological tests (MMPI and SCL-90), administered before therapy started and at three follow-ups (Nielsen et al., 1988; Barth, Nielsen, Haver, et al., 1988).

Finally, in their follow-up interviews many of those patients who continued to improve after therapy had ended referred to some kind of "internalized therapeutic dialogue" as the most important change factor. Thus, it seemed that these patients during therapy had been particularly well "educated" in asking themselves good questions and then answering them in a therapeutically useful way.

To our knowledge, no studies have been reported comparing STAPP to any alternative psychotherapy or to a placebo kind of control condition. Thus,

nonspecific effects have not been ruled out, and there is no published evidence that STAPP is uniquely effective. However, a preliminary comparative analysis of our own data revealed that patients treated by the STAPP method improved at a faster rate than patients treated with either Malan's (1963) brief intensive approach or the brief integrative psychodynamic approach described in a previous section. We may take this as an indicator that STAPP is not only an effective but also a cost-effective form of treatment.

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