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RUNNING HEAD: PLAN ANALYSIS FOR BIPOLAR AFFECTIVE DISORDER

Psychotherapeutic Case Conceptualization using Plan Analysis for Bipolar Affective Disorder

ABSTRACT

Valid individualized case conceptualization methodologies, such as Plan Analysis, are rarely used for the psychotherapeutic treatment conceptualization and planning of Bipolar Affective Disorder (BD), even if data do exist showing that psychotherapy interventions might be enhanced by applying such analyses for treatment planning for several groups of patients. We applied Plan Analysis as a research tool (Caspar, 1995) to $N = 30$ inpatients presenting Bipolar Affective Disorder, who were interviewed twice. Our study aimed at producing a prototypical Plan structure encompassing the most relevant data from the 30 individual case conceptualizations. Special focus was given to links with emotions and coping Plans. Inter-rater reliability of these Plan Analyses was considered sufficient. Results suggest the presence of two subtypes based on plananalytic principles: emotion control and relationship control, along with a mixed form. These subtypes are discussed with regard to inherent plananalytic conflicts, specific emotions and coping Plans, as well as symptom level and type. Finally, conclusions are drawn for enhancing psychotherapeutic practice with BD patients, based on the motive-oriented therapeutic relationship.

Key-Words: Plan Analysis, Case Conceptualization, Bipolar Affective Disorder, Emotion

PSYCHOTHERAPEUTIC CASE CONCEPTUALIZATION USING PLAN ANALYSIS FOR BIPOLAR AFFECTIVE DISORDER

In recent years, psychotherapeutic approaches began to offer theory-consistent clinical tools for practitioners to treat patients presenting Bipolar Affective Disorder (BD), as adjunct treatment to pharmacotherapy. Most of these tools are based on cognitive-behavioral and psychoeducation models (Basco & Rush, 2005; Lam, Jones, Hayward, & Bright, 1999; Leahy, 2003; Meyer & Hautzinger, 2004; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2001; Scott, 1995; Scott, Garland, & Moorhead, 2001), on interpersonal and social rhythm therapy (Frank, 2007; Frank & Swartz, 2004) and on various other models as extensions of the afore-mentioned (group therapy: Bauer & McBride, 2003; Bock & Koesler, 2005; family therapy: Micklowitz, 2004; integrative-cognitive: Mansell, 2007). Recent reviews of treatment outcome studies confirmed overall efficacy for manual-based treatments (de Jong-Meyer, Hautzinger, Kühner, & Schramm, 2007; Jones, 2004; Rizvi, & Zaretsky, 2007; Scott, 2004), for some treatments in the acute phase with highly severe symptom levels, and for all treatments in the remission phase. While these recent developments are encouraging and the structure of manualized treatments highly meaningful for the treatment of this challenging group of patients, to our knowledge no systematic psychotherapeutic case conceptualization approach – based on the individual case - has yet been applied to this population. The objectives of this article are to contribute to the question of psychotherapeutic case conceptualization by using the Plan Analysis approach (Caspar, 2007; Caspar, 1996), more specifically, to (1) Enhance the psychotherapist's conceptualization of patients' problems presenting BD and (2) Optimize treatment planning, including effective

implementation of manualized treatment strategies and the construction of a tailor-made therapeutic relationship.

Plan Analysis

Plan Analysis is based on the works by Grawe & Dziewas in 1976 (Grawe, 1980) who observed in behavior group therapy that basic behavioral concepts were not sufficient to explain difficult interpersonal patterns presented by the patients. The patient's verbal and non-verbal behavior is not solely influenced by external contingencies, but also by internal determinants, such as intentions, motives, schemas of the self and the self-in-interaction leading the individual to actions and perceptions congruent with his/her basic assumptions (Grawe, 1998). The basic principle of Plan Analysis is the instrumental vantage point: the patient's behavioral (self-reported or in-session clinician-observed verbal and non-verbal) patterns are related to *Plans* and higher-order *motives* (or goals and needs) responding to the question: "Which purpose, conscious or unconscious, underlies an individual's behaviors and experiences?" (Caspar, 1997, p. 260). Generally, the presence of countless specific answers to this question, related to a patient's situation and interactional behavior, oblige the psychotherapist to prioritize, structure and hierarchize the information within a framework of instrumental connections, i.e., as a Plan structure. Later, developments of Plan Analysis drew on the schema concept and information-processing approaches (Caspar, 1984; 1995; 2007; Caspar, & Moix, 2006; Grawe, 1986; 1992b; 1998). Although complexity (and the correlating time investment) may be the price to pay for such detailed case conceptualizations, we would advocate, especially for clinical diagnoses such as BD, that a detailed case formulation might reflect in a reasonably accurate way the psychological and psychopathological complexity of such disorders. The payoff is certainly the adoption of a radical constructivist perspective, leading to – by means of reliable and valid single-case

qualitative methodology – a greater range of treatment possibilities (Caspar, 1997; Grawe, Caspar, & Ambühl, 1990; Kramer, & Caspar, 2007).

Emotions and Plans

The notion of Plan refers to the individual's adaptational processes and, as such, to the concepts of emotions and emotional processes from the instrumental perspective. Four cases are envisaged by the approach as regards the linkage between emotions and Plans (Caspar, 1997; 2007): (1) A negative emotion arises when Plans are threatened or blocked; (2) Plans shape emotions; (3) Plans are used as coping to face emotions; (4) Emotion has itself an instrumental function. We will focus more fully on the first and third aspect. (1) As long as the (internal and external) context allows the individual to act according to his/her main Plans, no negative emotional appraisal is noticed. However, the latter emerges when important Plans (e.g., related to life goals) are blocked – e.g., by life changes or internal conflicts. Negative emotional arousal might be observed in patients undergoing psychotherapy, either as a reaction to (internal or external) circumstances blocking Plans, or specifically as a reaction to therapeutic interventions blocking Plans. Inversely, positive emotions result from favoring important Plans or goals within the interaction or the release of blocked or threatened Plans. (3) Plans may function as coping with negative emotional arousal, which in its turn can be due to blocked or threatened Plans, but not necessarily. For example, a person who has just lost a loved one, to avoid confronting the emotions of sadness or anger caused by blocked Plans related to the need of companionship, might start to drink as emotion-soothing coping Plan. This means that adaptational processes – the way the individual aims at eliminating or avoiding unpleasant emotional arousal – are conceptualized by Plan Analysis.

Plans and Psychopathology

Since they are based on individual case studies, Plan structures may differ greatly from one individual to another within the same diagnostic category. Nevertheless, the notion of "prototypical Plan structure" has been offered by Caspar (1996), to assist the trainee-psychotherapist in learning to do case conceptualizations. The purpose of prototypical Plan structures is after all to give a general idea, by no means a constraint for Plan Analyses on individuals with the same diagnosis or clinical problem. These prototypical Plan structures aim at describing typical Plan and motive dynamics related to groups of patients. As such, the prototypical Plan structure for depression (Caspar, 1995) shows that these patients have difficulty in controlling aggression and anger; they produce many avoidance Plans (e.g., Plans like "Avoid further deceptions in relationships" and "Avoid social contacts"); they have high expectations (e.g., a Plan like "Be a perfect mother for your children"), which serve to replace certain needs (e.g., the need for proximity and affection), along with an argument for avoidance of the pursuit of related goals (e.g., resulting a conviction such as "I am too vulnerable to be a perfect mother, so I'd rather not even try to"). Depressives may also present Plans related to expressing vulnerabilities, to obtain from a significant other, including the therapist, particular consideration or attention (similar to patients suffering from psychosomatic difficulties; Caspar, 1996). Prototypical Plan structures are, inexhaustively, available for Anxiety Disorders (Caspar, & Tuschen, 1987), Borderline Personality Disorder (Ansmann, 2002) and child molesters (Drapeau, Körner, Brunet, Granger, de Roten, & Caspar, 2003).

METHOD

Sample

A total of 30 inpatients with Bipolar Affective Disorders (BD) were included in the study. A total of 20 (67%) were female, with a mean age of 46.1 years (SD = 11.2 ; ranging from 21 to

60). Their socio-demographic level was assessed by means of the total number of years of education in any field. On average, the patients had 12.4 years of education (SD = 1.1 ; range from 10 to 16). All had a DSM-IV-R diagnosis of Bipolar Disorder I (either F30.x[296.x], F31.x[296.4x or .5x] or F31.6[296.6x]) and were included in the study irrespective of the nature of the most recent phase or of the level of chronicity. Some (13; 43%) presented co-morbid disorders, such as drug abuse (23% ; cannabis, alcool, cocaine), personality disorders cluster C (10%), compulsive-obsessive disorders (3%), acute suicidality (3%) and epilepsy (3%). Diagnoses were established by trained staff by means of SCID (Structured Clinical Interview for DSM-IV; only part on BD; First, Spitzer, Williams, & Gibbon, 2004). The number of inpatient treatments in psychiatry, including current treatment, varied between 1 and 29 (Mean = 7.7 ; SD = 7.0). All patients gave written informed consent.

Instruments

Plan Analysis (Caspar, 1996). Plan Analysis is an individual-based qualitative method yielding a complete case conceptualization for each patient. Data analysis for each patient follows a three-step procedure: (1) Conduct of tape-recorded clinical interviews (see under procedure), including post-session note-taking by the interviewer regarding the patient's in-session non-verbal behavior; (2) Establishment of chronologically-structured "extensions" on relevant instrumental manifestations (Breuer, 1985, cited by Caspar, 1996) for each patient, based on verbal and non-verbal cues in the recording and in the sessions notes (this intermediate step is specific to the research context and enhances transparency in the process of inferring Plans from concrete behaviors); (3) Construction of an individualized Plan Analysis based on the extensions, as well as of emotion frames for each rated emotion, encompassing the four aspects of emotion from an instrumental perspective (see Introduction section). At this point, reliability analyses were carried out by fully-trained Plan Analysis

raters, based on independent analyses on 10% of the cases (3 out of 30 cases; only the material detailed under step one was available for both raters) focusing on the 10 (judged by the rater) most important Plans in one structure, compared to all Plans in the second structure (Benkert, 1997; Ansmann, 2002). For each of the ten compared Plans, the following correspondence criteria and ratings were applied: 1 point for correspondence in the Plan itself, 2 points for correspondence in hierarchically superior Plans and 2 points for correspondence in hierarchically inferior Plans, yielding a possible total of 5 points. Percentages of the total correspondence of the ten main Plans between the two Plan structures were computed and averaged. An overall correspondence of 60% was defined as sufficient. For emotion frames, a similar procedure was applied: the total number of emotions submitted to reliability analysis for each case corresponded to the lower number of emotions rated between the two raters. Each component obtained a rating of 1 for perfect correspondence: type of emotion, blocked/threatened Plan and coping Plan (the aspects of emotion shaping Plans and of instrumentality of emotion were left aside for reliability analysis and also for further examination), yielding a possible total of 3 for each emotion. Percentages of total correspondence between each emotion of the two emotion frame structures were computed and averaged. An overall correspondence of 60% was defined as sufficient.

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study has been carried out by Pariente and Guelfi (1990) and yielded satisfactory

coefficients. Cronbach alpha for this sample was .98 and General Symptom Index averaged on 1.24 (SD = .87; range 0.12 – 3.17).

Bech-Rafaelson Mania Scale (BRMS; Bech, Rafaelson, Kramp, & Bolwig, 1978). The BRMS is a clinician-rated scale for manic symptoms, based on 11 items tapping activity level, mood, and other characteristics of mania. The items are rated on a scale from 0 (normal) to 4 (extreme). Clinical cut-off score for mania is 15 (hypomania 6). Inter-rater reliability has proven to be high (.80 - .95; Bech, Rafaelson, Kramp, &, Bolwig, 1978; Altman, 2004). BPRS is effective in assessing outcome in clinical trials on BD (Bech, 2002). The French translation has been realized by Chambon, Poncet and Kiss (1989). Cronbach alpha for our patient sample was .77 and the mean of this sample 3.10 (SD = 2.94; range = 0 - 12).

Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery, & Asberg, 1979). MADRS is a clinician-rated scale for depressive symptoms, including among others items on sadness, internal tensions, insomnia, appetite reduction, cognitive impairment and suicidal ideation. The 10 items are anchored on a scale from 0 (absence of symptoms) to 6 (invalidating presence of symptoms). Clinical cut-off score for depression is 15. Several validation studies have reported satisfactory coefficients for the original version (Montgomery, & Asberg, 1979) and concurrent validity (Kearns, 1982; Maier, & Philipp, 1985). The French translation has been realized by Lemperière, Lepine, Rouillon, Hardy, Ades, Luauté and Ferrand (1984) and validation studies on this version yield satisfactory coefficients on specificity, homogeneity and internal consistency (Pellet, Decrat, Lang, Chazot, Tatu, Blanchon, & Berlier, 1987). Cronbach alpha for our patient sample was .89 and the mean of the sample 12.87 (SD = 10.40 ; range = 0 - 38).

Procedure

All patients were asked to participate in a dynamic interview (Perry, Fowler, & Semeniuk, 2005) lasting 50 minutes. Dynamic interview (DI) as a research tool has been developed from clinical practice of psychodynamic psychotherapy; thus, the context of DI is comparable to the context of an intake psychotherapy interview (Perry, personal communication). It has been widely used in psychotherapy research (Perry & Cooper, 1989 ; Hoglend & Perry, 1998). As shown by Perry, Fowler and Semeniuk (2005) and Fowler and Perry (2005), high-quality dynamic interviews are associated with Interviewer's and Overall Dynamic Interview Adequacy (I-DIA and O-DIA). Five tasks of the interviewer compose the I-DIA : (1) Setting the interview frame : work-enhancing strategies ; (2) Offering support : questions, support strategies, associations ; (3) Exploration of affect : questions, reflections, clarifications, low-level defense interpretations ; (4) Trial interpretations : defense and transference interpretations; (5) Offering a synthesis. In particular, exploring affect and trial interpretations are highly correlated with O-DIA, when the patient's contribution is controlled for (Perry, Fowler, & Semeniuk, 2005). The author completed an intensive one-week-training at Austen Riggs Center, Stockbridge, USA, and later underwent regular supervision with senior supervisors in psychodynamic psychotherapy. All interviews were conducted in French by the author.

All inpatients participated in the dynamic interview, as soon as their symptomatic state allowed it. This means that the patients were included in the final third of the duration of inpatient treatment, shortly before discharge. Only two patients had to be excluded from the study due to non-feasibility of the research interview; all other patients responding to the inclusion criteria and willing to participate were included. The patients were given treatment as usual, encompassing non-specific supportive therapy and medication. All patients were appointed for a second interview at a three-month interval. Only $N = 18$ patients respected this

appointment, despite great efforts on the part of the researcher. At the second interview, the patients were all discharged from inpatient treatment. Along with the dynamic interview, the evaluation procedure encompassed clinician-ratings of depression and mania. The patients were given the questionnaires at the end of the interview and were asked to fill them in and send them back within two days. The study was endorsed by the expert ethical committee of the psychiatric hospital.

All Plan Analyses were done by the author; reliability was established with fully-trained colleagues and students on a randomly chosen 10% of all cases (for the results see under Results section). The establishment of a prototypical Plan structure respected the following 4 steps (inspired by Ansmann, 2002): (1) An inventory of all Plans was established, encompassing Plans and goals, excluding related observed behaviors. Clearly-overlapping Plan formulations were aggregated into one Plan and counted as such. Finally, a total of 198 different Plans were found (from a total of 483 Plans over the 30 patients; APPENDIX F3). (2) A threshold of absolute frequency of 5 occurrences in the whole sample per Plan was defined; a total of 26 Plans were found. These Plans were investigated concerning the relevant instrumental connections among them: we took into account only those instrumental linkages which presented at least 5 occurrences out of 30 cases. Finally, we composed an overall prototypical Plan structure. (3) For subtypes, an exploratory thematic analysis of the prototypical Plan structure allowed grouping based on frequency of instrumental links between the Plans and goals; two basic subtypes were found. Unlike Ansmann (2002) who performed a confirmatory study on theory-driven plananalytic subtypes of Borderline Personality Disorder, to our knowledge, BD has not been investigated with regard to subtypes. Thus, subtype formation in this study was exploratory and the strategy differed slightly from that used by Ansmann. For each subtype, in order to ensure non-ambiguous classification of all cases, one reference-Plan was defined, which was (a) present in all the

cases of the related subtype and (b) absent in all cases of the other subtype. The two subgroups taken together also had to cover more than 60% of all cases (at least 18 out of 30 cases). Two reference-Plans were found; the labels of the subtypes were derived from the labels of these two reference-Plans. Subjects presenting both reference-Plans were classified as mixed. (4) Inventories of emotion frames and specific coping Plans were established.

RESULTS

Reliability Analysis for Plan Analysis

Reliability analysis (Benkert, 1997) investigated two aspects of 3 randomly chosen Plan Analyses: (1) Plan structure; (2) Emotion frames. (1) For Plan Analyses, an overall acceptable average concordance between the author and three fully-trained raters was 64% (Case 1: 81%; Case 2: 64%, Case 3: 48%). One case yielded insufficient reliability. However, since the overall average was higher than 60%, we decided to include this case. Furthermore, three other cases from this sample rated by the author were presented in supervision classes and were approved by the senior supervisor. Thus, we decided not to add a supplementary case for reliability. (2) For emotion frames, similar results were found: i.e., a sufficient average of 66% concordance (Case 1: 66%; Case 2: 77%; Case 3: 55%).

Prototypical Plan Structures

The main prototypical Plan structure is shown in figure 1; figures 2 & 3 depict the subtypes. A drawn line depicts a direct instrumental relationship between Plans and goals in the order of hierarchy: lower-level Plans in the hierarchy serve higher-order Plans, goals, motives and needs; Plans are formulated in the imperative; specific behaviors at the service of low-level Plans are all left out of the presentation (Caspar, 1995). The two subtypes are each related to a prototypical reference-Plan: (1) Figure 2 depicts the left part of the main structure

and was called “(Internal) Emotion control” (reference-Plan 1: “Avoid being harmed”). A total of 10 patients presented reference-Plan 1, but not reference-Plan 2 in their Plan structure. (2) Figure 3 depicts the right part of the main structure and was called “Relationship control” (reference-Plan 2: “Control relationships”). A total of 8 patients presented reference-Plan 2, but not reference Plan 1 in their Plan structure. Finally, 12 patients presented both reference Plans and were classified as mixed (the main Plan structure representing this group best; see figure 1). The numbers in brackets in Figures 2 and 3 represent the occurrence of each Plan and the total number of subjects included in each subgroup.

Emotions and Coping Plans

With respect to emotions, which were all linked to specific Plans (to save space, these linkages will not be presented here), a total of 116 emotion events were rated in the whole sample, distributed into 27 distinct emotion categories. The three most frequently found emotions in the sample as a whole, as well as in both subgroups, are despair, fear and anger. In addition, in the subtype 1 emotion control, shame, guilt, joy, mistrust and disgust are more frequent than 5%, and in the subtype 2 relationship control the same can be said for sadness, shame, regret and hostility (see table 1). In terms of coping Plans, the inter-subject variability was very high: a total number of 126 different coping Plans were found in the sample as a whole. Because the frequencies per subtype were therefore all very low and the between-group differences not noteworthy, we present only the overall results. The main coping Plans used by BD patients are “Avoid talking about difficult events”, “Present yourself as competent” and “Search for help”. The remaining labels for coping Plans can be found in table 2.

Prototypical Plan Structures and Symptoms

Comparing subtype emotion control (n = 10) with subtype relationship control (n = 8), we found the following between-group differences: the former is associated with higher depressive symptoms and a higher general symptomatic level (GSI), than the latter. Both subgroups display the same clinically non-significant level of mania (see table 3). These differences are not attributable to between-group differences in socio-demographic variables (gender: $\chi^2(1; n = 8) = .22$, ns; age: $t(1, 16) = 0.55$, ns; level of education: $t(1, 16) = -1.83$, ns).

DISCUSSION

Our application of Plan Analysis as a method of psychotherapeutic case conceptualization to a sample of patients presenting Bipolar Affective Disorders yields an overall prototypical Plan structure. We will first discuss the characteristics and implications of this structure in detail, then elaborate on ensuing possible psychotherapeutic attitudes and interventions.

Prototypical Plan Structure for Bipolar Affective Disorder

The main Plan structure related to BD can reliably and meaningfully be divided into two parts, yielding two subtypes, emotion control and relationship control. These are abstractions of “pure” subtypes from a plananalytic perspective, represented by two rather small parts of our sample (respectively 10 and 8 patients), and a mixed type exists which presents Plan characteristics from both subtypes. Thus, all further considerations need to be interpreted with care within this context; the presence of two subtypes does certainly not suggest an all-or-nothing principle but rather a continuum between two abstracted and simplified extremes.

As positively formulated approach Plans, one can identify for the emotion subtype “Take care of yourself” and “Assert yourself”, whereas for the relationship subtype “Realize

yourself", "Be an achiever", "Search for help" and "Be close". As negatively formulated avoidance Plans, the emotion subtype presents many, e.g., "Avoid being hurt", "Avoid negative emotions", "Avoid conflict" and "Avoid mentioning difficult events", whereas there is only one for the relationship subtype "Avoid losing the other". Thus, the relationship control subtype presents more positively formulated Plans – resulting in more approach behavior generally known as resources - than emotion control patients, who may be qualified as "arousal avoiders". In our sample, this subtype yields higher levels of depression and general symptomatology which underlines the lower level of resources in these patients. Similar avoidance Plans (including the superior Plan of "Avoid negative emotions") have been found by Ansmann on a small sample of Borderline Personality Disorder (BPD), irrespective of the BPD subtypes (dependent v autonomous subtype; Ansmann, 2002). Avoidance of negative emotions in BD patients might also be more prevalent due to heightened levels of internal emotional arousal in these patients and the presence of more intense or subjectively more disturbing affects.

Several abstracted conflicts may be inferred based on the prototypical Plan structure. For patients from the emotion subgroup, the main conflict is situated between emotion activation (arousal) and avoidance of arousal (emotional distantiation; see also Zorn, Roder, Kramer, & Pomini, 2007). The first term of the conflict (emotion activation) is not directly mentioned in the Plan structure and is based on related emotion frames, where specific (external) situations or consequences of the Plan "Assert yourself " elicit unwanted emotions in the patient (e.g., guilt); the second term of the conflict (emotion distantiation) summarizes one of the goals of the prototypical Plans in this subtype (e.g., "Avoid being overwhelmed by emotion"). This might lead to a vicious circle which tends to affect symptom intensity, e.g., depressive symptoms, as shown by the higher levels of symptoms in the emotion control subgroup. For patients from the relationship subgroup, the main conflict is situated between

proximity seeking and autonomy seeking. The former is represented by a Plan such as "Attract the other's attention", the latter by "Be yourself". Finally, for patients with mixed Plan structures, an additional conflict might arise between consequences of Plans such as "Transgress rules", which probably tend to elicit unwanted emotions (e.g., anger or guilt) and "Avoid negative emotions". As shown in table 3, these conflicts tend to influence differentially symptom intensity and might be assumed as psychological core determinants for symptomatic evolution in BD.

Compared to the study on BPD (Ansmann, 2002), invalidation of self was not found as a prototypical Plan in BD. Moreover, the goal "Maintain your self-esteem" was only present in 6 out of 30 BD cases (1 out of 8 for the relationship subtype). This relative absence of self-esteem Plans and goals (either expressed in a negative or positive sense) in a large part of the sample underlines the fragility of BD patients, self-esteem being generally one of the main resource aspects of human functioning (see Grawe, 1998). Compared to the prototypical Plan structure of Major Depression (Caspar, 1995), BD patients develop more Plans related to the fear of loss of control over oneself and one's emotions. Such fears find their expression in Plans such as "Avoid negative emotions". In such patients, these fears might be based on previous experiences of loss of control due to heightened levels of emotional arousal, i.e., in manic states, or when a significant other has lost self-control, e.g., a parent's violent behavior as traumatic childhood experience. High expectations and eliciting consideration from others are reserved to the prototypical Plan structure for unipolar depression and was not found in the BD sample. This emphasizes the importance of prototypical Plan structures indicating specific dynamics for each group of patients and, ultimately, of tailor-made disorder-specific interventions.

With regard to emotions, in addition to what one might call the "BD emotional triad" despair, fear and anger, the most frequently observed emotions irrespective of the subtype,

several others are elicited in the patients in this context. Since no difference-testing was made, due to low frequencies, we will not interpret these scant between-group differences. However, it is remarkable that in BD, almost all rated emotions are negative, even if some patients present hypomanic symptoms. There are several exceptions, including joy. It can be hypothesized that the occasionally observed positive mood in these patients does not imply the presence of underlying positive affects and emotions; on the contrary, it might hide - defensively concealed - underlying emotion negativity in BD. This assumption can be exemplified by the two most frequently used coping Plans in BD: “Avoid talking about difficult events” and “Present yourself as competent”. Both Plans might elicit positive emotions in the short term – or on the surface - but as shown by the instrumental embeddedness of these two Plans in the Plan structure (and related negative emotions when the Plans are blocked), their real long-term effects might not always be helpful for an individual presenting these Plans (see Skinner, Edge, Altman, & Sherwood, 2003, for a detailed definition of coping adaptiveness).

Motive-Oriented Therapeutic Relationship and Tailor-made Interventions

The motive-oriented psychotherapeutic relationship (Caspar, Grossmann, Unmüssig, & Schramm, 2006; Caspar, 2007) was introduced by Grawe (1992a) under the label of Complementary Therapeutic Relationship. The principle is based on Plan Analysis and allows the clinician to adopt a constructive and malleable stance to deal with the Plan dynamics in the specific patient. In a radically instrumental perspective, the clinician asks the following questions (1) “Which Plans and motives in the patient may I fully endorse within the therapeutic relationship?” (the response as Plan is generally found in the upper third of the Plan structure, where more motive-related Plans are located) and (2) “How should I as the

therapist behave in each clinical situation, to respect this Plan and underlying motive and to show the patient that I respect the Plan and motive?"

For the emotion control subtype, possible therapeutic attitudes include reassuring to the patient that the therapist will do everything to avoid for the patient being psychologically harmed during therapy (see the Plan "Avoid being harmed"), conveying to the patient that it is perfectly acceptable for him/her to want to protect him-/herself (see the Plan "Protect yourself") and, finally, convey to the patient that therapy is a safe place (Reddemann, 2001). Motive-orientedness with the over-arching Plan "Avoid being harmed", if it is realized by the therapist as avoidance of negative arousal in the patient, might be accurate in the initial sessions, but therapy would probably fail if aimed only at avoiding talking about negative events, since we assume with our case conceptualizations that there are real negative – in some cases probably traumatic (see also above) - events to work through with such patients. Hence, trauma-related interventions, such as imagination techniques and carefully planned exposure therapy (Reddemann, 2001; Foa, Rothbaum, Riggs, & Murdock, 1991 ; for a tailor-made application of such standardized methods, see Kramer, accepted for publication) might be indicated for this subgroup, as they would enable the patient to experience safely emotion activation related to trauma-related contents. Finally, a well-tailored skills-training focusing on emotion regulation (Linehan, 1993) is an important therapeutic ingredient for patients from this subtype.

For the relationship control subtype, with slightly higher resources, the therapist might adopt the following attitudes according to the principles of the motive-oriented therapeutic relationship: the therapist must show the patient that the latter can completely count on the former within the limitations of the therapeutic relationship (see the Plan "Avoid losing the other"). In addition, the therapist should show that it is possible to realize one's own dreams and ideas and yet be dependent on significant others (see the conflict between "Realize

yourself" and "Avoid losing the other"). The therapist may also, where appropriate, pay great attention to the patient's discourse (e.g., by showing that he/she remembers what was said in the previous session). However, we also know from the Plan structure, that there are clinical situations where the patient tends to attract the therapist's attention by using unacceptable or less helpful means, e.g., by transgressing rules, by playing the role of a victim. If such behavior or low-order Plans are part of an "intransparent interactional play-structure" (Sachse, 2004), the therapist should point it out and, if the timing is correct, clarify it within the therapeutic relationship (Sachse, 2003). The therapist can at the same time reassure the patient of his/her presence as a therapeutic caregiver and a genuinely attentive listener, which would again be motive-oriented.

Finally, we mention several limitations of this study. First, by aggregating a host of individualized case conceptualizations into one single – broken down into two parts – prototypical Plan structure, we run the risk of ignoring clinically important information for individual cases, features that were observed rarely and which did not yield the significance level to be included the prototypical structure. Likewise, a complete case conceptualization and therapy planning for an individual patient needs to encompass far more detail in an individualized language adapted to the patient (see Caspar, 2007; for practical guidelines see Grawe, Grawe-Gerber, Heiniger, Ambühl, & Caspar, 1996; for a clinical example see Heiniger, Grawe-Gerber, Ambühl, Grawe, & Braun, 1996, and also Kramer, accepted for publication). As our aim is to apply Plan Analysis to an entire sample of BD patients and explore their similarities in terms of prototypicality, rather than their inter-individual differences, our suggestions for treatment planning can be understood as only a tentative illustration of the concept of motive-oriented therapeutic relationship. Our results of a prototypical case conceptualization based on individual clinical material may be particularly useful in clinically challenging situations with BD patients, where a negative emotional

reaction in the therapist (e.g., irritation) is involved, in situations when the manual-based set of interventions shows its limitations (Basco, & Rush, 2005) or when the therapeutic relationship with a patient is at stake. We believe these results are encouraging for the clinical work and we hope they may help clinicians to conduct even more efficient psychotherapeutic interventions as the adjunct to state-of-the-art pharmacological treatments for BD patients.

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Table 1

Frequencies of Emotions in Total and per Subtype

Emotion	Total (N = 30)	Emotion Control (n = 10)	Relationship Control (n = 8)
Despair	20 (17%)	7 (19%)	5 (19%)
Fear	15 (13%)	5 (14%)	4 (15%)
Anger	14 (12%)	4 (11%)	5 (19%)
Sadness	11 (9%)	1 (3%)	4 (15%)
Shame	11 (9%)	2 (5%)	2 (7%)
Guilt	6 (5%)	3 (8%)	0
Joy	6 (5%)	4 (11%)	1 (4%)
Regret	5 (4%)	1 (3%)	2 (7%)
Mistrust	4 (3%)	2 (5%)	0
Hostility	3 (3%)	1 (3%)	2 (7%)
Pride	3 (3%)	0	0
Satisfaction	2 (2%)	0	0
Disgust	2 (2%)	2 (5%)	0

Note. The following emotions were found once in the whole sample: Anxiety, Self-pity, Discouragement, Embarrassment, Apprehension, Inhibition, Irritation, Enthusiasm, Vexation, Fear, Worry, Admiration, Resentment, Emotional Fatigue. Total for Emotion Control: 37 Emotions; Total for Relationship Control: 27 Emotions; Grand Total: 116 Emotions.

Table 2

Frequencies of Coping Plans

Coping Plan	Frequency
Avoid talking about difficult events	14 (11%)
Present yourself as competent	11 (9%)
Search for help	10 (8%)
Avoid remaining alone	9 (7%)
Accuse your environment of causing your problems	8 (6%)
Conform with rules	8 (6%)
Take your responsibility	8 (6%)
Distract yourself	7 (6%)
Do everything to satisfy other people	6 (5%)
Do everything to impress the therapist	5 (4%)
Seduce a loved person	3 (2%)
Do everything to avoid being asked uncomfortable questions	3 (2%)
Isolate yourself	3 (2%)
Present yourself as a victim	3 (2%)
Minimize your difficulties	3 (2%)
Avoid engaging in too close relationships	3 (2%)
Avoid stressful situations	2 (2%)
Provoke a dispute	2 (2%)
Emphasize your need of a special treatment	2 (2%)

Note. Only frequencies greater than 1 reported in the table. Total Coping Plans for the 30 patients: 126.

Table 3

Between-Group Differences with regard to Symptoms

Variable	Emotion		Relationship		*T*(1,17)	ES
	M	SD	M	SD		
GSI	1.69	0.98	0.91	0.38	2.91*	1.05
MADRS	19.10	12.64	12.00	7.19	1.99*	0.69
BRMS	2.30	2.05	4.13	3.44	1.96	0.65

Note. Emotion: Plananalytic subgroup characterized by internal stress regulation (n = 10); Relationship: Plananalytic subgroup characterized by stress regulation by using interpersonal relationships (n = 8); GSI: General Symptom Index from the Symptom Checklist 90-R; MADRS: Montgomery-Asberg Depression Rating Scale; BRMS: Bech-Rafaelson Mania Scale. Bonferroni's correction applied.

* $p < .05$

Figure 1

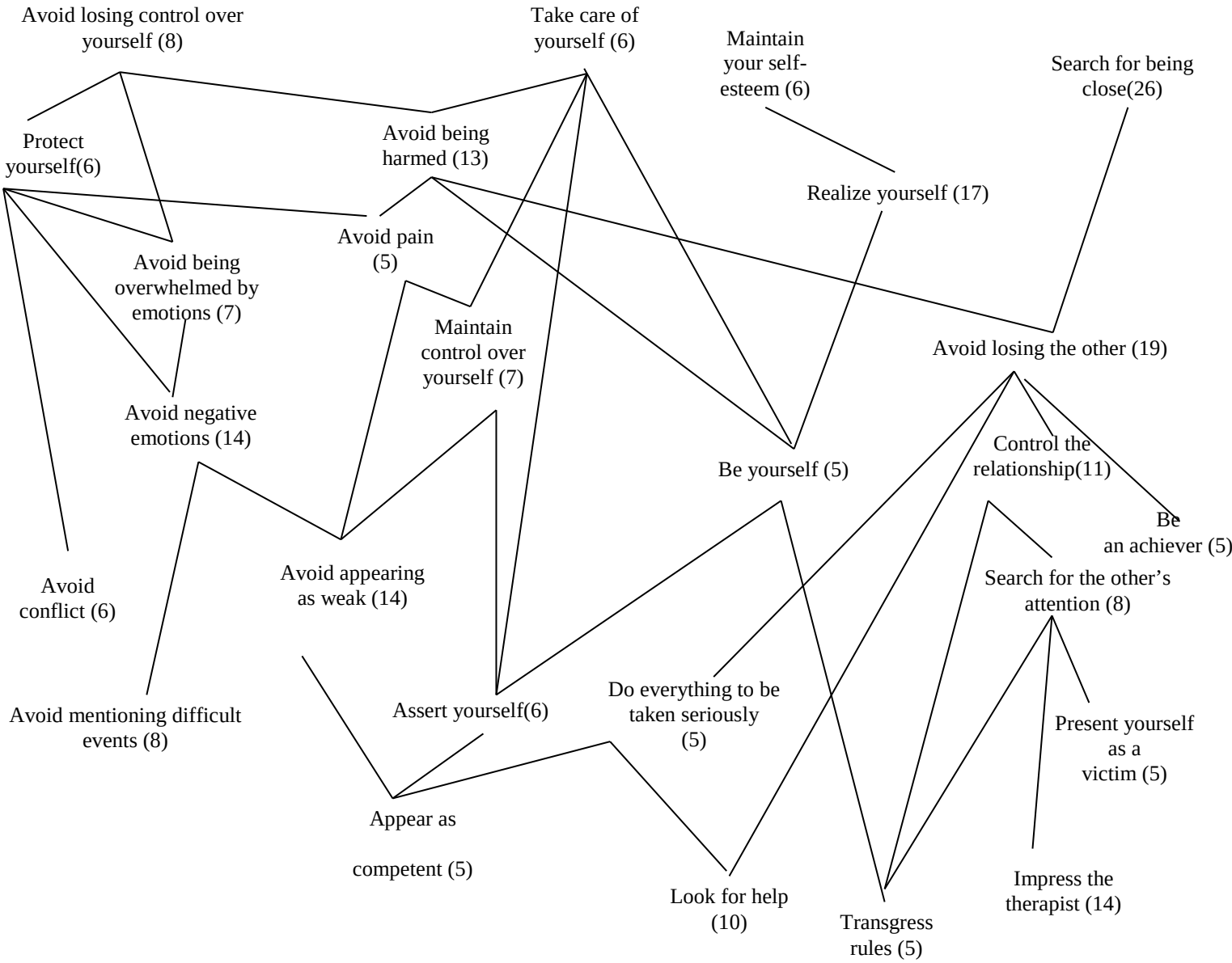

Avoid losing control over yourself (8)
Take care of yourself (6)
Maintain your self-esteem (6)
Search for being close(26)
Protect yourself(6)
Avoid being harmed (13)
Realize yourself (17)
Avoid pain (5)
Avoid being overwhelmed by emotions (7)
Maintain control over yourself (7)
Avoid losing the other (19)
Avoid negative emotions (14)
Be yourself (5)
Control the relationship(11)
Be an achiever (5)
Avoid conflict (6)
Avoid appearing as weak (14)
Search for the other's attention (8)
Avoid mentioning difficult events (8)
Assert yourself(6)
Do everything to be taken seriously (5)
Present yourself as a victim (5)
Appear as competent (5)
Look for help (10)
Impress the therapist (14)
Transgress rules (5)

Figure 2

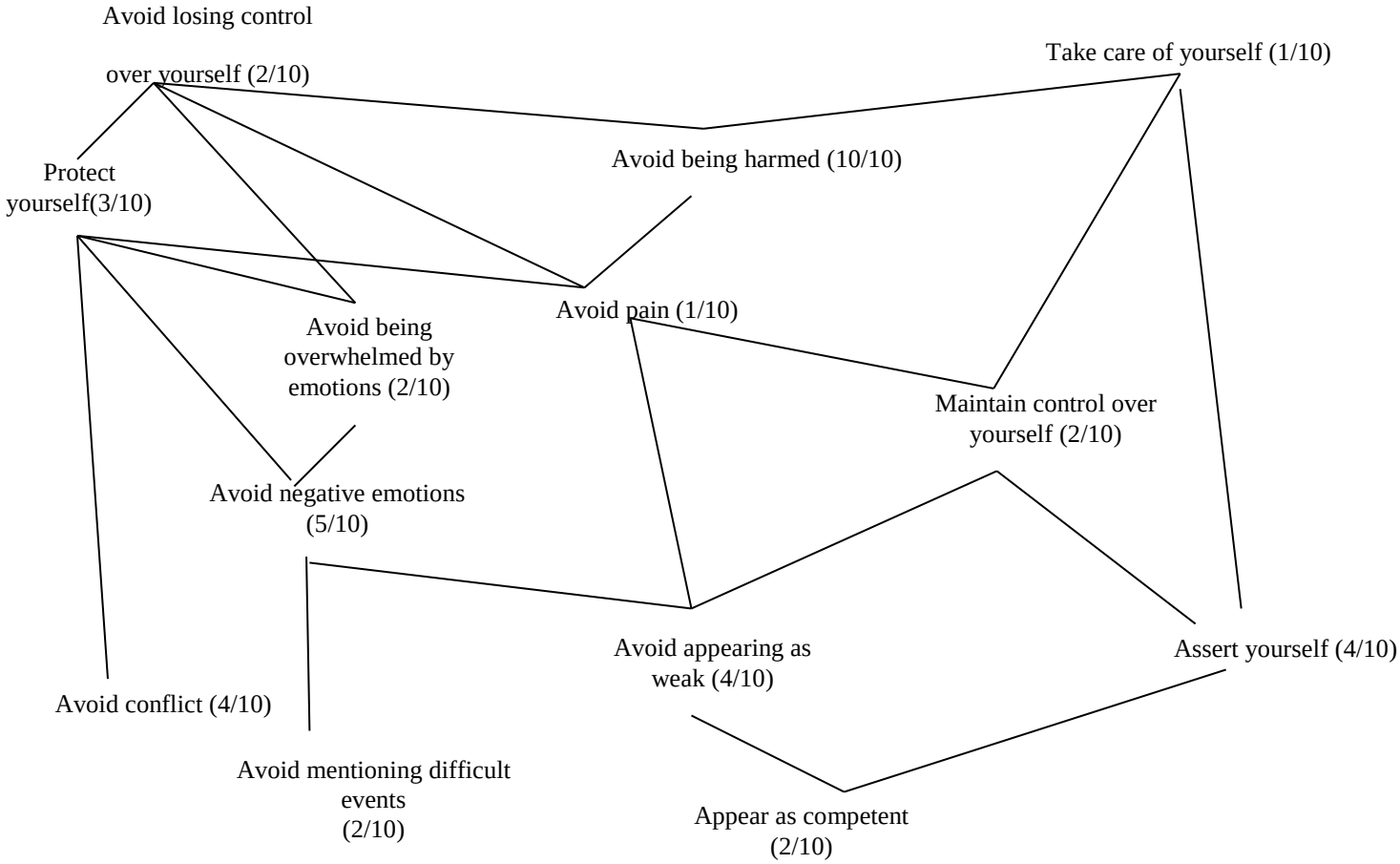

Avoid losing control over yourself (2/10)
Take care of yourself (1/10)
Protect yourself(3/10)
Avoid being harmed (10/10)
Avoid pain (1/10)
Avoid being overwhelmed by emotions (2/10)
Maintain control over yourself (2/10)
Avoid negative emotions (5/10)
Avoid appearing as weak (4/10)
Assert yourself (4/10)
Avoid conflict (4/10)
Avoid mentioning difficult events (2/10)
Appear as competent (2/10)

Figure 3

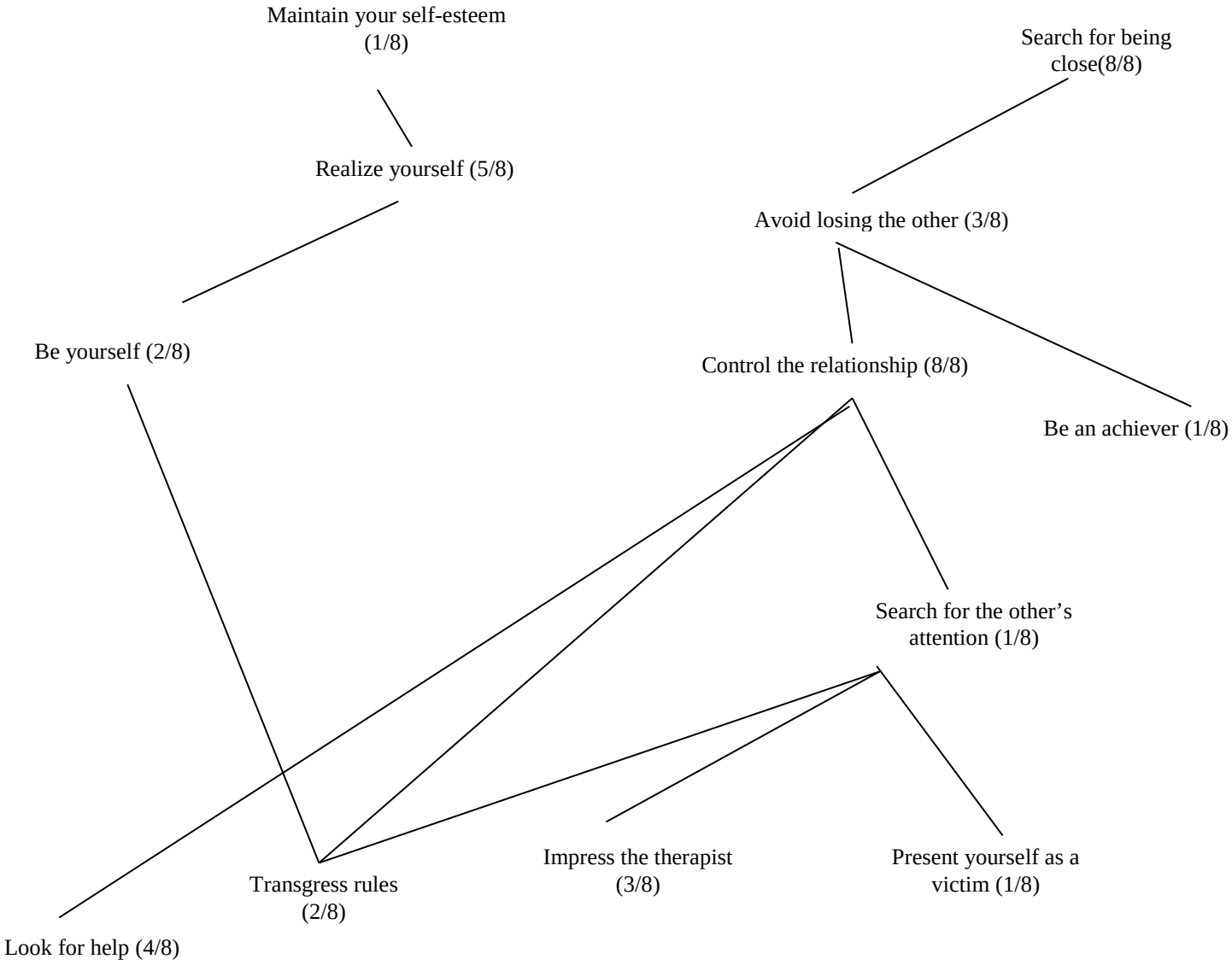

Maintain your self-esteem (1/8)
Search for being close(8/8)
Realize yourself (5/8)
Avoid losing the other (3/8)
Be yourself (2/8)
Control the relationship (8/8)
Be an achiever (1/8)
Search for the other's attention (1/8)
Impress the therapist (3/8)
Present yourself as a victim (1/8)
Transgress rules (2/8)
Look for help (4/8)

FIGURE CAPTIONS

Figure 1

Prototypical Plan Structure for Bipolar Affective Disorder (*N* = 30 patients)

Figure 2

Prototypical Plan Structure for the Subtype “Emotion Control” (*n* = 10 patients)

Figure 3

Prototypical Plan Structure for the Subtype “Relationship Control” (*n* = 8 patients)

Figure 3

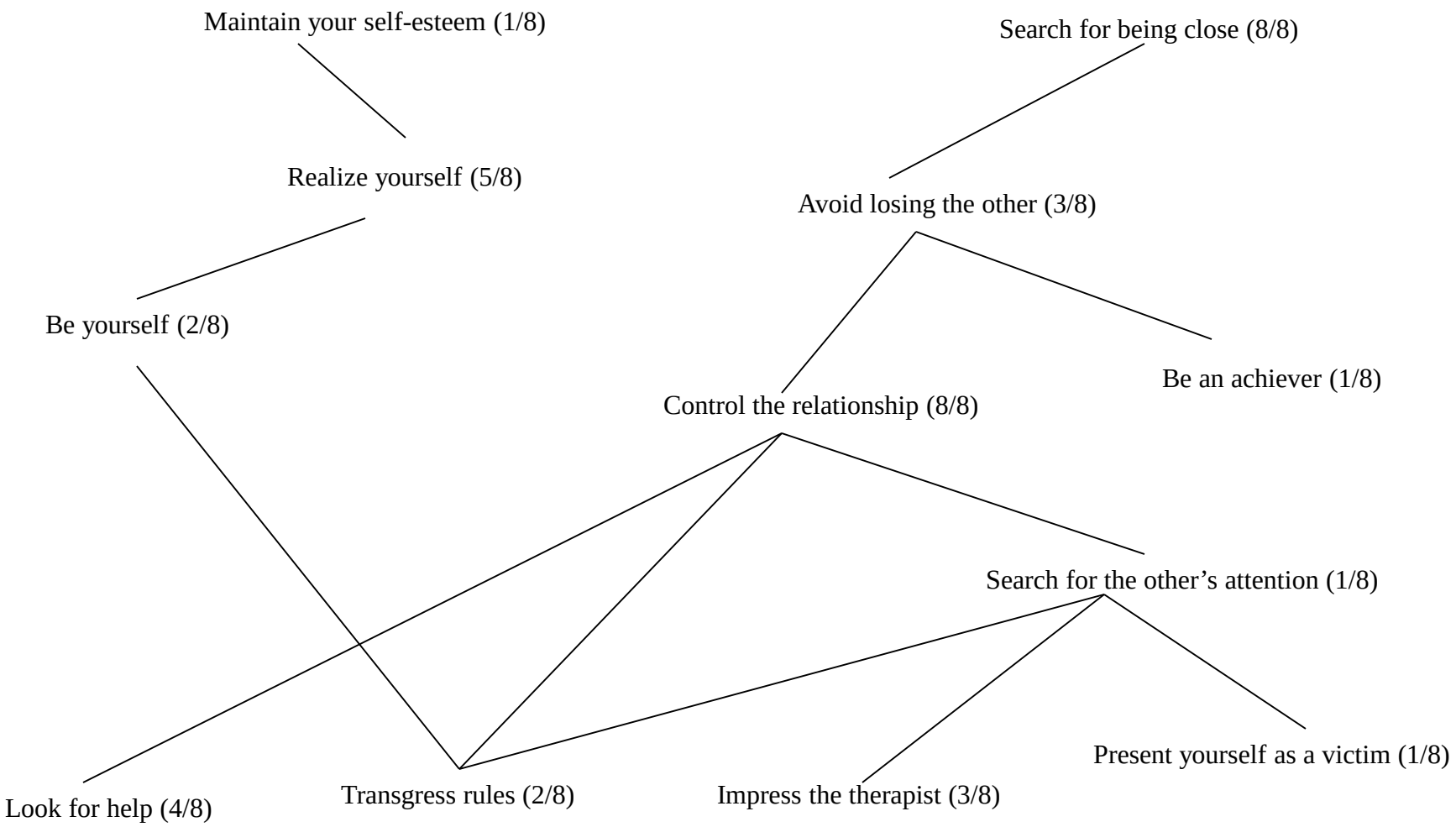

Maintain your self-esteem (1/8)
Search for being close (8/8)
Realize yourself (5/8)
Avoid losing the other (3/8)
Be yourself (2/8)
Be an achiever (1/8)
Control the relationship (8/8)
Search for the other’s attention (1/8)
Present yourself as a victim (1/8)
Look for help (4/8)
Transgress rules (2/8)
Impress the therapist (3/8)

Figure 2

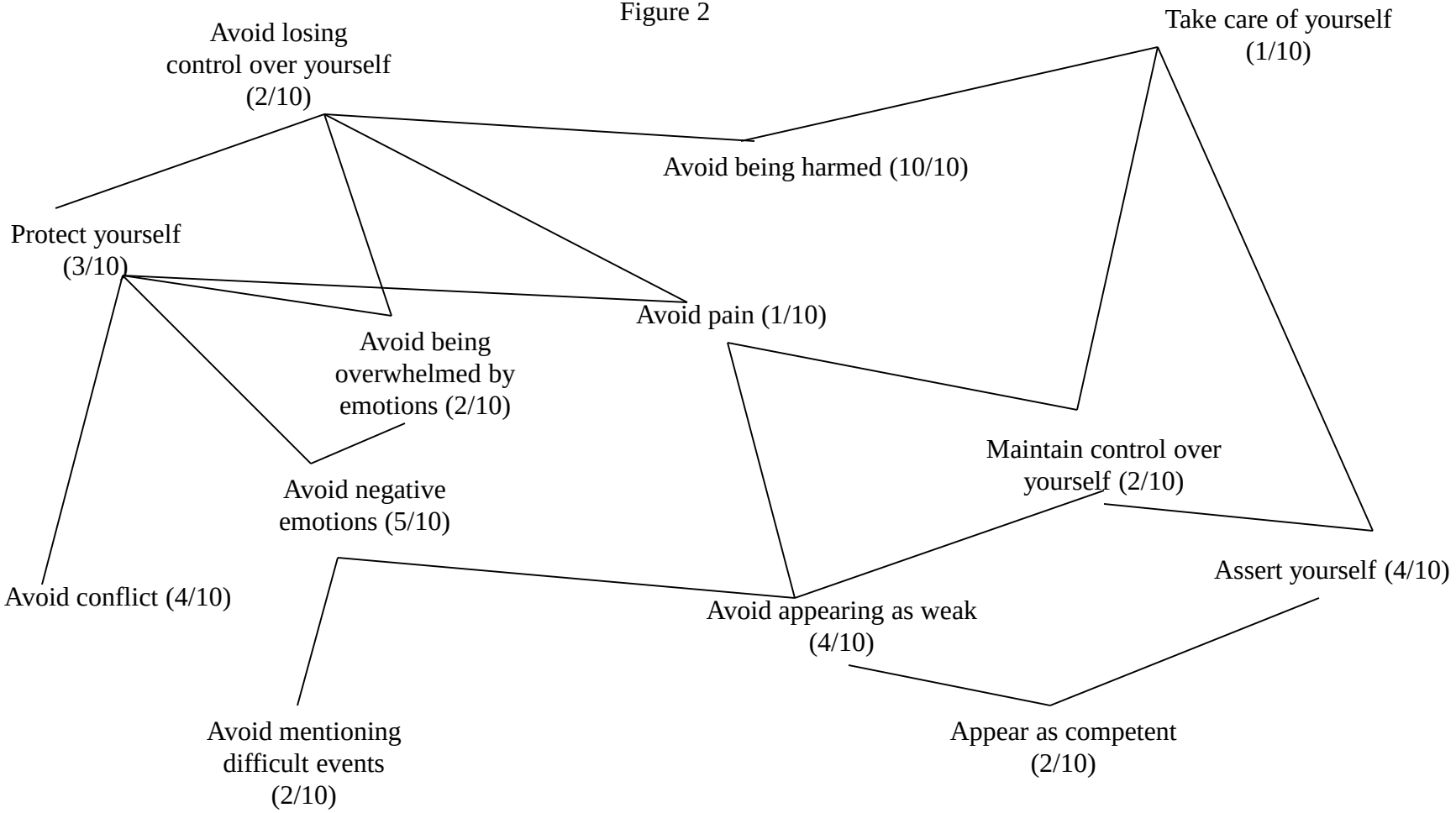
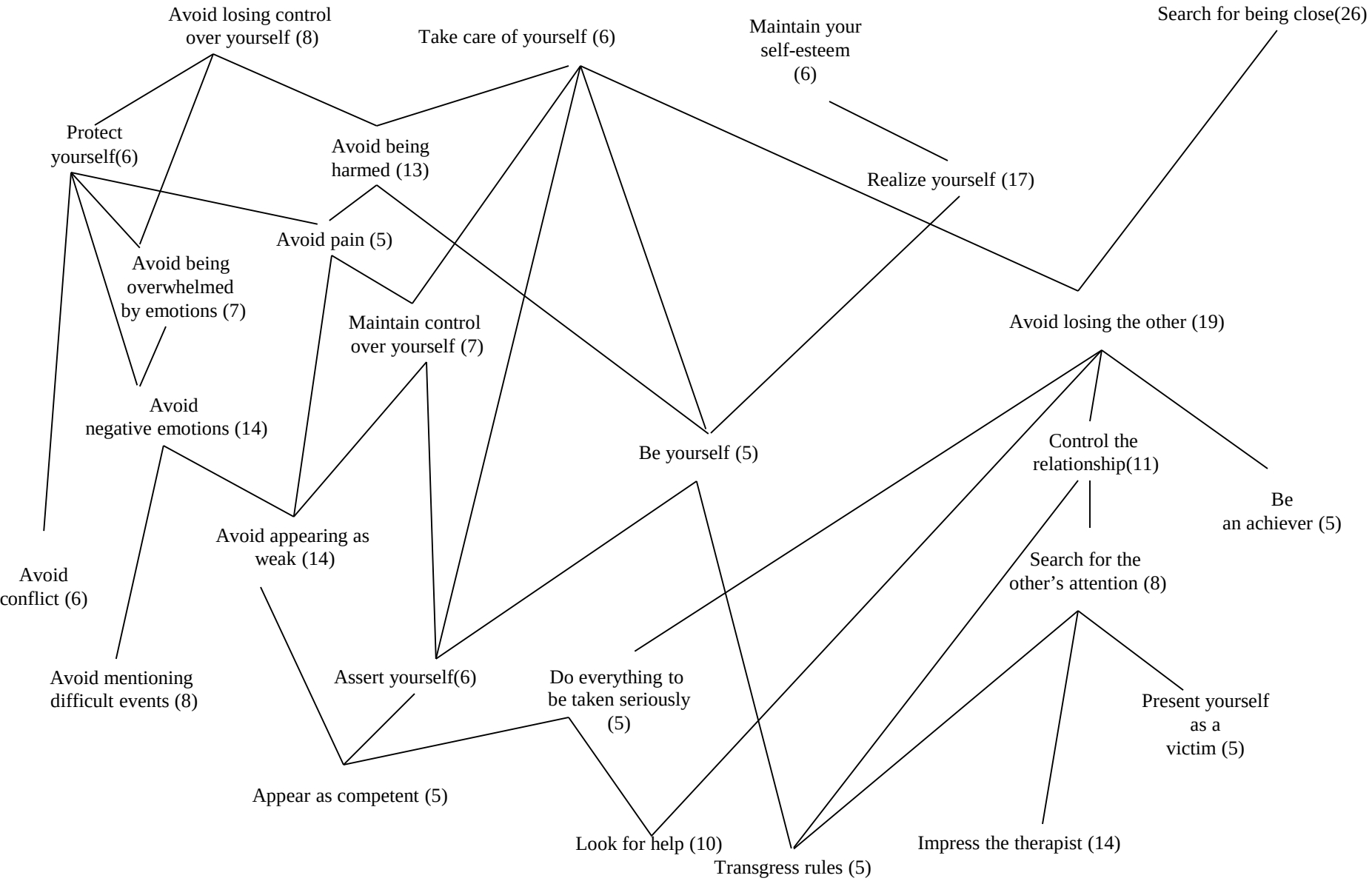

Avoid losing control over yourself (2/10)
Take care of yourself (1/10)
Avoid being harmed (10/10)
Protect yourself (3/10)
Avoid pain (1/10)
Avoid being overwhelmed by emotions (2/10)
Maintain control over yourself (2/10)
Avoid negative emotions (5/10)
Avoid conflict (4/10)
Assert yourself (4/10)
Avoid appearing as weak (4/10)
Avoid mentioning difficult events (2/10)
Appear as competent (2/10)

Figure 1


Avoid losing control over yourself (8)
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Avoid being overwhelmed by emotions (7)
Maintain control over yourself (7)
Avoid losing the other (19)
Avoid negative emotions (14)
Be yourself (5)
Control the relationship(11)
Be an achiever (5)
Avoid appearing as weak (14)
Avoid conflict (6)
Search for the other's attention (8)
Avoid mentioning difficult events (8)
Assert yourself(6)
Do everything to be taken seriously (5)
Present yourself as a victim (5)
Appear as competent (5)
Look for help (10)
Impress the therapist (14)
Transgress rules (5)