

## Unmet Needs and Maladaptive Modes: A New Way to Approach Longer-Term Problems

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Flanagan (2010) proposed an approach to longer-term problems that targets core psychological needs. Unmet needs were causally linked to early maladaptive schemas and faulty modes of coping. Here a novel approach to the treatment of maladaptive modes is described. It begins with a matrix of 8 modes, as they occur in healthy individuals. These distinct patterns are claimed to represent a basic inventory of coping strategies that equip individuals to adapt and satisfy ongoing needs. A matrix of the same modes is then introduced as they occur maladaptively. This matrix specifies components of the different modes, potentially facilitating interventions that address both mode structure and content, and is illustrated in a case study. I also examine the concept of mode as used in schema therapy, and acknowledge similar constructs in other schools of psychotherapy.

*Keywords:* matrix, modes, needs, schemas, self

In Flanagan (2010) the potential of a needs-based approach to psychotherapy was discussed with specific emphasis on applications in cognitive and schema therapies. It was proposed that humans are motivated to fulfill at least six basic needs—for desirability, connection, autonomy, stability, change, and self-comprehension. Identification of these needs was based on extended clinical observations, augmented by ethological research, and the model was compared to other listings of needs (Baumeister & Leary, 1995; Deci & Ryan, 1985; Epstein, 1991; Heine, Proulx, & Vohs, 2006; Young, Klosko, & Weishaar, 2003). None of the proposed needs was claimed to be the most basic or significant, nor were needs viewed as hierarchically organized. However, it was suggested that trade-offs and conflicts occur within three pairs of needs (connection-autonomy, stability-change, and desirability-self-comprehension). It was also proposed that needs are expressed through a repertoire of coping strategies, or modes. Little was said, however, about the properties of these modes or

how they operate in everyday life, a primary focus of the current article.<sup>1</sup>

Here, using the same model of needs as a point of departure, I begin by examining the short history of modes in cognitive psychotherapy (CBT) and schema therapy (ST), suggesting improvements in certain theoretical and clinical aspects of the mode concept as currently used in ST. I then compare the mode concept to similar constructs in research and clinical literatures and identify recent findings in the cognitive sciences that illustrate proposed mechanisms of modes.

In Flanagan (2010) a needs-based account that attempted to identify links between unmet needs, early maladaptive schemas (EMSs), and maladaptive modes was offered. The goal was to develop a more streamlined approach to the

<sup>1</sup> Before proceeding it may be helpful to say something about needs as components of a broader system of human motivations. As a heavily social species, humans are equipped with biological mechanisms that are specialized for social operations, and are predisposed to use those mechanisms strategically (Locke & Flanagan, 2013, in submission). Psychological needs are thus seen as providing the incentive to activate coping modes that, if exercised competently, will indirectly help individuals to meet biological goals and solve a variety of other environmental problems. Flexibility in the implementation of these modes is essential for healthy functioning (see Flanagan, 2010 for a listing of these proposed needs).

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treatment of longer-term problems, formalizing a long-held interest in the potential significance of modes (Flanagan, 1998). I expand on this topic here, characterizing modes as strategies intended to meet core needs and adapt to shifting environmental demands. Using a matrix as a heuristic, adaptive and maladaptive versions of eight modes are discussed. It is hoped that the matrix, as a new way of conceptualizing modes and examining their internal constituents, will help enhance features of treatment that address both mode structure and content. A case example illustrates how these ideas can be integrated in practice and how perceived challenges in the ST model might be resolved.

Many of the issues addressed here have been discussed by theorists from other orientations using the language associated with those perspectives (e.g., Westen, Gabbard, & Ortigo, 2008). Thus, much of what I will propose is relevant to the wider goals of integration and unification in psychotherapy and clinical science (Magnavita, 2008; Mayer, 2005; Pincus, 2010; Wolfe, 2008). Many other ideas are new and, although the speculations are mostly consistent with recent trends and findings in cognitive science and psychotherapy, each speculation ultimately must be empirically verified.

### The Concept of Mode in Cognitive and Schema Therapies

The first specific reference to modes in CBT came in the 1990s. In explaining the formation of the personality disorders (PDs), Beck suggested that each disorder is associated with certain core beliefs and strategies, giving them distinctive profiles (Beck, Freeman, & Associates, 1990; see also Beck, 2005). Later, recognizing the limitations of this model, he developed a theory of modes, defining them as an “integrated network of cognitive, affective, motivational and behavioral components” or “sub-organizations of personality” (Beck, 1996, p. 2).

In parallel with Beck, Young (1990) developed ST based on the assumption that chronically unmet needs in childhood result in EMSs, hypersensitivities to certain classes of experience, for example, abandonment, deprivation, or subjugation. EMSs are maintained through avoidance, overcompensation and maintenance, strategies that ultimately become self-defeating (see Bricker, Young, & Flanagan, 1993; Flana-

gan, 2010; Young, Klosko, & Weishaar, 2003). Later, Young also adopted the mode concept, first to explain borderline personality disorder (BPD), then to account for narcissistic personality disorder (NPD; Young & Flanagan, 1998). He offered two definitions of modes: (a) “those schemas or schema operations—adaptive or maladaptive—that are currently active for an individual,” and (b) “a facet of the self involving specific schemas or schema operations that has not been fully integrated with other facets” (Young et al., 2003, pp. 37, 40).

The introduction of the mode construct was intended to produce a simplification of the ST model and an elaboration of its treatment options. The concept has been greatly expanded in recent years with the labeling of Child Modes, Parent Modes, and Coping modes (the latter bearing some similarity to modes as discussed here). It has also proven to be extremely clinically effective (Giesen-Bloo et al., 2006). However, there are concerns.

The first concern relates to a shift in focus from individual EMSs to schema modes and a greater emphasis on early attachments. With the increasing incorporation of attachment and object relations theories (Bowlby, 1980; Sandler & Rosenblatt, 1962) and the related endeavor to identify Child and Parent modes, attention has been diverted from the broader agenda of unmet needs in general—the original goal of ST. Because schema modes, like EMSs, result from the frustration of basic needs, it is surprising that Young has not attempted to specify connections between particular unmet needs and either EMSs or modes. While acknowledging the pivotal importance of early attachments, the model proposed here emphasizes a *range* of needs. The clinical literature, moreover, is replete with evidence concerning the distinct roles of many needs, including self-esteem and self-enhancement (Beck, 1983; Gilbert & Irons, 2005), a stable base and consistent sense of self (Epstein, 1991), and autonomy and competence (Blatt, Shahar, & Zuroff, 2001; Deci & Ryan, 1985).

A second concern relates to the ever-expanding inventory of proposed modes. In the first version of the schema mode model, Young et al. (2003) defined 10 different schema modes. Recently others have proposed as many as 22 and “it is thought that clinicians and researchers will continue to ‘invite’ more modes because they feel these modes are required to understand

specific types of personalities” (Lobbestael, van Vreeswijk, & van Arntz, 2007, p. 82). As the complexities of this endeavor have become more apparent, however, questions are being raised as to the ultimate goal of mode conceptualization, that is, to continue with efforts to describe the modes of all the PDs or to provide a limited set of basic modes to understand PDs in more general terms (Lobbestael et al., 2007; Van Genderen, Rijkeboer, & Arntz, 2012). The latter objective seems more in keeping with the original goal of *simplification*. The matrix is expected to provide such a framework for both identifying, and differentiating between, Coping modes. These modes could then be linked to specific unmet needs and EMSs, and to particular Child and Parent modes, ultimately enabling construction of needs-based profiles for the different personality disorders and a more integrated model.

A third concern relates to the role of implicit processes in everyday life and in pathology (see Proposed Mechanisms of Modes). If we are to understand the microprocesses inherent in the mode shifts we are endeavoring to address and modify (Westen et al., 2008), schema therapists will need to keep abreast of advances in cognitive science. The matrix to be presented offers insights into the occurrence and function of rapid mode “flips.” In contrast with recent statements: “Normally, patients have only one coping style” (Van Genderen et al., 2012, p. 32), and cognitions, emotions, and behaviors “are so consistent with each other that they change synchronically” (Lobbestael et al., 2007, p. 82), these three components can and do change *independently* of one another. Moreover, it is precisely the flexible interplay of elements that explains the versatility and diversity of modes, and allows for the targeted interventions to be described (also see Baumeister, Bratlavsky, Finkenauer, & Vohs, 2001; Liotti & Gilbert, 2011).

Modes and mode-related constructs are also visible in the work of other CBT theoreticians, including Wells’s metacognitive therapy (Wells, 2000), Teasdale’s “mind in place” (Teasdale’s, 1997), and Gilbert’s “social mentalities” (Gilbert, 2005); also his compassionate mind therapy where three distinct modes of affect regulation are described (Gilbert, 2010). In summary, modes have been defined in purely cognitive terms, in relation to affect regulation,

as suborganizations of personality, and as parts of the self. As indicated, several theorists have also shifted their focus from coping strategies to what they view as the broader concept of modes.

Here coping strategies and modes will be treated equivalently. Modes are defined as adaptive strategies for satisfying needs, having behavioral, cognitive, and affective components. In optimal circumstances, they are likely to facilitate environmental adaptations and need satisfaction. I will propose that habitual modes can feel like parts of the self, especially where maladaptive forms of early survival strategies persist into adulthood. The goal of a needs-based therapy is to help clients meet their core needs by developing modes that are flexible and effective. As dysfunctional modes become more functional, clients can learn to draw on a larger menu of strategies and meet a wider range of needs.

### Modes Related Constructs and the Proposed Mechanisms of Modes

Below I explore constructs in the research and clinical literatures that share features with modes and I identify basic issues and recent findings in cognitive science that support the type of modes proposed here.

#### Research and Clinical Literatures

**1. Research literature.** There is an extensive literature on coping and coping styles but theorists differ in their use of these terms. Some refer to “coping strategies” as the ways people deal with change under normal conditions (Lazarus & Folkman, 1984), others emphasize adaptability in conditions of pressure or change (Latack & Havlovic, 1992). Some stress the role of trait-like aspects of coping (Endler, Parker, & Butcher, 1993) whereas others focus on state or situational qualities (Ouimette, Finney, & Moos, 1999). Modes are seen here as adaptive strategies that operate as states when deployed as momentary adaptations but if habitualized can come to feel more like traits. They are not simply recruited in stressful or novel situations but are an integral component of daily life and, as such, must be flexible. Paradoxically, clients with longer-term problems tend to show *more* consistency in their mode profiles and usage

than healthier people whose responses are adaptable and, therefore, diverse.

The interpersonal circumplex (IPC) model predicts that people will behave with relative consistency, at least with regard to agency and communion (Locke, 2011). By contrast, in the model proposed here modes are dynamic action possibilities, defined by six competing needs that include both agency (autonomy) and communion (connection; Flanagan, 2010). Moreover, although modes can become habitual, they are not viewed as global predispositions. The IPC has recently been incorporated into a dynamic control model that allows for nuanced analysis of real time interpersonal exchanges (Henriques, 2011). The motive to acquire social influence is seen as central, however, in contrast with the view espoused here that emphasizes the role of a range of needs (see Roche, Pincus, Conroy, Hyde, & Ram, 2013, for discussion of the cognitive-affective processing system and interpersonal theory).

**2. Clinical literature.** A number of mode-related constructs also appear in the broader clinical literatures. Jung postulated that humans inherit specific predispositions for thoughts, feelings and actions, calling these innate coping systems *archetypes* (Jung, 1970). Moreover, since Ainsworth (1969); Bowlby (1969), and Sandler and Rosenblatt (1962), many have tried to explain how early attachment experiences can result in distinctive cognitive-affective representations of the self and others, and in enduring patterns of relating and coping (Del Giudice, 2009).

Modern psychodynamic theory continues to emphasize the importance of competing motivations and unconscious processes and, increasingly also, core elements of attachment and object relations theory (Westen et al., 2008). For example, Blatt and colleagues have investigated several dimensions of object relations and developed new procedures to assess aspects of mental representations (Blatt, Auerbach, & Levy, 1997). Using constructs similar to Beck's dimensions of sociotropy and autonomy (Beck, 1983), another study concluded that because we need to establish warm, stable interpersonal relations and also a positive, clearly defined sense of self, an overemphasis on either one can lead to an anaclitic-dependent or to an introjective-self-critical personality organization, and predispose individuals to specific psychopatholo-

gies and distinct responses to treatment (Blatt et al., 2001). The current model is germane to a related endeavor that is, differentiating between clients for whom interventions that focus on mode content, or those that target mode structure, may be most effective. This point is illustrated in the case study.

Significant here also is recent work reflecting an increased attention to microprocesses and a need for greater precision in describing how psychological events transpire (see Westen et al., 2008). Examples include efforts to operationalize psychoanalytic and other concepts about mental states and processes, and develop an empirically derived taxonomy for personality diagnoses (Westen, Shedler, Bradley, & deFife, 2012; also Luyten & Blatt, 2011).

In other areas of contemporary psychotherapy one also finds various approaches to the description and modification of mode-like constructs such as selves, parts, facets, energy patterns, subpersonalities, ego states, and modes (Kellogg, 2004; Schwartz, 1995; Stone & Stone, 1989; Watkins & Watkins, 1997). All of these approaches embrace a multifaceted view of the self and personality, as does the model proposed here.

### Proposed Mechanisms of Modes

In recent years, awareness has increased in the role of implicit trade-offs in maintaining harmony between self and environment. Here I identify basic issues and recent findings in the cognitive sciences that illustrate the type of modes proposed here.

**1. Implicit processes and the everyday unconscious.** It is now recognized that a great deal of information processing occurs automatically and unconsciously (Bargh & Chartrand, 1999; Kahneman, 2012), limiting our ability to exercise conscious control (Bongers, Dijksterhuis, & Spears, 2010). Two fundamental modes of processing have been identified: the first is analytical and rational (or propositional), the second intuitive and experiential (or implicational; Kihlstrom, 1999).

Traditional dual-process models of cognition characterize the unconscious as relatively crude and inaccessible. However, covert learning can produce highly organized systems of tacit rules and assumptions. They are believed to hold evolutionary primacy over explicit learning but



are less manipulable (Kihlstrom, 2008). The flexible nature of implicit processes also suggests that many of the complex activities involved in goal striving and decision-making are carried out unconsciously (Huang & Bargh, 2014). In other words, people need not be aware of their goals to engage in goal-oriented behavior. The same is true for the effects of people's attitudes about themselves and others and ongoing social cognitions and behaviors (see Gawronski & Payne, 2010; Lieberman, 2000, and Strack & Deutsch, 2004). Thus, if healthy individuals automatically switch back and forth between modes then the unconscious mind must allow for such flexibility without signaling that such operations are underway.

**2. The mind in context: Goals, triggers, and trade-offs.** Recent evidence indicates that humans have several motivational systems that can be situationally activated, and there is a continual interplay between these systems and ongoing appraisals of environmental threats and opportunities (Neuberg, Kenrick, Maner, & Schaller, 2004; Van Vugt & Spisak, 2008). Along with feelings, motivational systems include specific problem-solving tools designed to manage the "trade-offs" involved in pursuing one goal or agenda over another (Gangestad & Simpson, 2000). According to Kenrick and his colleagues, the degree to which needs set adaptive responses in motion "must be calibrated to specific threats and opportunities in the immediate ecological context" (Kenrick, Griskevicius, Neuberg, & Schaller, 2010, p. 302; also see Bargh & Morsella, 2008; Mesquita, Feldman, & Smith, 2010). It is unlikely that this would be adaptive if, in evolutionary history, this calibration had to be done consciously. Furthermore, temporary activation of a single specific motive may influence a range of thoughts and behaviors that appear to be functionally linked. Life-history models assume that development itself involves trade-offs in the allocation of resources (Bogin, 2001). It follows that there are likely to be important individual differences in motivational priorities, including needs, and in the coping modes that have emerged from endogenous factors and formative developmental experiences.

In summary, distinctions have been made between the concept of mode as used in CBT and ST, and similar constructs in the research and clinical literatures. Modes are understood to in-

volve the operations of conscious and unconscious processes, to be context sensitive, to serve immediate focal goals and ongoing background needs, and to span a continuum from adaptive to maladaptive.

### The Matrix and the Eight Modes

The matrix I will present begins with a basic assumption, shared by others, that behavior, cognition, and emotion are primary aspects of our functioning (e.g., Gilbert, 2005; Liotti & Gilbert, 2011; Lobbestael et al., 2007) and, furthermore, that the range of activation in each of these three areas can span a continuum from "high" to "low." Combining these two sets of variables creates a three-by-two matrix of eight mutually exclusive and collectively exhaustive permutations. In other words, the eight patterns (or profiles) to be offered here are derived from combinations of behavior, cognition, and emotion at two levels of activation.

The idea of a matrix of modes came together for me while reviewing my clinical notes. I had observed that, despite some variability, there were consistent patterns in my clients' ways of coping and managing their lives. Some seemed to rely almost exclusively on their thinking while others frequently "lost it" emotionally and only afterward stopped to think about their actions or reactions. Still others spent a lot of time worrying but were paralyzed when it came to taking action. It was in contemplating these differences in style and content that I began to envision a matrix with as many as eight possible configurations.

I also anticipated implications of this perspective for my therapy practice. Even though certain ingredients seemed to dominate in different modes, the modes themselves operated as "composites." Consequently, a change in any one component would likely impact the mode as a whole. In other words, the effects of a behavioral, or cognitive, or emotion-focused intervention would not take place in isolation and this, I supposed, might be significant in addressing the problem of automaticity in how these modes seemed to operate.

Finally, because I was aware that clients with BPD or NPD display limited, yet characteristic, mode profiles (Young & Flanagan, 1998; Young et al., 2003) and the patterns displayed by healthier clients also showed clear consis-

cies, it seemed likely that similar patterns might also be present in normally adjusted individuals. On this reasoning, the configurations presenting clinically could be construed as exaggerations of a basic set, or repertoire, of coping strategies. In the case of my clients, these modes backfired because they were too intense or extreme, and thus interfered with their ability to meet their needs. I came to suspect, however, that the same suite of modes might be utilized—but more effectively and therefore less obviously—by all people.

### Matrix of Adaptive Modes

It is easier to appreciate the variety of modes and their permutations when displayed in the form of a grid or matrix, after Jung (1970) and Kelly (1955). This format appears in Table 1, the Matrix of Adaptive Modes.

As can be seen in the Table, the Matrix of Adaptive Modes consists of a series of columns and rows. The columns represent the “ingredients” of modes—behaviors (Column 1), thoughts (Column 2), and feelings (Column 3). The rows are the different possible combinations of these three ingredients in active (X), and passive (O) form. As explained, each row has been given a label, for example, Leader and Caretaker, to represent the primary flavor and function of the mode in question. Examining each pattern:

1. Leader (XXX): Behavior, thinking and feelings are all “active.” The Leader is in control, thinking constructively, and openly expressing feelings. Leaders are in touch with both their own needs and the needs of others.

2. Caretaker (XXO): Caretakers are mentally and physically “on,” and focused on meeting the needs of others. Connection is prioritized and the person’s own needs and feelings come second to those of others.
3. Free Spirit (XOX): The Free Spirit actively pursues goals, and reacts in the spirit of the moment. This is a “feel good,” autonomous mode. Thinking is ‘off’ to the extent that there is little forethought or self-reflection.
4. Deliberator (OXX): Deliberators thoughtfully weigh up the possible costs and benefits of different courses of action until a level of certainty is reached. Daydreams and fantasies are entertained for possible action at a later stage.
5. Doer (XOO): This mode is defined by action and a single-minded focus on getting a job done or project finished. Doers do not think beyond the task at hand. Little attention is paid to feelings or needs. This mode is neither connection-oriented nor reflective.
6. Strategizer (OXO): Here the pros and cons of various strategies are carefully and dispassionately considered. Unlike the Deliberator mode, there is little involvement of feelings. Action is suspended until it is considered appropriate or timely.
7. Emoter (OOX): The Emoter openly expresses his or her feelings, either to get urgent needs met or because the context elicits them. Problem-focused thinking and action are secondary to the immediacy of affect.
8. Follower (OOO): This is a “low key” mode, defined by passivity, and little emotional or cognitive activation. The Follower is the opposite of the Leader, content to hand over control. This mode may also represent a period of “down time” or rest.

Table 1  
*Matrix of Adaptive Modes*

	Behaviors	Thoughts	Feelings
1. Leader	X	X	X
2. Caretaker	X	X	O
3. Free Spirit	X	O	X
4. Deliberator	O	X	X
5. Doer	X	O	O
6. Strategizer	O	X	O
7. Emoter	O	O	X
8. Follower	O	O	O

*Note.* Rows represent different combinations of behaviors, thoughts, and feelings in active (X), and passive (O) forms.

Several points need to be made here. First it should be noted that labels such as Leader or Caretaker are terms of convenience, meant only to capture the primary flavor of the different modes, which could as easily been described in terms of action verbs, for example, caretaking, leading. Even though modes may come to feel like traits, as suggested earlier, they are seen

primarily as roles, or ways of operating, which become habitual due, mainly, to the prioritization of certain needs.

Second, there are undoubtedly both quantitative and qualitative differences in the cognitions, emotions, and behaviors that are characteristic of the different modes. Regarding the former, the bifurcation into “high” and “low” activation levels is an oversimplification but was considered a parsimonious way to present the matrix and synthesize the ideas behind it. There are probably many finer gradations of these components and, therefore, of the modes themselves.

As for qualitative distinctions, each of the three components could also be categorized into more nuanced groupings. Because we reason differently in different states of mind (Gilbert, 1998), thinking in Deliberator mode will tend to be more ruminative than in Caretaker mode, which would be more reflective and other-oriented. The same differentiations would be also expected of emotions and behaviors in other modes, like between a Leader and a Follower. In maladaptive modes, these differences are more pronounced.

By focusing on particular regions of the matrix, say, the contrast between the Caretaker and Leader modes, one can see how a single cell (Feelings) distinguishes these two modes. Thus, one can more easily understand how a Caretaker could switch to a Leader mode merely by prioritizing needs and feelings. Likewise, the Free Spirit and the Emoter are both emotionally expressive and cognitively inactive but differ where it comes to taking action. In contrast with Teasdale’s (1997) “mind in place,” here the idea is of a “mode-in-place” or, as one client calls it, her “online persona.”

### Balancing Stability and Change

In some situations mental focus is critical whereas in others it is the appropriate action or emotional response that counts. Thus, in some modes thinking is strongly activated (OXO), whereas in others behavior is the most obvious feature (XOO). In other words, depending on demands or opportunities, activation in these three areas will covary, essentially defining which mode is operating. However, how do people know when to switch from one mode to another—to act or to problem-solve, to pull

back or to redouble their efforts? As mentioned earlier, there is now compelling evidence for the pervasive role of nonconscious processes in the expression of motivated behaviors. This suggests that, generally speaking, the transition from one mode to another involves activity that can and must occur outside of conscious awareness.

Of course, not all behaviors are linked to goal pursuit or need satisfaction—there are nonmotivated behaviors that are purely habitual. Moreover, even though mode “flipping” is largely automatic, there are also occasions when people deliberately and consciously adopt a particular strategy or way of operating. Generally speaking, however, much of daily life involves a level of automaticity that enables the momentary cost-benefit analyses of everyday living to take place effortlessly. Thus, when mode transitions are adaptive they are also usually seamless.

Even though healthy individuals shift easily from one mode to another, habitual or preferred ways of operating also inevitably develop as certain needs are prioritized. Caretakers value connection whereas Free Spirits prioritize autonomy. These default modes become integral to people’s lives and identities. A person whose primary mode is to care-take, for example, may feel particularly comfortable in this mode—it may be a good “fit” for his or her temperament, as well as meeting needs for connection or desirability. The same person may be required to operate more autonomously or strategically at the office, however, where there is often a premium on clear thinking (OXO) or action (XOO). Thus, healthy people draw on a number of modes, as required, and this helps them to adapt and also get a range of needs met.

Shifting psychological needs motivate individuals to pursue particular goals, but do not specify the modes required to attain them. Clinical experience suggests that certain needs are frequently satisfied by specific modes, but also that no one-to-one relationship exists between needs and modes. Different modes may be enlisted to satisfy a particular need, and a single mode may facilitate the satisfaction of several needs (see Kruglanski, Shah, Fishbach, Friedman, Young Chun, & Sleeth-Keppler, 2002 for a discussion of goal systems). The identification of links between particular (unmet) needs and (specific) maladaptive modes requires further research (Flanagan, 2010).

### Turning Up the Heat

Relying on a relatively small range of modes means that the remaining modes in the repertoire will be less frequently utilized. People will resort to lesser-used modes, however, in challenging circumstances. In the current model there are two broad options when operating under pressure. In the first, people intensify their efforts and resort to a more exaggerated version of their present mode. The second is to resort to a very different mode. People are constantly switching into and out of familiar modes, but when default modes do not work less familiar modes are enlisted. Caretakers (XXO), in a moment of exhaustion, might intensify their efforts and become martyrs. Alternately, they might switch their thinking “off” (from X to O in Column 2) and their emotions “on” (from O to X in Column 3) and are then in Free Spirit mode (XOX) where, rather than orienting to others, they are self-focused and autonomous. Behaving, feeling, or thinking in ways that are unfamiliar can provide new perspectives on oneself and others, and allow needs that are not usually prioritized to be met. Extreme “flips” can also be disconcerting, however, both to the individual and those who know him so, unless they are effective, people usually fall back on familiar modes.

### Chronically Unmet Needs and Maladaptive Modes

Modes span a continuum from adaptive to maladaptive. Transient modes, when faulty, can be simple overreactions as when a person temporarily defaults to an extreme way of responding. What separates normal from chronically dysfunctional efforts to adapt is not only the intensity of these faulty modes but also their extreme rigidity and duration.

### Perpetuation of Maladaptive Modes

The clinical extension of this model is the proposal that each of the eight adaptive modes has a corresponding dysfunctional extreme where temporary aberrations become chronically dysfunctional ways of experiencing the self and relating to others. Clients with longer-term problems are doubly disadvantaged. First the heightened valence of unmet needs may lead to

distorted perceptions of behaviors and motives (Shah & Higgins, 2001), and to rigid overcompensations and avoidances. Second, maladaptive modes are particularly resistant to change because, as early survival strategies, they are central to the person’s sense of self. As a result, flexibility and openness to change—hallmarks of healthy adaptation—are severely limited (Flanagan, 2010; Young et al., 2003). Furthermore, because ineffective strategies co-opt resources, others modes may be underutilized and lower priority needs also go unmet.

### The Matrix of Maladaptive Modes

Maladaptive modes are extreme forms of normal patterns of adaptation. As unsuccessful efforts to cope with chronic thwarting of core needs, they are both exaggerated and ineffective. They can provide a sense of identity but they also ensure that the person remains stuck.

Table 2 contains a Matrix of Maladaptive Modes. This matrix is set up like the one in Table 1 except that the levels of activation ( $X^*$ ) and inhibition ( $O^*$ ), being more extreme, are represented in bold type with an asterisk. As with Table 1, each row has been given a label for example, Bully or Martyr to represent the primary flavor and function of these self-defeating modes. Looking at each pattern individually:

1. Leader (XXX) becomes Bully ( $XXX^*$ ). All systems are highly activated. The Bully operates by demeaning and controlling. Bullies need validation and respect but they elicit hostility and resentment, maintaining a vicious cycle.

Table 2  
*Matrix of Maladaptive Modes*

	Behaviors	Thoughts	Feelings
1. Bully	$X^*$	$X^*$	$X^*$
2. Martyr	$X^*$	$X^*$	$O^*$
3. Rebel	$X^*$	$O^*$	$X^*$
4. Worrywart	$O^*$	$X^*$	$X^*$
5. Controller	$X^*$	$O^*$	$O^*$
6. Schemer	$O^*$	$X^*$	$O^*$
7. Over-Reactor	$O^*$	$O^*$	$X^*$
8. Victim	$O^*$	$O^*$	$O^*$

*Note.* Rows represent different combinations of behaviors, thoughts, and feelings in overactivated ( $X^*$ ), and underactivated ( $O^*$ ) forms.



2. Caretaker (XXO), in extremis, becomes Martyr (XXO\*). Martyrs do not express their needs but expect that their obvious self-sacrifice will make others will respond in kind. The result is a build up of resentment. Martyrs' excessive need for affirmation induces guilt with the self-defeating effect of making other people pull away.
3. Free Spirit (XOX) becomes Rebel (XOX\*). Here a combination of strong behavioral and emotional activation, with cognitive avoidance, translates into an impulsive, or oppositional style. Rebels' exaggerated needs for autonomy and change ironically elicit a reaction of correction and control, reinforcing the cycle of rebellion.
4. Deliberator (OXX) becomes Worrywart (OXX\*). An excessive need for certainty and an intolerance of ambiguity lead to cognitive and emotional overcompensation and behavioral avoidance. Worrywarts avoid acting or taking risks until they are sure of the outcome. Chronic obsessing or indecision can result in procrastination, reassurance-seeking, or resentful dependency.
5. Doer (XOO) becomes Controller (XOO\*). Cognitive and emotional avoidance, combined with behavioral overcompensation, means that Controllers are closed to feedback from others. When projects are complete they go straight to the next one, reaching goals with little sense of satisfaction or connection with other people.
6. Strategizer (OXO) becomes Schemer (OXO\*). For Schemers life is a battle of wits, a game of chess. This is an impersonal, observing mode. Thinking predominates and results in covert manipulations and passive-aggression. This mode precludes authentic connections with others.
7. Emoter (OOX) becomes Over-Reactor (OOX\*). Emotional outbursts, which are intended to elicit validation or reassurance, backfire and can produce rejection or ridicule. Frantic efforts to maintain stability and connection are self-defeating in the same way as a child's temper tantrum.
8. Follower (OOO) becomes Victim (OOO\*). This is a markedly passive, subjugated mode where affect is flat, de-

tached, or depressed. Victims need connection, stability, and validation but, by shutting down, the likelihood of getting these needs met is decreased even more.

As indicated earlier, one can expect quantitative and qualitative differences in the cognitive as well as the emotional and behavioral components of modes. These will be even more significant in the case of maladaptive modes, all of which are self-defeating. In the short-term, the intense activation or inhibition of the different mode components can translate into self-defeating emotional overreactions, cognitive distortions and misinterpretations, and social disruptions or disconnections. Such occurrences can be disturbing even if temporary. By contrast, people with chronically unmet needs tend to repeat the same maladaptive cycles endlessly, with little or no core change. Interpersonal interactions lack a sense of trust, reciprocity, or authenticity, and result in patterns of failed relationships and careers, misunderstandings and resentments, and lonely detachments and withdrawals.

### Clinical Implications

Key issues in current efforts toward unification and integration in psychotherapy, clinical science, and personality research include development of a unified conceptual framework that allows for a synthesis of therapy techniques (Pincus, 2010; Wolfe, 2008), and provision of an integrated view of personality where change techniques are organized according to the specific areas of personality they target (Greenberg, 2002; Mayer, 2005). It is hoped that the model presented here will facilitate these goals.

Earlier the concept of mode was examined as it is currently used in CBT and in ST. Similar constructs such as selves, parts, personality styles and ego states were also acknowledged in other schools of psychotherapy. Recent developments in ST have produced interventions that focus primarily on the *content* of Child and Parent Modes. The goal here is the additional one of modifying the *structure* of maladaptive modes, giving clinicians an opportunity to choose the most effective tools for different clients, or at different stages of the therapy process. The approach that emerges from this model has two phases: assessment and change.

### Assessment Phase

Michael is a 23-year-old college student who grew up in an affluent home in New York City. His parents are both successful professionals with demanding schedules. Michael was materially indulged and given a lot of freedom but there was extreme rigidity when it came to academic success and church attendance. His father, an engineer, has a simple philosophy: "Life is linear: You do this to get that." Michael is temperamentally labile like his mother, whom he describes as a big worrier. By contrast with his gregarious sister, he remembers having always felt like an outsider, strategically using his head to get what he wanted. When I first met Michael he was worrying excessively about his grades. His anxiety quickly reached panic proportions. He believed that if he failed his father would not support him financially and, without the requisite social skills, he would not be able to survive. He was also having difficulties "scoring" with girls, even though, as he repeatedly said, he had the resources to take them to expensive places.

As in the ST model, assessment here involved multiple methods of data collection including cognitive, behavioral, and experiential measures (see Young et al., 2003). A number of instruments, both formal and informal, were also utilized specifically to identify Michael's unmet needs and modes. The Young Schema Questionnaire identified the following EMSs: Defectiveness, Failure, Vulnerability, Subjugation, Emotional Deprivation, and Social Isolation. In line with this schema profile, it was obvious from our talks that Michael had chronically unmet needs for Desirability and Change and also, for both Connection and Autonomy. In addition, I administered two questionnaires I have developed for the purpose of validating such clinical impressions. The results of these questionnaires reinforced my observations, and clarified Michael's major modes, which fell in the extreme range: Schemer (OXO\*), Drama Queen (OOX\*), Worrywart (OXX\*), and Victim (OOO\*). A "needs circle" (a circular arrangement of the six needs proposed in Flanagan, 2010) and the Matrix of Maladaptive Modes were then used as visual heuristics to illustrate the areas in need of attention and change.

When I showed Michael his matrix profile he could clearly see that none of his major modes involved action, that is, an X in the first position. They were all O's. He reported that he was generally afraid to act in case he made a mistake that is, Worry Wart (OXX\*), and when he did act it was always as part of a carefully orchestrated plan that is, Schemer (OXO\*). Only when he was absolutely sure would he go into action that is, Doer mode (XOO). If his plan backfired he got extremely upset that is, Drama Queen (OOX\*). When we studied the "needs circle" together it was obvious that, despite chronically unmet needs for Desirability, Change, and Autonomy, maintaining a sense of stability and connection with the few friends he had was winning out. His best friend was a "natural" with girls and Michael believed that without him his own social life would be nonexistent. He resented this dependency and also the shoddy treatment, but he was afraid to assert himself. He could also see that buying friendship made him come across as a show-off but he considered that without his credit cards he was a complete loser. To avoid his feelings of isolation and failure, he detached by watching movies alone for hours on end. This took his mind off his unhappiness but reinforced his underlying sense of futility and victimization (OOO\*).

### Change Phase

Two distinct methods of treatment stem from this model. In the first, mode dialogues are utilized to target the *content* or process of the different modes. In the second, the focus is on modifying mode *structure* by targeting specific components of faulty modes using the matrix as a guiding visual. Even though the primary focus of this article has been on Coping modes, the clinical example will also illustrate how Child and Parent modes can be conceptualized in a new way that coheres with the basic tenets of this model.

**1. Changing content: Mode dialogues.** As noted, there are constructs in the broader field of psychotherapy that resemble modes (e.g., "selves," "parts"), and the use of dialoging is common to all these therapy models. Here dialoging is also central. Because modes can easily be accessed in dialogues, conversations can be initiated between the different need "voices" or

Child modes, between Coping modes, and also between the different Child, Parent, and Coping modes.

Initially it was very difficult for Michael to do imagery work, so dialoging was helpful in working through areas of conflict. The “voice” of his unrelenting standards, or Schemer mode (OXO\*), reminded him of his father pressuring him to study and get ahead; whereas the voices of his unmet needs for autonomy and change pleaded for opportunities to socialize and connect. The voice of his need for autonomy also dialogued with the anxious part, or Worrywart mode (OXX\*), who feared total social isolation if he did not put up with his friend’s demeaning behavior. Finally, when he role-played the boorish mode he adopted with girls (XXX\*), he could see how self-defeating it was in meeting his needs for Desirability and Connection.

The goal of these content-focused interventions is not to eliminate maladaptive modes as prescribed in some other approaches. Mode dialogues serve to both externalize and explore the *content* of unmet needs and modes. Clients can gain an awareness of their emotional investment in certain modes, the voices of their unmet needs, and the pain that surrounds parts of them that are asking to be loved, protected, or nurtured. By understanding the intensity of what lies behind their extreme coping efforts, unexpected levels of empathy, and self-acceptance can often emerge. Identifying the origins of maladaptive modes and linking them with unmet needs and EMSs, allows faulty modes to be recast as coping efforts that became dysfunctional but can be made more effective in meeting the needs that drive them (see Flanagan, 2010).

**2. Changing structure: Reconfiguring and recalibrating.** Whereas dialoging explores mode content, the second avenue to treatment—one unique to this model—focuses on mode *structure*. Modes are long-standing “composites,” or gestalts, of behaviors, thought patterns, and emotional reactions that function in an integrated way. Consequently, change in any one component will affect the mode as a whole. Because their operations are largely automatic, one goal of this second approach is to alter the strength of individual mode components and, in doing so, to alter the mode itself—much as changing the proportions of certain ingredients in a recipe will change the entire dish. Another

goal is to weaken the mode by decreasing the intensity of all three components thereby allowing adaptive features of the mode to emerge, for example, transforming a Bully into a strong Leader, or a Martyr into an effective Caretaker. Thus, using tools specifically geared toward cognitive, emotional, or behavioral change, modes can be “dismantled” and reconfigured, or recalibrated as adaptive strategies of less intensity.

**Behavior.** Michael could see how his tendency to overcompensate with his wallet (XXX\*) or to surrender control by being submissive (OOO\*) were maintaining his sense of social isolation and helplessness. Because he spent a great deal of time scheming (OXO\*) and worrying (OXX\*), focus was placed on building active coping skills. Michael needed help with assertion and conversational tools so that he could talk more comfortably and confidently, especially with girls. Additionally, he needed to learn how to take calculated risks and to always have a backup plan. By keeping in mind that there was something he could “do,” he felt less stuck and dependent.

**Cognitions.** Standard CBT techniques were effective in helping Michael to manage his paralyzing level of anxiety (OXX\*). Daily Thought Records helped him see how “all or nothing” his thinking was. By tuning in when he was alone in his apartment he also became aware of an underlying depressive “tape” that was making him feel even more hopeless. Monitoring his self-talk in the presence of his father and his best friend also helped him realize how angry he was for the ways he felt compromised. Likewise, he learned that, in general, he was extremely self-focused and concerned with how he was coming across and, consequently, was not attending to social cues from others. This discovery provided him with a direction, that is, to focus out, and interact by asking questions of other people. The Vertical Arrow Technique revealed the degree to which his beliefs and expectations were extreme, leading to the amusing observation that he and his father were more alike than he had realized. Finally, Michael learned that by toning down his highly developed strategic ability he could use it to his advantage.

**Emotions.** Self-change was daunting for Michael because it brought him face to face with his sense of defectiveness and self-

loathing, and the childlike voice of his unmet need for Desirability. Training in emotional regulation helped him to moderate his extreme reactions (OOX\*), his “meltdowns,” by internally calming himself to a point where he could reflect on a constructive course of action. Recognizing schema triggers and the unmet underlying needs also equipped him to mitigate the intensity of his affect and switch to a more appropriate mode. Finally, Michael became aware of emotional buildups before they reached a point of panic, impulsivity, or withdrawal.

In summary, Michael had always relied on his thinking to control his environment, rather than learning to take calculated risks, assert himself, and manage his feelings of anxiety and helplessness. As described, cognitive reframing, emotional regulation, and behavioral skills training were strategically utilized to modify his maladaptive modes. Other tools, such as guided imagery, mindfulness meditation, or EMDR could equally have been enlisted. The point is not so much to specify the exact choice of technique but to target specific mode components with whichever tools are likely to be most effective in the individual case. Michael gradually learned to recognize his faulty modes (and their “problem” constituents) and to consciously decrease the intensity of these maladaptive components or switch to another, more effective, mode.

### Summary and Concluding Remarks

The aims of this article have been to integrate recent findings in the cognitive sciences and contemporary clinical research into an adaptive model of modes, and to offer a clinical approach that links unmet needs with EMSs and faulty coping modes and that, ultimately, could generate comprehensive needs-based profiles for the different personality disorders. I have also attempted to address areas of perceived concern in the direction ST, and to offer suggestions that would potentially augment STs treatment options and expand its theoretical base. These include maintaining the original focus on a range of core needs, developing a basic framework for defining and differentiating between modes, and understanding the microprocesses clinicians are trying to impact when doing mode work. Tactical methods for addressing the con-

tent and the structure of maladaptive modes have also been offered, providing opportunities for clinicians to consider which tools might be used most effectively with different clients, or at different stages of the therapy process. All of these topics are consistent with current concerns in the field of psychotherapy and with the goals of unification and integration.

Years ago, Wendell Garner pointed out that practical applications can lead to new theories, just as new theories can suggest novel solutions to actual problems (Garner, 1972). Here I have presented a new theory of maladaptive modes and a novel approach to their treatment, both of which grew out of repeated clinical observations. It is hoped that this theory, as illustrated in a clinical case, will have demonstrated the viability of developing a streamlined approach to the treatment of longer-term problems (Flanagan, 2010).

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