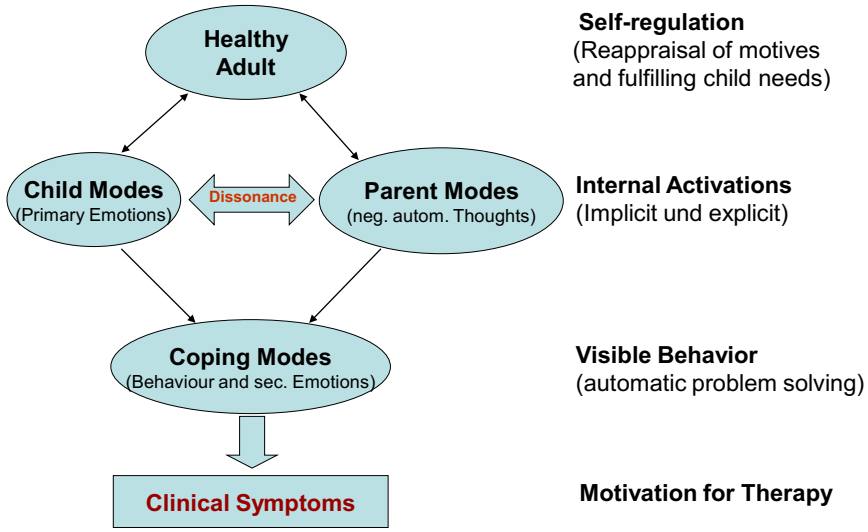
Basics of a dimensional and dynamic Mode Model: How to use the Mode Map and the Mode Cycle Flashcard to reveal the patient´s internal dynamic.

by Eckhard Roediger, IST-Frankfurt

- Usually modes are regarded as categories to describe a complex pattern of emotions, cognitions, physiological activation and behavior. Especially from a research perspective this might be useful because the SMI-1 helps to label and document modes and training in a manualized treatment is easier. The approach described here is different. It tries to look deeper into the background behind the surface of the appearing mode and tries to connect them with the neurobiological background. This leads to a dimensional model used in the DSM V does and helps to understand the interaction between the modes.
- There are three groups of modes plus the Healthy Adult (see fig. 1):
  - *Child Modes*: Essentially they are primary or basic emotions such as anger, fear, happiness, surprise, disgust and grief (Ekman 1999); closely related to bodily sensations (Damasio 1999)
  - *Dysfunctional Parent Modes*: Resulting from internalized appraisals of significant others inducing core beliefs and reoccurring as negative automatic thoughts (Beck 1967)
  - *Maladaptive Coping Modes*: Visible behavior as persisting coping reactions to early childhood experiences accompanied by secondary emotions such as disgust, superiority, shame or guilt.
  - *Healthy Adult*: Adaptive self regulating function, composed of 3 steps: mindfulness, detached reappraisal and functional self instructions

Mode-Model (simple) *(Fig. 1)*



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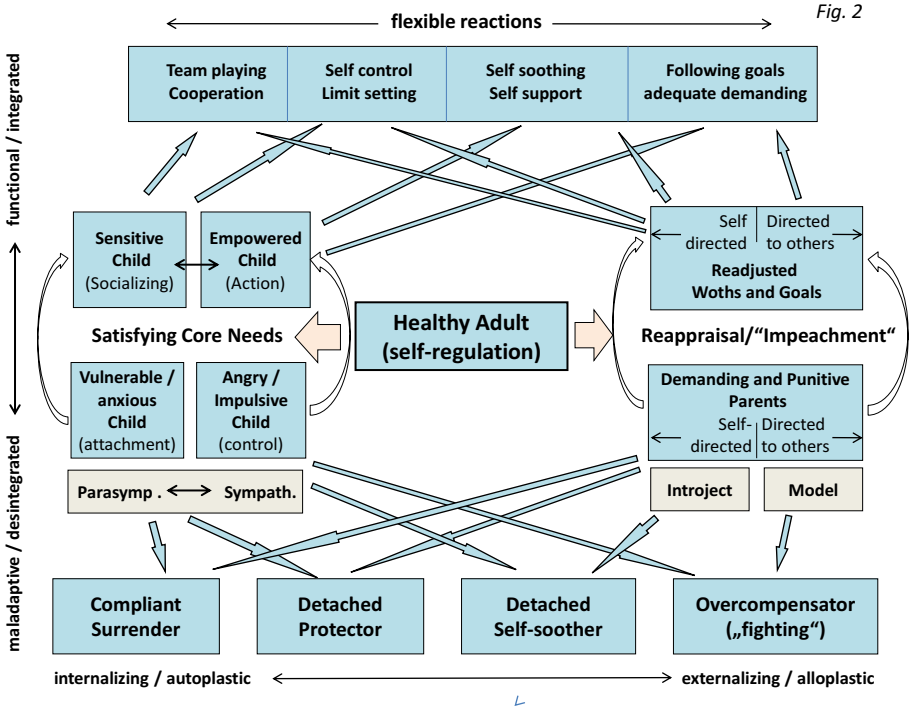
- **Child Modes** are primary emotions related to spontaneous physiological reactions that are not yet altered by any cognition. They occur if core needs are not adequately met and they are stored in the implicit memory. Secondary emotions like feeling proud or superior, guilty, ashamed or worthless already include implicit appraisal and belong to the coping modes. Helpful questions to detect primary emotions are: “Did you already feel this way when you were born? What do you feel in your chest or in your stomach?” Child modes switch between a polarity of a vulnerable and anxious pole and an angry and impulsive pole. This polarity can be related to the polarity of the autonomous nervous system divided into sympathetic and vagal (parasympathetic) activation (Porges 2007). Sympathetic activation is connected with a powerful feeling and emotions of anger or “aggression” in a broad and literal (latin: a-gredi) sense: Being “ready to go”, stand up for someone´s needs and take control. Given that anger is inevitable for adequate limit setting too. When shifting to the vulnerable pole the sympathetic activation changes into a vagal dominance. Vagal activation is related with more nervous or “weak” sensations in the upper stomach and feelings of vulnerability or fear inducing socializing behavior seeking for attachment.
- Dysfunctional **Parent Modes** are understood only as the dysfunctional, “noxious” part of the complex introjects of significant others and are experienced as a “voice in the head”, resulting essentially from comments of the significant others in our early days. They are stored in the explicit memory and quite easy to access by questions like: “What does the voice in your head say?” The significant others were internalized probably in the mirror neurons in a dual way: (1) as a persisting, self directed voice beating oneself up and (2) as a model how to treat others. This helps to explain how victims turn to offenders: They just switch their internal representations and “turn the voices outwards”.
- Maladaptive **Coping Modes** are visible behavior reactions resulting from the current emotional and cognitive activations. In the orbital frontal lobe they converge and the most promising action is taken. Child and parent modes usually remain internal activations leading to action, but they are not directly visible among adults. Acting out a child mode is perceived as “childish”. The guiding core beliefs remain covert as well. Visible is only the coping mode driven by a combination of primary emotions (child mode) and beliefs (internal parent mode). All coping modes derive from a primary emotion (energizing the system) and related appraisals (directing the power in- or outwards). Coping modes are elaborations of the biologically based fight/freeze/flight/surrender behavior. Each prioritizes different core needs and has an interpersonal “meaning” defining the relation with another person: Either I am on top (overcompensator striving for control), I surrender (to gain attachment) or I withdraw from a relation passively (detached protector as “freezing” behavior to avoid harm) or actively (detached self soother as “flight” reaction to protect myself and my self esteem or gain lust). The goal of the coping mode itself is not generally dysfunctional, but the attempts to reach it are too strong, too rigid, alternatives are lacking or changing strategies appear disintegrated in a “flipping” way.

Which coping mode occurs depends on the current internal activation of the child- and internal parent mode (follow the arrows in the lower part or fig. 2): An anxious child together with an self directed punitive parent mode will lead to surrender, an angry child and an outwards directed punitive parent mode tend to overcompensation. If the angry child´s tendency to fight is blocked by a inward directed punitive parent this might result in an avoidant coping like a detached self protector or self soother (e.g. cutting oneself or drinking).

Fig. 2



- **Case vignette** explaining mode flipping
  The therapist of a borderline patient has to terminate therapy because the insurance company refuses to pay any longer for the inpatient treatment. In the patient the angry child mode gets dominant and together with a therapist directed punitive parent she start yelling at him (overcompensator). When he didn´t react in the expected way but stays calm the anger gets mixed with a feeling of uncertainty (vulnerable and angry child activated at the same time) and she runs out of therapist´s office slamming the door (angry protector). Entering her own room she feels alone (the vulnerable child mode gets stronger) and the self directed punitive parent mode starts complaining: "How could you be so stupid to attack the first person who ever understood you!?" Because there is still anger remaining she starts cutting herself (detached self soother). Right away the anger is gone and the vulnerable child mode longs for attachment. She humbly approaches the nurse asking to treat her wounds and later knocks on the therapist´s door excusing her (compliant surrender).
- **Healthy Adult (HA)**
  The HA represents reasonable thinking and self-reflection and enables functional problem solving. This requires mindful here-and-now perceptions, an interruption of

spontaneous, maladaptive coping behavior, an emotionally detached reappraisal of internalized parent mode cognitions and at least supportive self-instructions to induce and maintain functional coping. This conception of the healthy adult is close to other "3rd wave" therapies (Hayes).

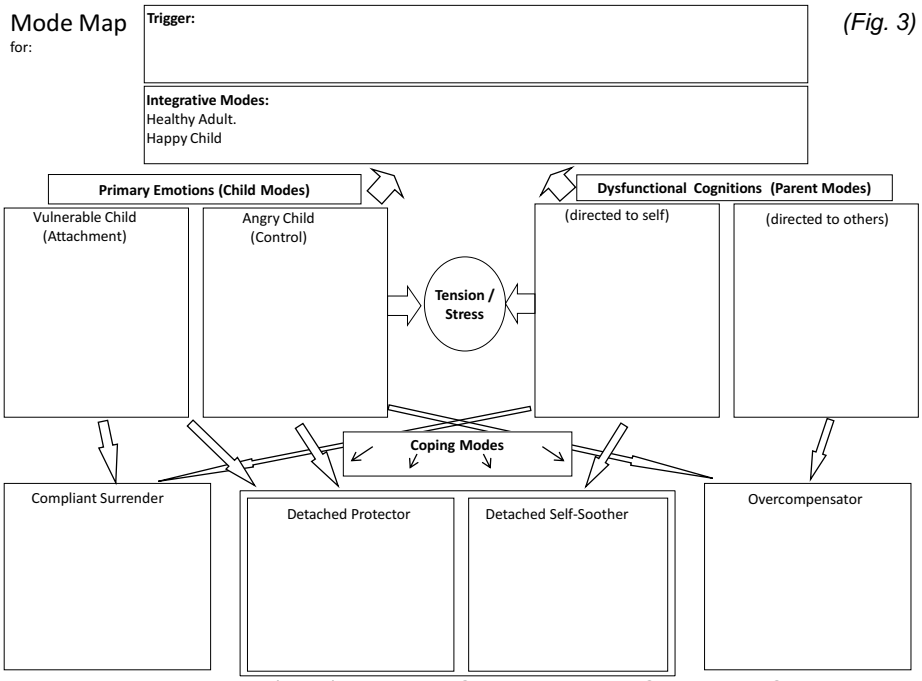
The main tasks of the HA (see center of fig. 2) is on one side to reappraise the automatic thoughts and core beliefs, replace them by adequate thoughts about the self and others and dis-empowering or "impeaching" the dysfunctional parent modes. On the other side the anger of the child mode has to be guided and transformed into an "empowered child" providing the patient with the strength required to attain the readjusted goals and fulfill his or her core needs. The general question is: "What does the child really need?" The feelings of fear are calmed and the sensitivity of the vulnerable child is used for socializing behavior. It is not necessary to change the emotions and beliefs themselves. They are there and have to be accepted the way they are. But they have to be perceived mindfully, so the spontaneous dysfunctional coping impulses can be interrupted. This is closer to the 3rd wave acceptance strategies than fighting dysfunctional parent modes. The functional behavior induced by the HA is also balancing between internalizing / "autoplastic" (Piaget 1985) and externalizing / "alloplastic" behavior in an adequate and flexible way (see upper part of fig. 2), combined from emotional and cognitive sources.

- **The Mode Map as case conceptualization form**

  Fig. 3 shows an adaption of the lower part of fig. 2 giving a comprehensive case conceptualization form. The therapist inserts core information related to the given modes into the boxes. Typically some boxes remain vacant revealing the "blanks" in the patient´s mind map. The bottom line shows the deficits in the spectrum of coping behavior, the middle section "forbidden" emotions and thoughts. The section representing the primary emotions (child modes) contains two boxes to implicitly show the patients the two essential and necessary emotional poles. The patients usually start sessions in a coping mode and the therapist bypasses the coping mode by asking "what do you feel (in your body) right now?" Usually one emotion is dominant and the therapist might continue asking: "Is there another emotion beside the first one you felt?" Having the Mode Map on their mind helps therapist and patient to look for the blocked emotion, needed for the missing coping behavior.

  A Case vignette: Submissive or depressed patient are usually not able to "fight" in a functional way and the "overcompensation" box remains empty. Asking the patients: "What does the voice in your head say when it comes to fighting?" the typical answer is something like "I have no chance, I never tried to fight in any way, I was not allowed to resist!" Transformed into "you have no chance, you are not allowed to resist us" this reflects the introject´s voice. In consequence in the parent mode-box the self directed content is dominant over the other directed part. On the child mode side the feelings of vulnerability or fear are dominant and the "angry child" box remains empty. Looking at that picture the therapy goals get clearer: The parent modes have to be re-evaluated and more directed to others, the "forbidden" anger feelings have to be integrated into the HA behavior.

Some patients make use of all modes but show mode flipping. In that case the HA has to prevent from falling into action and combine emotions and appraisals in a smoother and more adaptive way. The core idea is: the maladaptive coping styles are not essentially bad, but have to be applied in a flexible and socially adaptive way by the guidance of the HA (left vertical line in fig. 2).



(Fig. 3)

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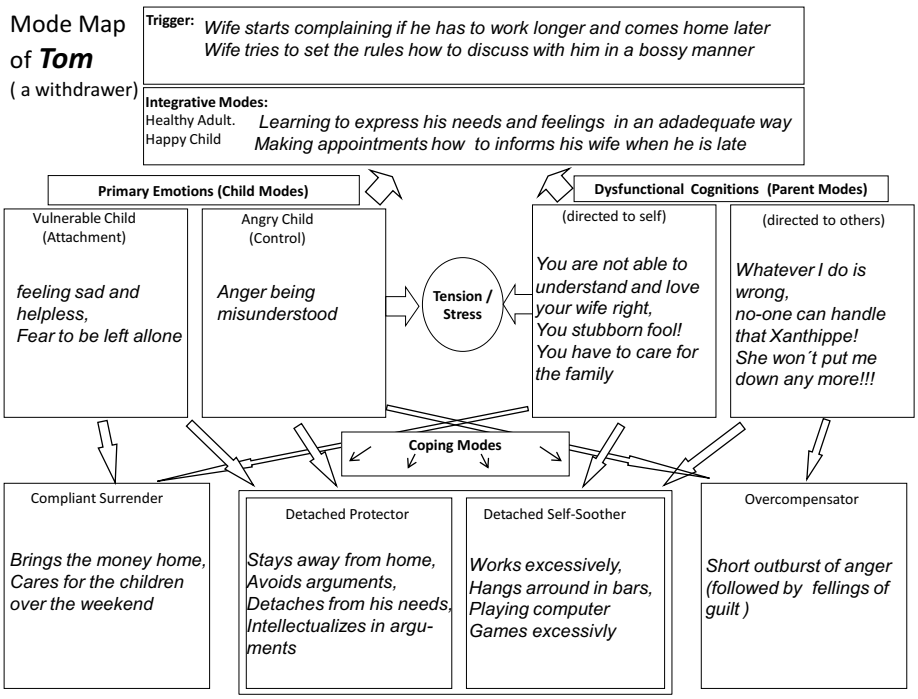
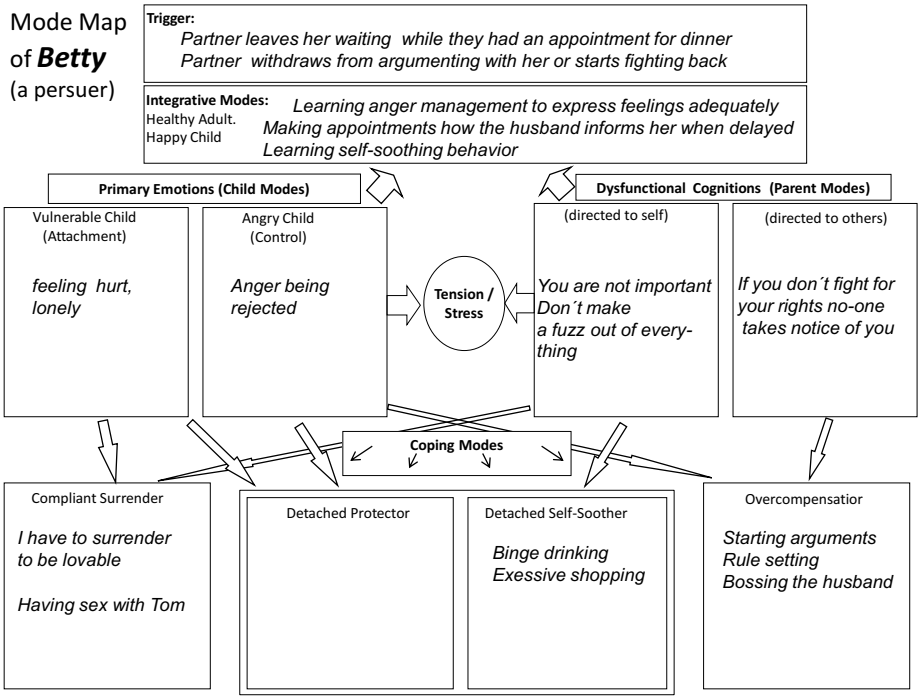
- **Two Mode Map examples**

Tom sometimes has to work longer than expected and is coming home late for dinner leaving his wife Betty waiting. Because she always beats him up when he tells her on the phone that once more he will be late he stopped calling her thinking: “I will get trouble anyway, so better get the trouble later”. At home she is yelling and he hides behind his computer. Later Betty reconciles after calming down having sex with Tom.



Mode map of ***Tom*** who withdraws from conflicts with his wife Betty.

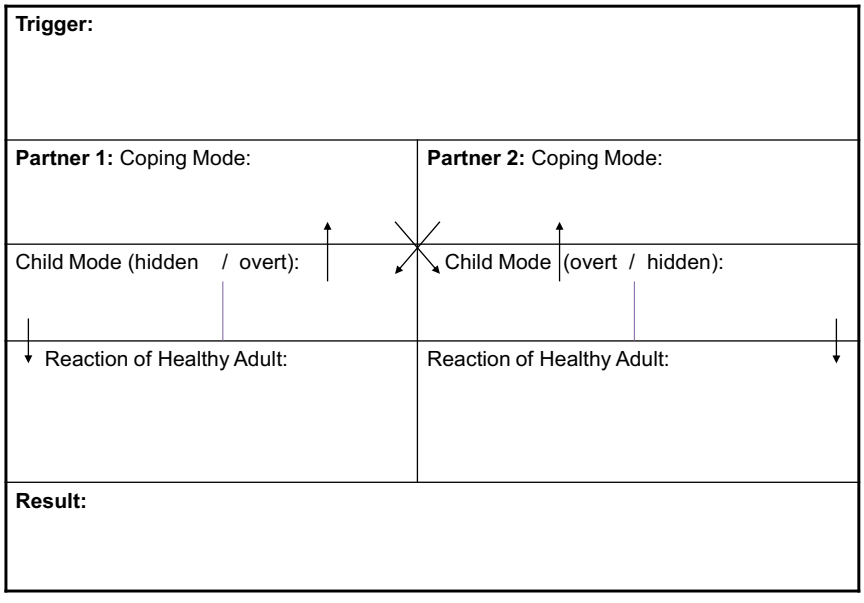
Mode Map of ***Betty***, who persues her husband Tom when leaving her alone.



- **The Mode Cycle Flashcard for working with couples**
  To conceptualize the mode cycle among couples the Mode Cycle Flashcard (MCF) has been developed (see fig. 4). It contains the most relevant information to understand a mode cycle and how to find a better solution. The internalized parent side is disregarded to reduce complexity, for it is included in the coping behavior anyway.

After starting with the triggering situation, in the second line the visible coping behavior of both partners is inserted. The next step is accessing the dominant affect behind this coping mode. The overcompensator is usually anger driven, withdrawal by anger or fear (or a mixture of both). The arrows in the core section show how the cycle is perpetuated by the mutually induced emotions of each partner´s coping.
In the next step the couple is educated about the core needs and that all of them have to be fulfilled, followed by an analysis of the core need balance under the given coping behavior.
The way out of the cycle requires detecting the currently de-activated child mode and the related unmet core needs, shaded by the dominant affect. Than the partner is asked: "What does that child mode really need, what is he or she longing for?" Than the patients receive training in functional communication skills and learn to express their feelings and needs in a functional way.
Usually the couple doesn´t ask for therapy as long as the mode cycle between an overcompensating and a surrendering partner remains stable. In that case the overt child mode behind the surrendering coping would be an anxious child. For a better relation the hidden anger has to be revealed to empower the patient and enable him to stand up for his rights and care for his unmet core needs.

Mode Cycle Flashcard *(Fig 4)*



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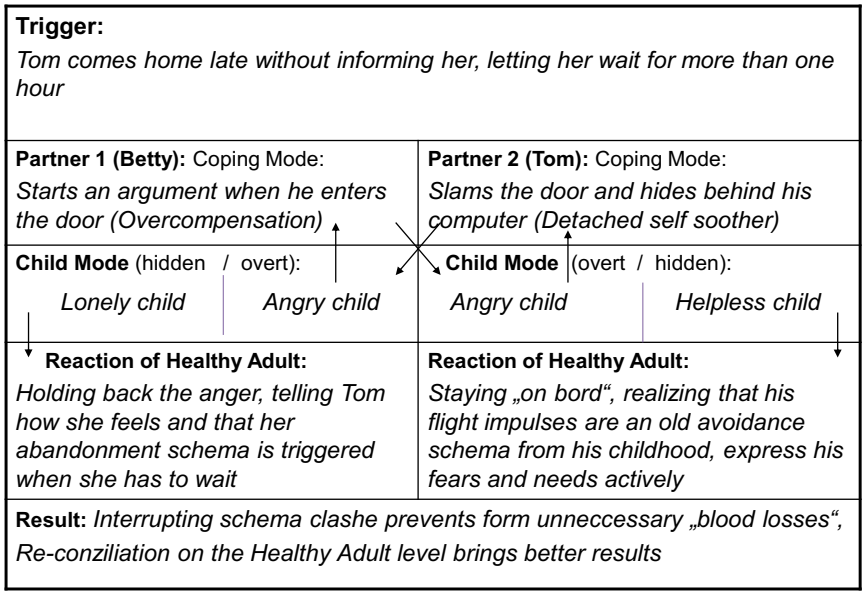
A case example:

The case example in the Mode Cycle Flashcard below is based on the Mode Maps of Tom and Betty given above. It starts with the same conflict: Tom comes home again late from work. Betty gets angry about waiting in vain. When Tom finally shows up she is yelling him (overcompensator). Tom turns around and goes into his favorite bar (avoidance). Betty´s´s affect is anger, Tom´s too (with a slight portion of fear, because he is afraid of the arguments with Betty). Betty is going for control, Bob tries to avoid pain and save his

self esteem. When Betty is asked, what the hidden vulnerable child needs she is able to see, that she finally longs for love and attachment. Tom basically is looking for peace and needs a reasonable sense of control. Tom´s latent anger is necessary to give him the strength to face Betty and withdraw from avoidance. After Betty expressed her sad feelings she appears less threatening to Tom and both can "negotiate", how much commitment Tom can give before feeling "trapped". The "contract" is documented in the healthy adult line, the effects of the new behavior in the bottom line.
The form is introduced by the therapist first, than both partners can try to use it separately during the "time-out" following a schema clash and compare them in the reconciliation phase. Finally they are able to talk in MCF terms reflecting their every day interaction.

Mode Cycle Flashcard



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"Pros" of the dimensional Mode Model

- Linking child modes to bottom up emotional and physiological activations from the limbic system (LeDoux 1996) helps to understand and validate them from a neurobiological perspective.
- Regarding the toxic essence of the parent mode as a dysfunctional "voice in the head" makes distancing in early therapy stages easier and relates the model with Beck´s CBT approach.
- The model is dimensional (not categorizing) and allows to place each possible behavior on the given dimensions in a tailored way.
- The map reveals deficits and excesses among the used coping modes.
- Following the arrows upwards from the blank coping fields to the motivational level leads to the blocked primary emotions and the "forbidden" cognitions. Unblocking them is a key to activate the blocked coping resources.

- The distinction between motivational (internal modes) and visible behavior (coping modes) helps bypassing the secondary emotions like disgust, feeling superior, guilt and shame related to the coping modes and discover the hidden primary emotions resulting from the core need frustrations.
- The two levels help to identify the angry child´s primary emotion embedded in the angry protector or the overcompensatory modes and open the door for our essential question: "What does the child really need?"
- Separating behavior from the inner activations (child and parent modes) allows to accept the internal modes, but to keep them away from the executive functions (3rd wave approach). The meta-cognitive treatment goal is to change behavior, not the primary emotions or automatic thoughts. The latter have to be accepted, reappraised, let go and the attention is focused on actions trying to reach the desired outcome.
- Distancing from internal modes is more efficient than fighting them. Because they are "hard-wired" they reoccur anyway.
- The comprehensive Mode Map as a "third party" in the therapeutic relation giving the patient a general outlook about the full spectrum of primary emotions, balanced appraisals and coping behavior. So it is not the therapist who confronts the patient but the Mode Map itself is showing what to do. This triangular situation helps patients to change into the observer perspective.
- The box in the third (upper) level contains the healthy adult behavior integrating the four coping modes in a functional and flexible way. So the map shows in the vertical direction a polarity between maladaptive and functional use of the biologically based coping behavior. This means a validation of the former coping modes as childhood reminiscences but includes the goal to improve their functional adaption.

"Cons":

- The Mode Map is a normative model and has to be individualized while filling it out together with the patient. Sometimes the labels of the boxes have to be readjusted to reflect the patients coping behavior best.
- For some patients (e.g. narcissistic or not very self reflective patients) it might work better to start with a personally drawn mode map and later switch to the printed version to give the patient the impression that the map is individually designed for him or her.
- Confronting the patient with the complexity of the Mode Map right away can be too overwhelming and beginning with the simple mode model (see fig. 1) might give a better start.
- Therapist need some training to monitor parent and child modes and their interaction simultaneously and get a deeper understanding how helpful the Mode Map is to bypass the coping modes and access the hidden primary emotions and core beliefs for treatment, for they are the main goal of our interventions. In the

beginning it is probably easier to work with each single mode and the HA in a dyadic relation.

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Eckhard Roediger

(Director of the Frankfurt Schema Institute, IST-F)

kontakt@eroediger.de; www.schematherapie-roediger.de