Mode Observation Scale (MOS)

Manual

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Child Modes – involve feeling, thinking, and acting in a "child-like" manner

1. *Vulnerable Child (Abandoned, Abused, or Humiliated Child) -- feels vulnerable, overwhelmed with painful feelings, such as anxiety, depression, grief, or shame/humiliation.*

The manifestations of the Vulnerable Child can be more obvious or subtle. For example, sadness or grief can be manifested openly through crying or speaking openly about feelings of inner pain. Or more subtly, through lowered voice, downcast eyes, quiet, introspective demeanor, sad facial expression, sighing, slumped shoulders, and so forth. Feelings of anxiety can be manifest openly in feelings of panic, shock, startle, rapid breathing, or more subtly in stuttering, rapid speech, losing track of the thread of the conversation. The content of the conversation typically matches these expressions of vulnerability, for example, talking about recent or past experiences of loss, violence, hurt, etc. On the other hand, sometimes patients may stay silent or avoid talking about painful topics, but still show the non-verbal manifestations of the vulnerable child (e.g., facial expressions of sadness or anxiety). Because the vulnerable child involves intense feelings of inner pain, it often leads to attempts to escape from or avoid painful feelings. Thus, patients may rapidly switch from vulnerable child mode to other modes, which may show itself in suddenly falling silent, becoming angry or arrogant, or changing the topic of conversation.

In contrast to the Vulnerable Child, which involves intense and overwhelming emotional pain, the Lonely Child involves feelings of emptiness and loneliness. Thus, the Lonely Child often involves more inward experiences of sadness or emptiness, while the Vulnerable Child is usually more overt.

2. *Angry Child – feels and expresses uncontrolled anger or rage in response to perceived or real mistreatment, abandonment, humiliation, or frustration; often feels a sense of being treated unjustly; acts like a child throwing a temper tantrum.*

Angry child is evident in uncontrolled, or poorly controlled, expressions of anger. More extreme manifestations include screaming, shouting, swearing, throwing things, banging on things, breaking things. More subtle manifestations include hard breathing, loud voice. The content of the angry child mode almost always involves a sense of injustice or unfairness that has been perpetrated on the person. This feeling of injustice can be justified, but often involves some distortions or a disproportionate reaction to the provoking incident. At times, the person may be very quickly triggered to anger, or the trigger for the anger may not be obvious.

In contrast to the Angry Protector, the Angry Child mode involves uncontrolled or poorly controlled anger, as opposed more controlled expressions of hostility or oppositionality. The Angry Child mode serves the purpose of ventilating anger about a perceived injustice, whereas the Angry Protector serves to make distance from

others. In contrast to the Bully and Attack mode, the Angry Child mode does not involve an attempt to threaten or intimidate. Therapists or others may at times feel intimidated or frightened by the intensity of the emotions seen in Angry Child mode; however, it is not the intention of this mode to threaten or intimidate, whereas it is the intention of Bully and Attack mode. Finally, the predator mode involves a cold, ruthless anger that is directed toward eliminating a threat, rival, enemy, etc. The Predator mode is more controlled and calculating than the Angry Child.

3. *Impulsive, Undisciplined Child – acts like a spoiled child who "wants what he wants when he wants it," and can't tolerate the frustration of limits.*

The impulsive child lacks patience. He wants what he wants *right now*, and becomes frustrated, angry, or agitated if he doesn't get it. His lack of frustration tolerance may be because he is spoiled, and feels entitled to get what he wants. Or, he may never have developed the capacity to postpone or delay, and therefore finds waiting intolerable. He has little tolerance when other people take their time, or don't respond rapidly on demand. He often acts without thinking first. His feelings can be translated immediately into action, with stopping to reflect about consequences. In his frustration, he may look for objects or persons to act on immediately, for example, throwing things, banging, breaking, hitting people, and so forth. Thus, he may switch rapidly from impulse child to angry child mode if his demands or needs for action are not immediately met. Although impulse child and angry child modes are often seen in conjunction with each other, they are different modes. The impulsive child may also present without anger. For example, he may speak rapidly or switch quickly from topic to topic, move quickly and frequently (e.g., getting up and sitting down again and again), and show restlessness, distractibility, and a general tendency to respond quickly to stimuli. He may also react impulsively in response to his felt needs, such as impulsively buying things he doesn't need, taking drugs or drinking when the opportunity is there, or engaging in promiscuous sex. He may lack the patience to engage in long-term planning, as indicated by starting projects but losing interest and quickly abandoning them, or shifting frequently from one plan to another.

The patient may show impatience towards the therapist. He may express impatience for the session to end, or become frustrated by having to listen to the therapist. He may push the therapist to give in to his demands. He has a hard time accepting boundaries, and therefore may feel that it is acceptable to pressure the therapist to give him what he wants, or do him special favors. He may become impatient or agitated when a therapist hasn't had the time to act on his request (e.g., complete a report), isn't immediately available (e.g., goes on vacation), or refuses to give in to his demands. He may make excessive claims on the therapist's attention and time, badger the therapist, or find it difficult to share the therapist's time with other patients.

4. *Lonely Child – feels lonely and empty, as if no one can understand him, sooth or comfort him, or make contact with him.*

The Lonely Child feels sad, lonely, empty, and disconnected from other people. He feels that he will always be alone in life, that others will neglect him, or ignore him. He feels that he has to take care of things on his own, because no one will want to meet his needs. He feels that no matter what he does, no one will understand him. He may feel that this is his fate in life. That he is destined or determined to bear the

burden of his loneliness. He may feel devoid of love, or even devoid of a sense of personal identity, as if his existence has no meaning.

Patients often describe feelings of being alone, even in situations when others are present. They may describe feelings of connection to nature, mankind, doctrines, abstractions or belief systems, or the spiritual, but not to specific people.

The Lonely Child obviously has some similarities to the Vulnerable Child, but is more of an interior experience, so it is less likely to involve strong overt expression of feelings. Usually, the Lonely Child remains hidden from view, but it may become evident when the patient talks about feeling isolated, not understood, ignored, or feeling unimportant or invisible. Sometimes, life events may trigger the emergence of the Lonely Child, for example, the death of a family member or friend, or long periods of isolation. In these cases, the pain of the Lonely Child may suddenly become evident.

Dysfunctional Coping Modes – involve attempts to protect the self from pain through maladaptive forms of coping

5. *Detached Protector – Uses emotional detachment to protect one from painful feelings; is unaware of his feelings, feels "nothing," appears emotionally distant, flat, or robotic; avoids getting close to other people*

The detached protector may speak in an emotionally flat, distant, numb, or superficial manner, even when discussing apparently emotional topics. His voice may be monotone, his facial expression unchanging. Thus, there may be a disparity between the manner in which the patient expresses himself, and the topic over which he is speaking. The patient may appear tired, bored, or uninterested; he may choose topics that lack substance, and avoid emotionally laden ones. He may be overly intellectualized or concrete, or talk excessively about other people or the situation around him, but avoid talking about himself in a personal way. If asked about his week, he may respond that everything is fine, that nothing significant has happened, and that everything is the same as it usually is. The purpose of the detached protector is to make distance from people and to avoid painful situations or emotions. Thus, the patient may avoid interacting with people to whom he has strong emotional reactions. He may refuse to do experiential techniques that threaten to trigger strong emotions. When the patient is in detached protector mode, the therapist may experience feelings of boredom or frustration, because the session does not appear to be progressing. He may sense a lack of connection between himself and the patient. He may find that the patient denies feelings when asked about them, or that the patient responds concretely to such questions (e.g., describes thoughts or actions rather than feelings). Sometimes, the therapist may unconsciously adapt to the patient's detached protector by avoiding emotional topics himself, or conducting an overly intellectualized discussion with the patient.

6. *Detached Self-Soother/Self-Stimulator – Uses repetitive, "addictive," or compulsive behaviors, or self-stimulating behaviors to calm and sooth oneself; uses pleasurable or exciting sensations to distance oneself from painful feelings.*

The detached self-soother tries to sooth and calm himself through repetitive, compulsive, or addictive behaviors, such as drug or alcohol use, gambling, eating, shopping, sex, self-mutilation, and so forth. Thus, the detached protector seeks a pleasant physical state of buzz, high, excitement, thrill, or euphoria, in order to keep unpleasant or painful feelings away. The scorer may be tempted to rate this mode whenever the patient is talking about addictive behaviors. However, the patient may be in modes other than detached self-soother when describing his addictive or compulsive activities. For example, he may describe addictive behavior in an emotionally detached way (i.e., detached protector mode), or in an emotionally vulnerable way where he expresses painful feelings (i.e., vulnerable child mode). Thus, what is important in rating this mode is to describe the state the patient is in at the present time – that is, in the session itself. For example, the patient may talk about his drug use with evident pleasure, as if he is re-experiencing pleasurable feelings he associates with drug use. He may tell sexually provocative stories or fantasies in an effort to stimulate himself (and possibly his therapist) during the session. He may act seductively towards the therapist as a form of self-stimulating "entertainment," rather than having to focus on painful or personal topics. He may tell stories about his past acts of violence, to generate a sense of satisfying excitement. The detached protector may manifest itself in more subtle ways, for example, in stroking himself on the arm, picking at his skin, pulling on or twirling his hair, biting his lip or nails. He may suddenly experience the urge to have a cup of coffee, or to have something sweet to eat. He may begin to day dream about some pleasant fantasy, where he suddenly feels far away from the present. He may begin to experiencing cravings or urges in the session itself, although patients often will not report this to therapists, unless they are asked.

7. *Compliant Surrenderer – Gives in the to real or perceived demands or expectations of other people in a anxious attempt to avoid pain or to get one's needs met; anxiously surrenders to the demands of others who are perceived as more powerful than oneself.*

The compliant surrender attempts to please other people, and to go along with other people's perceived or real requests, needs, or expectations. He may be very eager for others to like and approve of him. He needs a great deal of reassurance that he is liked or worthwhile. Thus, the compliant surrender is driven by anxiety that others will leave, hurt, or dislike him, unless he makes excessive attempts to comply with others' needs or demands. The compliant surrenderer may be excessively focused on the needs and well being of others, to the neglect of his own needs. He may be exquisitely sensitive to other people's needs or feelings, but quite unaware of his own. He may experience himself as helpless or powerless without the presence of others, whom he perceives as more powerful than himself. Thus, he may attempt to ingratiate himself with others to gain the protection or support that he needs.

In the therapy session, the compliant surrenderer may be overly solicitous of the therapist's needs and emotional state. He may need constant confirmation, for example, by giving regular reports on his progress, which he expects the therapist to respond to with approval. He may tell the therapist how terrific he is, how much he trusts him, and how well he is progressing in the therapy. He may go out of his way to tell the therapist how much time he has been thinking about his last session, how insightful the therapist is. If the therapist has to miss a session or go on vacation, the compliant surrender will not complain, stating that, of course, the therapist has his own needs that sometimes come before those of the patient. However, the patient may actually suffer when the therapist is away, though he fears showing this

openly. Sometimes the compliant surrenderer will not express feelings of disappointment or anger, feeling that they are not justified, or that the therapist might reject him if he were to express them openly. However, sometimes these feelings accumulate, and suddenly lead to outbursts of anger, either verbal or physical. More commonly, however, they manifest themselves indirectly in passive-aggressive ways, such as missing or being late for sessions, or talking behind the therapist's back to bring them into discredit.

8. *Angry Protector – Uses a "wall of anger" to protect oneself from others who are perceived as threatening; keeps others at a safe distance through displays of anger; anger is more controlled than in Angry Child Mode*

The Angry Protector shows his anger in an indirect, controlled manner. He may come across as sullen, sulking, hostile, or withdrawn. He may speak little, giving one- or two-word answers to questions, and making the therapist desperate to find topics that the patient will talk about. Although his facial expression, voice, and body language indicate that he his angry, he is unlikely to admit it. He does this for a reason, because it is safer to keep people at a distance. His non-verbal behavior sends a message to "stay away from me." His indirect hostility makes it difficult to confront the patient, or to empathize with him. Thus, the patient hides his vulnerability behind a wall of controlled anger. The patient's anger may come out in the form of snide, cynical, devaluing, or critical comments, or complaints. The therapist may feel that the patient is dissatisfied with him, or is impossible to please; at the same time, the detached protector gives the therapist little or no room to approach him more directly.

In contrast to the Angry Child, who vents anger openly, the Angry Protector communicates his anger only in an indirect manner, and strives to keep emotional distance.

9. *Complaining Protector – complains, whines, and demands in a victimized, dissatisfied manner; expresses his dissatisfaction in an off-putting manner that masks his real feelings and needs*

The Complaining Protector complains or whines about situations over which he feels a sense of helpless, but dissatisfied, victimization. For example, he may complain about his physical ailments, and his futile attempts to get them treated. He may complain that doctors have little patience with him, don't take his complaints seriously, see him as a nuisance, or are incompetent. He expresses his complaints in a manner that implicitly or explicitly expresses a sense of victimization. The implication is that others are not doing enough to help, yet the listener may often be left with the feeling that the patient is never satisfied. Paradoxically, the patient's complaining draws attention to his suffering, but often leaves people with the feeling that they are incompetent to help him. The patient's complaining thus keeps others at a distance. The Complaining Protector doesn't show his emotional pain in an open manner, as in Vulnerable Child mode. Instead, the emotion in Complaining Protector mode is expressed indirectly, as irritation, frustration, helplessness, or resignation. The feeling is one of "poor me."

The Complaining Protector bears some similarity to the Angry Protector mode. In the Angry Protector mode, the therapist senses in the patient a smoldering, though controlled, hostility that keeps the therapist (and others) at a safe distance. For example, patients in Angry Protector mode often feel mistreated, and may complain

bitterly about the unjust way in which they are being punished, the privileges they are being denied, and so forth. The patient's affect is one of controlled or suppressed anger directed at the person who is mistreating him. In the Complaining Protector mode, on the other hand, the patient's neediness is more apparent than in the Angry Protector mode. He seeks help, but at the same time, rejects it. His affect may include feelings of anger and victimization, but usually also includes feelings of neediness, helplessness, and self-pity.

Maladaptive Parent Modes – involve internalized dysfunctional parent "voices"

10. *Punitive, Critical Parent – internalized, critical or punishing parent voice; directs harsh criticism towards the self; induces feelings of shame or guilt*

The punitive parent makes itself manifest in the negative, critical, or self-punishing way in which the patient views himself and talks about himself. He may come across as dejected, inadequate, or defeated, telling the therapist that he isn't making progress, has no skills, feels like a failure, and will always be a failure. He may feel guilt and shame, as if he is the source of the problem, even when that is objectively not the case. Thus, he may have an exaggerated sense of responsibility when things go wrong.
He responds to compliments by denying or undoing them, reflectively pointing out his own deficiencies. He may report that he hears a negative, critical voice in his head that causes him to suffer. He is constantly aware of his flaws, which the punitive parent criticizes relentlessly. This is not a psychotic state, because the internalized voice is experienced as a part of the patient. However, it is an indication that the patient is in a punitive mode. This may also express itself in some patients as a general tendency to be critical, intolerant, and moralistic, which may directed towards others as well as toward the patient himself. In general, however, this is more likely to be self-directed in the therapy session. The patient may be so self-punishing as to experience any form of vulnerability or normal human fallibility as weakness.

11. *Demanding Parent – directs impossibly high demands toward the self; pushes the self to do more, achieve more, never be satisfied with oneself.*

The patient experiences the demanding parent mode as a feeling of internal pressure to perform. He constantly feels that he has to do better, that he has to strive to achieve more, that he needs to set higher goals. He is always busy trying to live up to his own expectations. In contrast, the compliant surrenderer is busy trying to live up to the expectations of others. No matter how hard he tries, the demanding parent never feels satisfied that he has done enough. Thus, the demanding parent never makes it possible for the patient to feel satisfied with his progress, or to accept himself as he is without having to prove himself. In the therapy session, the patient may say that he isn't working hard enough, expresses dissatisfaction with his own progress. The demanding parent may also express itself as a general tendency to have too high standards, both for one self and others. Thus, he may put pressure on the therapist to do more, make more progress. However, this tendency is mostly

self-directed. The demanding parent often compares the patient to other patients, viewing the other patients as doing better than he is.

In contrast to the punitive parent, which involves a critical, punitive voice, the demanding parent voice constantly exhorts the patient to do better or more. Thus, while the punitive parent is punishing, the demanding parent is pushing.

Over-Compensatory Modes – involve extreme attempts to compensate for feelings of shame, loneliness, or vulnerability

12. *Self-Aggrandizer Mode – feels superior, special, or powerful; looks down on others; sees the world in terms of "top dog" and "bottom dog" shows off or acts in a self-important, self-aggrandizing manner; concerned about appearances rather than feelings or real contact with others.*

The self-aggrandizer mode likes to present himself in a positive light. He spends a lot of time on his appearance. He tells stories that highlight his specialness. He views himself as superior to others. He feels that he is deserving of special treatment or attention. He feels that the normal rules do not apply to him. He sees himself as an expectation to the normal rules. He can be quite arrogant and devaluing towards others. He puts himself above other people, seeing people in terms of superior and inferior. He finds the idea of being ordinary abhorrent. He likes to talk a lot about himself, focusing on his successes, or on his special personal attributes. He has a marked lack of self-criticism. On the other hand, he easily finds fault with others. He may be very devaluing and critical towards his therapist. However, sometimes he may feel that he and the therapist share a special bond, that they are both special people who are superior to others. The patient may see himself as no ordinary patient. He may tell the therapist or other patients that they can learn a lot from him. He may tell the therapist that he (the therapist) is lucky to have the patient on his caseload. Sometimes the self-aggrandizer may manifest itself more subtly. For example, if the patient has sufficient self-awareness, he may know that blatant self-aggrandizement can make a negative impression. However, his innuendoes make it obvious that he sees himself as superior to others. In more subtle or obvious ways, he wants to dominate or control others, including his therapist. Thus, he make dictate the choice of topics to be discussed, or make it difficult for the therapist to confront him. He is sensitive to the power relationships between people, and needs to assert his dominance when he feels that others are getting the upper hand.

13. *Bully and Attack Mode – uses threats, intimidation, aggression, or coercion to get what he wants, including retaliating against others, or asserting ones dominant position; feels a sense of sadistic pleasure in attacking others*

Patients in bully and attack mode threaten or intimidate others in obvious or more subtle ways. For example, a patient may say that he has a weapon and that he is planning to use it against someone (usually unspecified) in the clinic. He may say that the family members of a treatment provider he doesn't like better be worried. He may raise his voice, stare, point his finger, or interrupt the person whom he is speaking with, to make his point in an intimidating way. He may speak in a loud or out of control manner, get up and pace around the room, suddenly throw objects or slam doors, to make the point that he is angry and that he is someone not to be

ignored. The purpose of these displays of anger is not just to ventilate or express frustration as in Angry Child mode. In Bully and Attack mode, they serve to put the therapist on notice that he ought to be careful of whom he is dealing. Thus, they convey the impression that the patient could become dangerous, and that the therapist better be careful of what he says and does. The patient may attempt to find the therapist's weak points, speaking in denigrating ways about the therapist's personal appearance, personality traits, or events that he knows about from the therapist's life. In contrast to Self-Aggrandizer mode, where the purpose is to make the other person feel inferior, in Bully and Attack mode, the purpose is to cross a boundary so that the therapist feels unsafe or powerless. Thus, the patient tries to gain the upper hand by attacking the therapist's character. When the therapist empathizes with him, the patient may suddenly turn against the therapist, saying pointedly that the therapist has the privilege of leaving the institution, while that he, the patient, cannot, and that the therapist has no idea of how bad it is to be incarcerated. Again, the purpose here, unlike in Angry Child mode, is not just to ventilate frustration; instead, in Bully and Attack mode, the purpose is to keep the therapist off-balance, to leave him feeling that he is "walking on egg-shells," to the point where the therapist may feel afraid every time he considers speaking to the patient. The patient may challengingly ask the therapist what he plans to say about the patient at his next hearing, not simply to inquire, but to put the therapist on notice that he better have good things to say about the patient. The Bully and Attack mode may be evident not only in how the patient interacts with the therapist; it may arise when the patient describes his interactions with other staff members, patients, family members, and so forth. For example, a patient may boast about how he told off a staff member, reveling in how he intimidated or verbally abused the person. There may be an element of Self-Aggrandizer mode in such stories, which present the patient as powerful and superior, and the staff member as stupid, weak, and inferior. However, they can be scored also for Bully and Attack mode if the patient shows the side of himself that uses threats, attacks, or intimidation to put someone else in his place.

14. *Conning and Manipulative Mode - cons, lies, or manipulates in a manner designed to achieve a specific goal, which involves getting what he wants, victimizing others, or escaping punishment.*

In contrast to Bully and Attack mode, which involves direct threats or intimidation (either overt or subtle), in Conning and Manipulative mode, the patient uses indirect methods to get what he wants. The patient may claim to help other people, express sympathy for others, have empathy for the therapist, or present himself as kind, caring, and understanding, in order to curry favor with the therapist. The patient may use or manipulate other patients who are weaker or more vulnerable than he is, for example, asking other patients to do him illegal favors (e.g., hiding drugs in their room), or keep secrets for him. The patient may also spread rumors about others, for example, claiming that another patient is gay or having emotional problems, or that a therapist is having a sexual relationship with a patient. The patient may seek information that he can use against someone, or probe for emotional weak points that he can use to blackmail or manipulate others. The patient may claim to be privy to confidential information about others, in order to trick other people to share confidential information with him. The patient may make up stories about his misfortunes to make others sympathetic to him. The patient may dress in a provocative or inappropriate way in order to provoke a reaction in others (e.g., to gain attention, or to divert attention from other, more emotional issues). The patient may attempt to form a special bond with the therapist, for example, by

speaking in a local dialect with him or her, or claiming to share certain interests or a common background. The patient may use the therapist's sympathy for him to get special favors, like getting the therapist to give him his home telephone number, to intervene for him with other staff members, or to change his report in ways that present the patient in a favorable light. The patient may offer to trade favors with the therapist, like agreeing to do something or make something for the therapist (e.g., making a painting for the therapist), if the therapist gives him something in return. In some cases, the patient may do the therapist unasked favors, like bringing a cup of tea or some candy for the therapist, to create a feeling of good-will or obligation. This is different than in the Compliant Surrenderer mode, where the patient is genuinely concerned about the therapist's approval of him, and is bending over backwards to be a "good" patient. In Conning and Manipulative mode, the patient has learned the adage, "I'll scratch your back, and you'll scratch mine."

15. *Predator Mode - focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.*

The patient in Predator mode seems cold and unreachable, or too calm and under-reactive. He treats others like objects to be used, pushed aside, or destroyed, rather than as human beings. The violence of the Predator is typically cold and calculated. For example, a patient may spend several weeks secretly planning an attack or making a weapon, which he then uses against his victim, either to get rid of him, to take revenge, or to demonstrate his power to others. In contrast to Bully and Attack mode, which involves attempts to threaten or intimidate, the patient in Predator mode simply wants to take care of business, to handle a situation that he finds unacceptable. For example, a patient may take a staff member hostage, not to frighten him, but to gain access to something he wants (e.g., letting the hostage go free, in exchange for being allowed to leave the institution). Similarly, a patient may decide to attack another patient who has been behaving seductively towards him, not because he is enraged, but because he finds the other patient's behavior unacceptable and has decided that it must be stopped. Thus, the purpose is to gain an objective, rather than to frighten someone (e.g., Bully and Attack mode), or to give expression to anger (e.g., Angry Child mode). The victim is treated as an object to be used for a particular end, or if necessary, to be eliminated. In contrast to Angry Child mode, where the patient's rage may lead him to attack someone, the aggression in Predator mode is cold and mechanical. When in Predator mode, the patient's eyes may look blank and empty, his face immobile and expressionless. In contrast, in Bully and Attack mode or in Angry Child mode, the patient's angry and aggression are more visible, his expression more lively. While Predator mode is often involved in calculated forms of violence, patients may also suddenly flip into Predator mode, if something unexpected triggers them. For example, a patient may suddenly get a blank expression in his eyes, begin to talk or act in a strange and frightening manner, not to achieve the effect of intimidating others, but because he was offended or threatened by something that has occurred, and is preparing to respond aggressively. Predator mode can often be seen in patients who have histories as enforcers or hired killers. They may describe their work as "just business" or "nothing personal." The may claim to have no feelings or regrets about they have done, or blame their victims (e.g., for provoking them).

16. *Over-Controller Mode (Paranoid and Obsessive-Compulsive Types) – attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control. The Obsessive type uses order, repetition, or ritual. The Paranoid type attempts to locate and uncover a hidden (perceived) threat.*

The patient in Paranoid Over-Controller mode is sure that others have ill intentions, and is always on the look out, because nothing is what it seems. He easily misinterprets the behavior of others, and has a tendency to focus on small details, misreading them and coming to the conclusions that others are out to hurt him or humiliate him. For example, a patient may notice that his therapist raised an eyebrow, and conclude that the therapist is mocking him. He may notice that the therapist picks up a pen, and become concerned, wondering what the therapist is up to. The patient may combine unrelated bits of information, weaving a story about others malevolent intentions toward him. For example, he may notice a smudge on a photograph, and a red mark on it, and conclude that someone has placed a curse on him. The patient in Paranoid Over-controller mode may ruminate about perceive hurts or injustices that others have done to him, revisiting these episodes and plotting revenge. The patient in this mode is often vigilant to possible threats around him. He may insist on sitting in a corner of the room where no one can sneak up on him. He may refuse to be alone in a room with a door that cannot be locked, or to take a shower with a closed curtain. The patient make go to considerable effort to discover who is out to get him, seeking information, often based in small details, that will reveal the identity of his enemies.

The Obsessive Over-controller uses order, detail, ritual, or repetition to cope with anxiety-provoking or threatening situations. In therapy sessions, patients with an Obsessive Over-controller often tell stories in mind numbing detail. They include many more details than are actually needed, or get so caught up in the details that the main thread of the story is lost. At times, the story can have a pressured quality, as if the patient needs to tell it "just right," or exactly as it happened. The patient may become upset if the therapist attempts to interrupt before the story is finished. In some cases, the mode may dominate the therapy session, as when a patient spends an entire session describing a difficult situation in minute detail (e.g., "I said…, then he said, …, then I said…"), making it difficult or impossible for the therapist to break in. The therapist may sense the patient's underlying anxiety, which the patient attempts to control through the obsessive telling of the story. While the patient is in this obsessive mode, he is often not aware of his underlying anxiety, or of the effect that this side of him has on his listener.

The Obsessive Over-controller may manifest itself in other ways, for example, through the use of obsessional rituals, such as counting or checking. For example, one patient, when worried, would comfort himself by thinking of his "lucky" numbers. The Obsessive Over-controller may also manifest itself by an excessive devotion to certain topics, such as work, where the patient can feel "in control." For example, the patient may prefer to spend the session talking about the details of his working life, rather than other areas (e.g., family, relationships) where he feels less in control. When the Obsessive Over-controller mode is extreme, the patient may appear to be overly intellectual, under rigid self-control, speaking deliberately or precisely, lacking spontaneity, or cut off from his feelings.

Obviously, the Obsessive Over-controller bears some similarity to the Detached Protector mode, which also involves an avoidance of emotion. However, the Over-

controller involves an obsessive focusing on detail, where the Detached Protector does not. The Detached Protector may tell a story in a mechanical, robotic, or unemotional way, but the amount of detail included is not greater than average. Moreover, in the Obsessive Over-controller, the underlying feeling is one of pressure or anxiety; in contrast, in the Detached Protector mode, there is an emotional numbness or absence of feeling. Of course, these two modes may be present in some of the same patients.

Healthy Modes – involve healthy forms of emotional expression and adaptation

17. *Healthy Adult Mode – reflects on himself and his situation in a balanced, realistic manner. Is aware of his needs and feelings; realistically appraises situations and considers how to get his needs met in a productive, appropriate, and adaptive manner.*

The healthy adult is able to look at situations in a balanced way. He is able to integrate thoughts and feelings, so that he is not just using his intellect or his emotions in an extreme or rigid way. He is able to take different perspectives on a situation, including looking at situations from the perspective of another person. Thus, he is able to say, for example, "I can imagine that from her perspective it looks different…" He is able to make room for feeling and expressing emotions, but also to take distance from them in a healthy way. Thus, he moves back and forth from experiencing to reflecting. In contrast, the detached protector mode involves a rigid and immediate distancing from feelings. The healthy adult also involves a realistic appraisal of situations. For example, some patients may have unrealistic views about their future, stating that it will be no problem to find a job, start a family, or avoid problems. Patients with a healthy adult mode are more realistic about their strengths and weaknesses, and can anticipate problems and therefore make realistic plans for the future. For example, a patient may say that his past problems were just due to drug or alcohol problems, or from hanging out with the wrong kinds of friends, or choosing the wrong kind of partner. Thus, he has difficulty in recognizing that some of these difficulties lie in himself. These patients may make statements like, "I'm not doing drugs any more, so it won't be a problem for me to keep a job or avoid crime in the future." These patients have a tendency to externalize, minimize or deny problems, and distance themselves from their feelings. They may believe that they are engaging in healthy behavior. However, their approach indicates the presence of some kind of protector mode (e.g., Detached Protector, Over-controller, Self-Aggrandizer). On the other hand, patients in the healthy adult mode can acknowledge the part of themselves that is scared or has concerns about the future. Thus, the healthy adult is aware of and in contact with the vulnerable side of himself, and acknowledges his fears or feelings of inadequacy.

18. *Playful Child Mode – acts in a playful, fun-loving, free and spontaneous manner; experiences genuine pleasure in people or activities; is open in the expression of his joyful feelings.*

In the therapy session, the playful child can show spontaneous, playful behavior in an appropriate way. For example, making jokes, laughing with the therapist, or laughing about a situation can all be examples, so long as they are done with genuine good will and a sense of humor about oneself as well as others. On the other hand, humor whose purpose is to hurt or belittle others, or to avoid dealing

with real feelings, does not indicate a playful child. Rather, it indicates the presence of a self-protective mode, such as bully and attack, self-aggrandizer, or detached protector. Thus, this humor is more cynical, sarcastic, or devaluing. The playful child is often present at the beginning of the session, if the therapist and patient have a good bond and feeling of mutual trust. The patient may tease the therapist in a playful way about how she drinks her coffee, or her new hairstyle, and so forth. There is genuine affection and mutual positive regard in such interactions; thus, a sense of playful sharing and caring for one another that emerges in small ways. The playful child enjoys sharing his interests or activities with others. For example, a patient may enthusiastically talk about or show the therapist the latest drawing he has made, computer game he has learned, pictures of the family, or the film he has seen. These moments may move from enthusiasm and pleasure, shared in an open and spontaneous way (Playful Child) to more serious reflection of what such activities mean to him (Healthy Adult mode). The therapist and patient may discover that they share mutual interests, for example, discussing with enthusiasm the latest episode of a reality TV program. While the playful child can be very enthusiastic, laughing, smiling, and sharing in a fun and mutual way, he rarely shows the extremes or recklessness of the Impulsive Child. The Impulsive Child sometimes gets carried away with his enthusiasm. He wants what he wants now, or is unstoppable, even when his emotions get out of hand. Thus, he may transgress boundaries, insist on having what he wants immediately, behave in a chaotic or disorganized way, or show bad judgment in acting on his impulses. In contrast, the playful child has more appreciation for the feelings, needs or rights of others. If the patient goes too far in his joking, he will quickly notice the therapist's reaction, and stop, inquire, or apologize. The Impulsive Child is essentially egocentric. He is too caught in what he is doing, in his own impulses or desires, to take account of how they are affecting others. The playful child is engaged in play and fun that is essentially mutual. There is a shared sense of fun and thus also a sense of appropriate limits and sensitivity towards the other person. This mutual fun can help to lighten some of the serious moments of human interaction. For example, the patient may make fun of himself when he persists in doing something that he and his therapist have agreed is not productive. Thus, the therapist and patient can laugh together about human foibles.