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Short Communication

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Enhance Sexual Health with Schema Therapy

Peregrine M Kavros

Director, Schema Therapy Institute SouthEast, Hillsborough, NC, USA

***Corresponding author:** Peregrine M. Kavros, Director, Schema Therapy Institute SouthEast, Hillsborough, NC, USA.

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Abstract

In this Brief Communication, Schema therapy is described as a way of enhancing the therapist's ability to incorporate sexual health interventions when treating a couple for sexual infrequency. The sexual health intervention described in this communication is Sensate Focus [1]. After assisting the couple in identifying their unmet needs in childhood, as well as their schemas (rigid belief systems) and modes (default repetitive emotional and behavioral cycles), the therapist can guide the couple to a greater understanding of how these default emotional and behavioral cycles can contribute to intimacy infrequency. The therapist, drawing upon a series of experiential interventions used in schema therapy: connection dialogue, imagery rescripting, mode chair work, empathic confrontation, and limited reparenting, can assist the couple in the resolution of conflict and establish a stronger emotional and physical bond.

Keywords: Schema Therapy, Sexual Health, Sensate Focus, Schemas, Modes, Experiential Interventions, Emotional Needs

Introduction

A common referral in sex therapy involves couples who report infrequent or no sexual intimacy [2, 3]. Analyzing and guiding the couple toward a deeper understanding of the underlying reasons for the lack of intimacy can be challenging. Difficulties implementing evidence-based interventions, such as sensate focus, are common, even when couples express a desire for change. The therapist may discover that, as treatment progresses, the couple is unable to follow treatment guidelines, particularly concerning Sensate Focus [1]. Reasons for not completing the practicum associated with Sensate Focus may include busy schedules, fatigue, parenting responsibilities, and a preference for passive activities such as watching television or movies.

Schema Therapy, a developmental attachment-based form of psychotherapy, is helpful when avoidance of intimacy is present in a couple. Developed by Dr. Jeffrey Young in the 1980s and 1990s, Schema Therapy provides couples with a clear and understandable framework for understanding why their personalities and ways of interacting with the world and others developed in a particular way [4-6]. Specifically, it explains why couples become stuck in behavioral patterns that block their ability to experience deeper intimacy or physical connection [7-10]. Instead of the couple feeling deficient, default coping modes are described as early survival strategies that originate in childhood [11, 12]. These coping strategies, learned early on and in some cases still useful, tend to be long-lasting. However, they are now often experienced as less effective, especially in nurturing close relationships. Instead of viewing behavioral patterns as uncontrollable, such as "I just can't help the way I react" (a comment I hear often), repetitive functioning that does not meet the couple's core needs is now referred to as a "mode cycle" and a " mode clash " between the couple. Less effective behavioral patterns, modes, can be identified, reduced, and managed [13]. Couples are taught how to identify their modes and mode cycles, stop their mode clash, and adopt new ways of interacting.

Evidence supporting Schema Therapy has demonstrated that when a child's core needs—such as attachment, safety, autonomy, the freedom to express valid needs and feelings, spontaneity and play, realistic limits, and self-control—are unmet, schemas, or rigid belief systems, develop [14-16]. Maladaptive schemas,

if left unaddressed, persist and, when triggered by perceived threats, activate a default coping response that involves emotions and behavior [14, 17]. Essentially, this chained reaction becomes a survival strategy that helps the child cope in an environment that fails to meet their core needs [11, 12]. Ironically, despite a desired positive outcome, the individual can activate the same implicit, chained reaction when threatened, whether consciously or unconsciously. Schema Therapy has been proven to help individuals identify which core needs were unmet and, with the guidance of the therapeutic relationship, fill in the gaps of what was not provided during those early years, transforming their thoughts, emotions, and behaviors to meet their needs in a healthier, more adaptive manner [14, 11, 12, 18-20].

When couples enter treatment, Schema Therapy Inventories (Young Schema Questionnaire-L3 (YSQ-L3); Schema Mode Inventory-1 (SMI-1); and the Young Parenting Inventory Revised (YPI-R3), added to the customary sexual health assessment, provide additional data regarding the impact of selected relational exchanges such as whether individuals have been present over the course of one's life to meet emotional needs [21-23]. Analysis of the completed inventories provides the therapist and the couple with a selection or "mode map" of the schemas and modes that might be activated when the individual is placed in an explicit or implicit threatening situation. Additional schemas and modes that are not revealed in the completed inventory are drawn from clinical interviews, imagery, or role-playing [11, 12]. The YPI-R3 provides information regarding the family of origin's cultural context and potentially how the individual's schemas and modes developed [23]. Young defined eighteen early maladaptive schemas and four basic categories of modes [10]. The relationship between unmet needs, schemas, modes, and possible behaviors reported in treatment is described below (Table I).

Table 1: The Relationship between unmet needs, schemas, modes, and potential behaviors

Needs	Schemas	Modes	Potential Behaviors
Attachment, emotional and physical nurturance, unconditional love, safety, and predictability; autonomy, competence, encouragement in forging an identity separate from the family, striking out on one's own, and expressing ideas safely that went against the grain.	Emotional Deprivation, Mistrust, Abuse, Emotional Inhibition, Defectiveness, Shame, Social Isolation, Dependence, Vulnerability to harm, Enmeshment, Undeveloped Self, Failure	Vulnerable Child	Innate responses to unmet needs
Realistic Limits, self-control, were your caregivers supportive in helping you to identify, name, and express your anger in a regulated way, or that not everyone around you is going to agree with you all of the time.	Entitlement, Grandiosity, Insufficient Self-Control, Self-Discipline	Angry/ Impulsive Child	Innate responses to unmet needs
Spontaneity, play, feeling free, having fun, expressing creativity, sharing thoughts and ideas without judgment.	Negativity, Pessimism, Emotional Inhibition, Unrelenting Standards, Punitiveness	Dysfunctional Critic Demanding/ Punitive	Selective internalization of negative aspects of early caregivers, relatives, teachers, etc.; Projection of negative aspects of early others onto partner.
Freedom to express needs and emotions	Self-Sacrifice, Subjugation, Approval Seeking/ Recognition Seeking	Maladaptive Coping Modes	
		Avoidant/Self-Soothing Protector	Avoidant (Compulsive or Inhibitory Expressions of Sexuality, Substance (alcohol, drugs, internet, porn, work, food), Detachment, Social Isolation);
		Overcompensator	Overcompensator (Aggression, Irritability, Overcontrol, Micromanaging, Demanding, Perfectionism, Manipulation, Excessive Self-Reliance);

Compliant Surrender		Compliant Surrender	Compliant Surrender (Shutting down, Compliance, Somatic Reactions, Avoidance of Intimacy)
Needs of safety, attachment, validation, autonomy, competence, identity, the freedom to express needs and emotions, guidance with respect to limits and self-control, playfulness, and spontaneity were met in an adaptive manner.	Schemas may have been activated, but a caregiver or other was present to help the child modify the impact of the threat.	Happy Child Healthy Adult	Nurtures, validates, and affirms the Vulnerable Child Mode, sets limits for the Angry/Impulsive Child Mode, promotes and supports the Healthy Child Mode, challenges and eventually replaces maladaptive coping modes, and neutralizes critical modes.
Adapted with permission by Joan Farrell, Ph.D., and Ida Shaw, MA, Experiencing Schema Therapy from the Inside Out, The Guilford Press, New York, 2018.			

The interplay between needs, schemas, modes, and behaviors in a composite couple (an example of which is illustrated in the following Mode Clash Form) is described below in the context of an identified heterosexual cisgender couple (Figure I). While the male is defined primarily as Avoidant due to his robust Failure schema, and the female overcompensates in her attempt to please her partner and internalized critic, this gender differentiation can easily be and has been reversed.

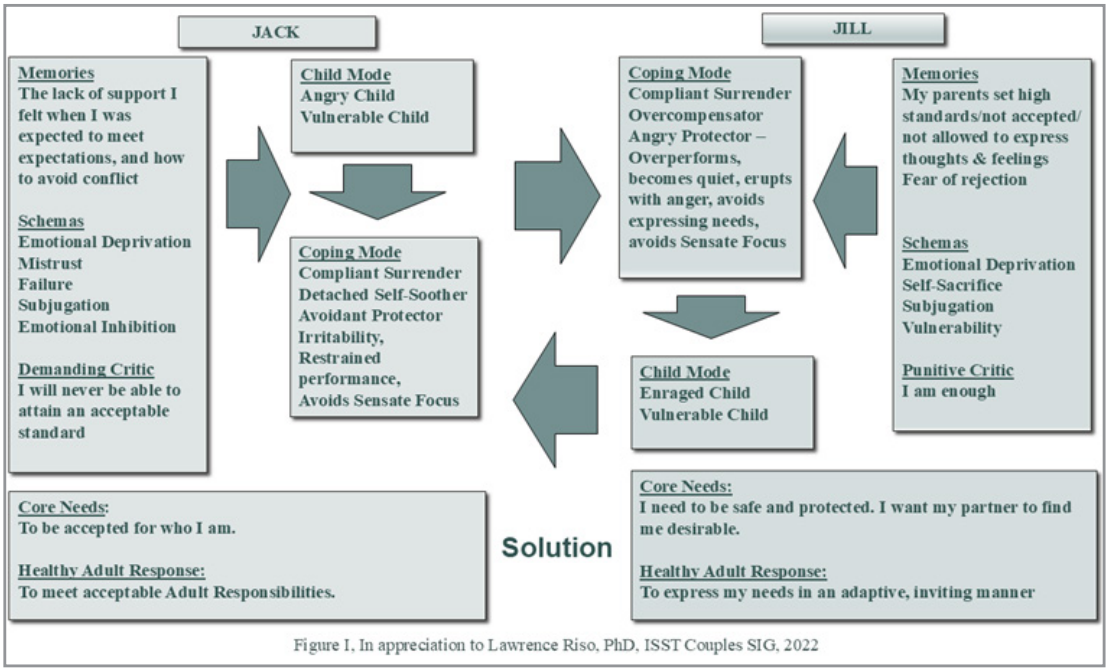

Figure 1: Composite couple experiencing a mode clash

Rather than continue to explore cognitively why the couple appears to be having difficulty implementing Sensate Focus, the therapist, drawing upon the Schema Therapy model, integrates a corrective emotional experience by incorporating any number of the multiple experiential interventions (Connection Dialogue, Conjoint Imagery Rescripting, Mode Chair Dialogue, Empathic Confrontation, and Limited Reparenting), which modifies and integrates the client's internalized early experience of need satiation, strengthening the adaptable and flexible quality of the Healthy Adult mode [8, 10, 12].

For example, the couple guided by the therapist utilizes a form of connection dialogue to identify and express the core need that is at the heart of the conflict. In the composite couple, the core need of Jack is to be seen and accepted for who he is. Jill needs reassurance that she is loved and that Jack finds her desirable emotionally and physically [8].

With Image Rescripting, the therapist, after identifying the feeling of pressure that Jack experiences when Jill approaches him for Sensate Focus practice, encourages the client to hold the feeling and trace it back to its origins. Using imagery, the therapist helps Jack identify his needs in that early experience and then steps into the image, advocating and protecting "young Jack." With exposure to the therapeutic modeling, the older Healthy Adult Jack learns to emulate the protective posture. Then, in another example of conjoint imagery, Jill is asked to step into the image and advocate for "young Jack," strengthening the sense of safety and connection in the face of an early unmet need, and between the couple [8, 10, 12, 25]. Felt closeness and mood

are enhanced in both partners when Imagery rescripting is used compared to cognitive therapy techniques [24].

There are multiple forms of Mode Chair Dialogue that the Schema Therapist can use with a couple. One example is to place the modes that block the desired action of the Healthy Adult on chairs. Jill then engages in dialogue with the modes as she sits in the chair, representing her Vulnerable Child (she can also hold an object such as a stuffed animal, puppet, or even a pillow), thus feeling the impact of what it is like to feel small and vulnerable. By doing so, Jill recognizes early unmet needs and the effect of the more dominant default modes on her younger self. Jack stands behind and beside the Vulnerable Child or the Healthy Adult, along with the therapist, providing protection and encouragement as Jill explores the impact on her most vulnerable feelings [8, 10, 12, 26].

Empathic confrontation and Limited Reparenting are interventions that involve the therapist directly. With Empathic Confrontation, the therapist aligns with the Vulnerable Child by identifying unmet needs. The therapist explains in a warm, nurturing, attuned tone that the couple is unlikely to have their needs met if they continue interacting with their partner while their schemas and modes are triggered. The activated mode cycle tends to push the partner away rather than draw them close towards the emotional and physical intimacy that they desire. The therapist offers guidance and suggests alternative ways for the client to obtain the support they both need and desire. [8, 10, 12].

Limited Reparenting occurs when the therapist uses their emotional, cognitive, and creative toolkit to provide the couple with corrective emotional experiences [8, 10, 12]. For example, suppose the couple's past involved episodes of fragmented attachment, unpredictability, or mistrust. In that case, the therapist describes how they can be available to the couple outside of therapy, such as through email or phone. The therapist can also provide the couple with an audio recording that describes the feelings triggered by the schema mode sequence, coupled with alternative suggestions designed to soothe the activated schema mode pattern. The recording serves as a reminder for the couple of their personalized and couple-focused experiential interventions, which they can utilize to address their underlying core needs. In this way, the therapist and the couple work as a team to fill in the gaps in attunement that were created in childhood. The sound of the therapist's voice offers a soothing and nurturing foundation for the couple, which can counteract mood dysregulation and remind them of their connection with the therapist and with one another [12].

There are a myriad of interventions in Schema Therapy designed to help couples identify, tap into, and heal their core needs. This Brief Communication has described just a few of the interventions available with Schema Therapy and how the integration of Sensate Focus can be facilitated with a couple who express a desire for increased sexual intimacy but who frequently avoid the intervention.

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