SCHEMA THERAPY BULLETIN

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International Society of Schema Therapy

In this issue our colleagues provide rich descriptions of how schemas and modes can become sexualized, and how through careful assessment and targeted schema therapy interventions we can help our patients to develop healthier and more satisfying sexual identities and practices.

Liz Lacy outlines some of the ways that schemas and modes may become sexualized, and reinforces the suggestion that authentic sexuality be considered a core need. She discusses ways in which schema and mode development may be influenced by early, unhealthy exposure to sexual practices, and the ways in which sexualized coping modes may be an attempt at emotion regulation in the face of unmet core needs. Through case examples she shows how particular modes may become sexualized and suggests a number of strategies for therapists to consider in working with these modes, as well as specific challenges to therapists in addressing sexualized modes.

Wendy Behary explores the "complex interplay of developmental, biological, interpersonal, and cultural factors" that may lead to the sexualization of schemas and modes, including early sexual experiences and exposures, cultural influences, and early relationship and attachment styles. A description of how specific schemas may become sexualized is provided. Finally, narcissistic hypersexualization is explained, and through a case example the author shows how schema therapy can heal early wounds and provide a path toward healing.

Andrew Phipps suggests that healthy sexual experiences are associated more with the engagement of the happy child mode than with the healthy adult mode, as has been traditionally conceptualized in schema therapy. He suggests renaming the mode as the "happy/playful" mode to reduce limitations on the range of adult activities that can be considered play. This renaming, he suggests, may be helpful to us in helping to differentiate healthy adult sexual behavior from maladaptive coping behavior as well as better enabling us to validate patients pleasurable play while avoiding judgments and biases.

Ruth Holt highlights the ways in which unmet needs and the presence of childhood trauma, particularly sexual or physical trauma can lead to schemas and modes which may become sexualized as the child matures and begins to develop a sexual self. Healthy sexual intimacy will require the reprocessing of earlier experiences of abuse and neglect. This article focuses on the detached protector mode in particularly, and the ways this mode can impact sexual health and adult intimacy.

Through an in depth case description, **Lars Bang Madsen** writes about the use of schema therapy to address sexual sadism. Exploring how unmet childhood needs, a chaotic childhood and his patients' attempts to cope with anger, loneliness, invalidation and powerlessness led to sexualized coping modes and sadistic fantasies resulting in shame, isolation and anger. Interventions are described and explained as the author is able to help his patient find alternate means to meet the needs unmet in his childhood.

Finally, **Rachel Chapman** describes the ways in which a compliant surrender mode may develop in childhood, and how that mode may play out in relationships, both in the bedroom and out. She illustrates this with the story of a patient she worked with with a strong compliant surrender mode, accompanied by a demanding critic mode, showing how schema therapy techniques enabled her to recognize mode activation and envision a relationship in which her authentic needs and wants could be recognized and met.

Co-edited by
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In addition to these articles, we are pleased to present an overview of the ISST Sexuality and Gender Special Interest Group co-led by Nicole Manktelow and Offer Maurer.

LIZ LACY

THE PLEASURE AND PAIN OF SEXUALIZED SCHEMAS AND MODES: CONSIDERATIONS FOR SCHEMA THERAPISTS

INTRODUCTION

As schema therapists, we are well-versed in the intricacies of modes and their role in complex, chronic psychological disorders. However, when working with patients struggling with those involving sexual behaviors, we encounter a phenomenon that warrants closer examination: the sexualization of schemas and modes. This brief article looks at the nuanced process of mode and/or schema sexualization, its implications for treatment, and advanced considerations for schema therapy practitioners.

THE SEXUALIZATION PROCESS: A DEEPER LOOK

The sexualization of schemas and modes adds complexity to our understanding of their development. This process occurs when sexual thoughts, feelings, or behaviors become intrinsically linked (even fused) with schemas and modes during childhood and adolescent development. This can occur for a variety of reasons. We will first look at many common reasons and then examine how, due to the power of sexuality to soothe and attach us, sexualized coping modes can become overused, compulsive, and/or result in addictive disorders.

1. EARLY EXPERIENCES LEADING TO SEXUALIZED SCHEMAS

Repeated experiences and the fulfillment or frustration of core needs throughout childhood, internalized through attachment processes, modeling, environment, and culture, lead to the development of internalized "maps" for understanding ourselves, others, and the world. These maps, which we call schemas, can be either adaptive or maladaptive. All schemas contain emotional and cognitive content, with maladaptive schemas holding the pain of unmet core needs. Building on the five core needs identified by Young et al. (2003), Maurer and Rafaeli (2016) proposed at the Vienna ISST Conference that authentic sexuality should be considered an additional core need.

THOMAS

Thomas, a 50 year old insurance executive, spent his childhood either alone in his room or in another room listening to his mother having sex with the "man of the day" as he called it. This event occurred several times a week from age 7 to 12. It was his way of being close to her and distracted him from his loneliness. He remembers being both attracted and repelled by the sounds and feelings it evoked. By his mid-twenties, his emotional deprivation (ED) schema, feelings of loneliness and disconnection especially, became fused with sexuality. When I met with him in consultation for couples counseling his wife reported that he would "almost sexually harass" her several times a day insisting on having sex, that he needed it to "calm down" from his day. She could not show him any affection whatsoever without it becoming sexual for him. He also increasingly needed more and more stimulating behaviors (e.g., such as a ball gag so she could not speak during sex) which upset her. So, by the time we met, Thomas not only had developed a sexualized ED schema but also hypersexual, thrill-seeking/self-soothing detachment modes – they brought him both initial pleasure and then pain generated by shame, rejection and more feelings of isolation.

Beyond the usual early maladaptive schema (EMS) experiences we typically see, sexualized schemas and modes often have roots in specific early experiences:

- Exposure to age-inappropriate sexual content or behavior
- Sexual trauma or boundary violations
- Inconsistent or problematic messaging about sexuality from caregivers or culture
- Modelling and acting out of sexually inappropriate behaviors from attachment figures

These experiences can lead to the development of any number of sexualized schemas that interact with and influence mode formation (Young et al., 2003). Schemas that I have found are particularly affected by these early experiences are Emotional Deprivation, Abandonment, Mistrust/Abuse, Defectiveness/Shame, Subjugation, and Enmeshment. Primarily with an association with one of the adverse childhood experiences named above. e.g., sexual abuse leading to feelings of mistrust or abuse with any sexual behavior or needing a component of abuse to experience sexual pleasure.

2. EMOTION REGULATION AND MODE ACTIVATION

We know that modes are activated in response to intense emotions generated from the activation of EMS. In cases of sexualized coping modes, sexual thoughts or behaviors become an expedient means of regulating these emotions (Aldao et al, 2010). This creates a self-reinforcing cycle where emotional distress triggers a sexualized coping mode activation, leading to sexual behavior that temporarily alleviates the distress but ultimately reinforces the schemas and strengthens the mode (Briere & Scott, 2014). As with other schema/mode cycles, primarily because the core needs remain unmet.

3. CONDITIONING AND REINFORCEMENT

The pairing of sexual arousal or behavior with mode activation can create powerful conditioning effects (Boog and Tibboel, 2023; Carnes et al., 2007). Over time, the mode and sexual content become so intertwined that one automatically triggers the other. This is particularly relevant when working with patients who use sexual behaviors as a method of coping with a wide range of emotional states (Hall & Hall, 2011).

MODE-SPECIFIC CONSIDERATIONS

While any mode can potentially become sexualized, certain modes seem particularly prone to this process in hypersexual mode disorders and Compulsive Sexual Behavior Disorder (ICD-11):

1. VULNERABLE CHILD MODE

In its sexualized form, this mode may manifest as sexual fantasies or behaviors aimed at gaining nurturing or validation. The sexual content serves as a substitute for unmet nurturing and safety needs (Arntz & Jacob, 2013).

2. DETACHED PROTECTOR MODE

When sexualized, this mode might engage in impersonal or dissociated sexual behaviors as a means of maintaining emotional distance while still seeking some form of connection, particularly if an enmeshment schema is present in the conceptualization (Young et al., 2003). Other types of sexualized, detached protector modes may also be present with elements of overcompensation, self-soothing, thrill seeking or impulsivity. Some may lead to symptoms of behavioral addictions while others may not.

3. SELF-AGGRANDIZING OR OVERCOMPENSATING MODE (OC)

A sexualized version of this mode often involves fantasies or behaviors that reinforce a sense of sexual prowess or desirability, compensating for underlying feelings of inadequacy or defectiveness (Rafaeli et al., 2015). e.g., often in cases of multiple affairs.

TONY "MILD" OC

Tony felt isolated, defective and rejected in high school and had two very detached parents. As Tony became a teen, he discovered that girls liked him and even the boys who earlier in life bullied him "thought I was cool as shit" because I had sex before they did. Tony still at the age of 47 gets almost all his needs met through having sex with his wife. If she is sick or exhausted during a week, he feels deflated and depressed. As soon as he has sex again, he "feels like part of the human race".

4. IMPULSIVE CHILD MODE

In its sexualized form, this mode may lead to reckless or compulsive sexual behaviors without consideration of consequences (Dir et al, 2014). e.g. jumping from one pornography video to another repeatedly at work when you are bored.

MARTA

Marta was sexually assaulted by her aunt and uncle (primary attachment figures) several times from the age of 6 to 10. She was tied up while it happened. Marta came into my office for her consultation with a tattoo of a rope around her ankle. She associated sexual pleasure with submission, abusive language and degradation. While she did experience pleasure, she also experienced intense shame afterward.

5. PUNITIVE PARENT MODE

When sexualized, this mode might manifest as engagement in degrading or self-punishing sexual activities, reinforcing feelings of shame and worthlessness (van Maarschalkerweerd et al, 2021) e.g. degrading sexual talk during sex, inability to have an orgasm without being hurt or humiliated.

6. COMPLIANT SURRENDERER MODE

In the case of sexual and physical abuse, this mode may become sexualized when the mistrust/abuse schema is activated (Briere and Scott, 2014).

CLINICAL STRATEGIES

Given the complex nature of sexualized modes, we need to adapt and enhance our usual schema therapy techniques:

1. REFINED ASSESSMENT TECHNIQUES

Develop more nuanced methods to identify and map sexualized modes. Consider adapting the Schema Mode Inventory (SMI) to include items specifically addressing sexual thoughts, feelings, and behaviors within each mode (Lobbestael et al., 2010).

2. ENHANCED IMAGERY RESCRIPTING

When using imagery rescripting with sexualized modes, focus on the sexual content of images. Help patients understand the emotional needs underlying these sexual images and guide them in meeting these needs in healthier ways (Arntz, 2011).

3. SPECIALIZED CHAIR WORK

In mode dialogues involving sexualized modes, explicitly address the sexual components. For example, have the Healthy Adult mode empathically confront the sexualized Detached Protector about its use of impersonal sexual encounters (Kellogg & Garcia Torres, 2021; Pugh, 2015).

4. INTEGRATION OF SEX THERAPY PRINCIPLES

Incorporate principles from sex therapy to address issues of sexual health and functioning alongside mode work, helping patients develop a more balanced approach to sexuality (McCarthy & Wald, 2013).

5. TARGETED LIMITED REPARENTING

When engaging in limited reparenting with sexualized child modes, address and normalize sexual development in an age-appropriate way to heal early sexual experiences (Farrell et al., 2014).

6. MODE-SPECIFIC RELAPSE PREVENTION

Develop detailed relapse prevention plans that account for the unique triggers and patterns of sexualized modes, including identifying mode-specific sexual triggers and developing alternative coping strategies (Lacy, 2024).

7. COMPLIANT SURRENDERER MODE

In the case of sexual and physical abuse, this mode may become sexualized when the mistrust/abuse schema is activated (Briere and Scott, 2014).

CHALLENGES AND FUTURE DIRECTIONS

As schema therapists working with sexualized modes, we face several significant challenges:

1. THERAPIST SCHEMA AND MODE ACTIVATION

We must remain acutely aware of our own reactions to sexual content and how these might impact our work with sexualized schemas and/or modes (Lanza, 2001). The typically limited training in sexual assessments and processing of personal sexual feelings can lead to behaviors such as avoidance, punitiveness, over-indulgence, or minimizing the impact of these behaviors in our patients' lives. Addressing this gap in professional development is crucial for effective therapeutic intervention.

2. ETHICAL CONSIDERATIONS

Navigating the complex ethical terrain of addressing sexual behaviors while maintaining appropriate therapeutic boundaries is paramount (Levine et al., 2017). As therapists, we must consistently model and communicate corrective emotional experiences for patients, including appropriate sexual messages, while adhering to professional ethical standards.

3. INTEGRATION WITH ADDICTION MODELS

There is a pressing need to explore how our understanding of sexualized modes can be integrated with established addiction treatment models. Hypersexual modes share similarities with detached protector modes in other behavioral addictions (Lacy, 2024; Ferre et al, 2015). However, the ongoing debate surrounding the classification of hypersexuality as a behavioral addiction in diagnostic manuals like the DSM presents challenges for treatment conceptualization and implementation.

4. CULTURAL COMPETENCE

Developing a more nuanced understanding of how cultural factors influence the development and expression of sexualized modes is essential (Hall et al., 2012). This must encompass not only the LGBTQ+ community but also other cultures whose sexual norms may differ from those of the therapist. Enhancing cultural competence in this area is crucial for providing effective, respectful, and inclusive treatment.

Addressing these challenges will require ongoing research, professional development, and open dialogue within the schema therapy community. By confronting these issues head-on, we can continue to refine our approach to treating sexualized modes, ultimately improving outcomes for our patients and advancing the field of schema therapy.

CONCLUSION

Understanding and working with sexualized schemas and modes presents both challenges and opportunities for schema therapists. By refining our assessment techniques, adapting our interventions, and continuing to explore this complex area, we can enhance our ability to help patients achieve lasting change and improved overall well-being.

Schema therapists are uniquely positioned to address the deep-rooted patterns underlying sexualized schemas and modes. By applying our mode-based understanding to these complex issues, we can offer hope and healing to patients struggling with some of the most challenging forms of addictive disorders and those grappling with sexualized modes. This approach not only aids in treating the presenting symptoms but also addresses the underlying emotional and developmental factors that contribute to these patterns.

As the field of schema therapy continues to evolve, further research and clinical experience in working with sexualized schemas and modes will undoubtedly yield new insights and refine our therapeutic approaches. By remaining committed to evidence-based practice and ongoing professional development, schema therapists can continue to make significant contributions to the treatment of these challenging clinical presentations, ultimately improving the lives of our patients and advancing the field of psychotherapy.

ELIZABETH LACY, LCSW, is an accomplished psychotherapist and clinical supervisor based in New York City. With over 25 years of experience in the mental health field, she has made significant contributions to agency-based administration, program development, and clinical work. Elizabeth holds an advanced certification in schema therapy, as well as certifications in numerous cognitive-behavioral therapy (CBT) protocols and emotion-focused couples therapy (EFT). Her expertise in these evidence-based approaches has solidified her position as a leading authority in the treatment of complex mental health issues.

Throughout her career, Elizabeth has demonstrated a strong commitment to the advancement of mental health care. She is an active member of the Sexuality, Trauma, and Attachment Network in New York City, where she collaborates with other professionals to develop innovative solutions for individuals struggling with trauma and attachment-related challenges. Elizabeth's passion for teaching and mentoring has led her to train clinicians internationally for the past decade. She has also been supervising master's and doctoral-level therapists for 15 years, helping them refine their skills and provide exceptional care to their clients.

Elizabeth's clinical work focuses on the treatment of personality disorders, sexual and other addictive behaviors, and couples therapy. Her extensive knowledge and experience in these areas have earned her recognition as a top therapist in New York City by New York Magazine in 2022. Elizabeth's warm, empathetic approach, combined with her deep understanding of the complex interplay between mental health, trauma, and relationships, has helped countless individuals and couples achieve lasting healing and growth. Her unwavering dedication to her clients and to the field of mental health has established her as a respected and sought-after clinician and supervisor.

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RUTH HOLT

DETACHED PROTECTOR SEX: UNLEARNING PATTERNS OF AVOIDANCE IN A SEXUAL RELATIONSHIP

As I write this I am sitting in a cafe across from a two and half year old eating a gigantic plate of French toast (like pancakes for those who don't know!) He has cream and food all over his face and hands and his focus is intense as he eats. His parents glance over from their breakfast occasionally and smile. His dad is now trying to poke a strawberry towards him and he is showing with his body that he has had enough. Dad doesn't force the issue, although mum now leans over and rubs his back, leaning close to give a kiss on his head. Dad tries one more time with the strawberry and this time, the little boy takes the fruit and devours it. Learning about our bodies, our pleasure and our "appetites" happens in so many of these interactions and we hope that they happen in a context of love, safety and growing autonomy. The accumulation of our experiences of our body and our desires in relationship are the building blocks to Healthy Adult sexuality.

However, sexuality is a complex and vulnerable space for our clients who have had significant unmet needs in childhood. For many of our clients who have experienced abuse and neglect, healthy sexual intimacy requires processing this trauma, and unlearning patterns allowing the opportunity to experience safe, healing sexual contact. I am hoping in this article to provide some ideas for exploring a particularly challenging way that our clients experience their sexual selves: through their detached protector, focussing on 2 common ways this presents in our schema therapy work; detaching through problematic pornography use and detachment resulting from childhood sexual trauma.

HEALTHY ADULT SEXUAL SELF

What is Healthy Adult sexuality? If a child's emotional needs are met in a good enough family and cultural dynamic, with no significant trauma the adult sitting in front of us will have a capacity to have a "Healthy Adult" sexuality that emerges developmentally. Healthy Adult sexuality is a unique configuration of many aspects listed below (Table 1).

CORE EMOTIONAL NEEDS				
Safety, Attachment Predictability & Love	Autonomy, Competence, Identity development	Freedom to express feeling and needs	Play, Spontaneity & Creativity	Realistic limits & self control
WHEN NEEDS ARE MET HEALTHY ADULT SEXUAL SELF EMERGES				
Able to be vulnerable in safe ways, feel worthy of connection, give and receive love sexually	Have sense of autonomous sexual self, feel like a competent lover, have courage to try new things	Assert own needs and feelings without fear of criticism or punishment	Erotic sexuality, imaginative sensory, playful sex, without self-consciousness	A considerate and respectful lover, patient, playful and able to manage impulses in a healthy way

HOW UNMET EMOTIONAL NEEDS IMPAIR HEALTHY SEXUALITY DEVELOPING

Sexual behaviour is a window into a client's relational template – both their relationship to self and others (Johnson & Zuccarini, 2010). Therefore, a client's schemas will provide a way of formulating difficulties in their sexual functioning. Take a moment to think about the clients you have in mind – in what areas were their needs not met? How does this map on to current sexual issues? What are their significant schemas and how might they be present in their sexual functioning?

CASE STUDY

Tim experienced a lonely childhood, with both parents pre-occupied with their own lives, often out at night and then one day when he was 8 years old his mother suddenly left the family. Soon after he found himself connecting more with neighbourhood kids. He told me "I'd already had a lot of experimentation with girls who were my friends from school and of a similar age being 9 or 10 too. I called them my girlfriends and I claimed 3 of them as mine. It wasn't sex but I was very familiar with 3 of my female friend's vaginas and vice-versa, we'd play around with each other a lot on weekends at my house when they would come over to visit me. I know it's common for children at this age to begin to become curious however I also had in my possession hard-core pornographic magazines that I had found including pornographic novels that I read which I'd collected from the local tip (garbage dump) and my friends had them too. So I knew what sex was all about before beginning masturbation. And I remember even from the first attempts that I was into it as much as I could handle." Unfortunately, Tim also experienced sexual abuse from a teacher around the age of 13. Tim learnt to detach from the physical pain of these experiences, but reported that it also made him feel very special to be singled out.

What schemas and modes do you hear in Tim's story?

WHAT IS DETACHED PROTECTOR SEX?

In Young et al.'s (2003) work Detached Protector (DProt) mode is described as including "depersonalisation, emptiness, boredom, substance abuse ... 'blankness' and robot-like compliance" (p. 310) in order to distance from painful feelings. Detached protector can develop, particularly in relation to sex, when

- children are exposed to sexual contact and information without a capacity to understand or process this abusive experience (developing into a detached protector)
- children soothe their unmet needs through masturbation/pornography use/acting out sexually at a young age (developing into detached self-soother or stimulator)

As adults, sex is then often experienced as disembodied. Detached protector mode also exist on a spectrum, from an active decision to move away from emotions and sensations through to dissociation, which is often outside of a client's conscious control.

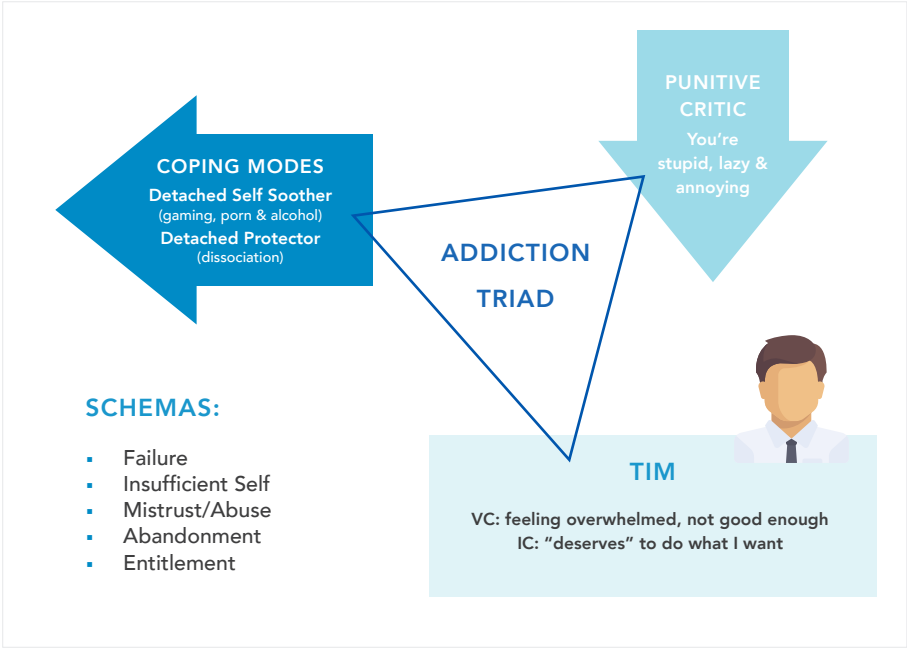
WHAT ARE THE MECHANISMS THAT REINFORCE SEX AS A COPING MODE?

Orgasms are highly pleasurable and involve the release of oxytocin and endorphins, which act as a natural opiate. This creates a sense of relaxation, peace, and calm. In fact studies have shown that orgasm reduces physical pain. Oxytocin is known as the "bonding" hormone – it helps you feel connected. When adult caregivers

are absent or the relationship does not provide safety, sex is a powerful way to feel better, blocking out emotional pain (Esch, & Stefano, 2007). Masturbation and sex can also get risk-taking needs met. Some people are more sensation seeking than others and if life is dull and predictable, sex and porn can meet that need for stimulation and excitement. Pornography can also be addictive and young people can find themselves needing to watch "harder" pornography or masturbate in more risk-taking ways to get the same level of arousal. The higher the quality of family of origin connections the later a young person tends to use masturbation, pornography and sexual contact in young people (Astle, Leonhardt & Willoughby, 2020). If a child has been sexually abused they are more likely to use masturbation as a soothing activity or as a way of trying to make sense of the abuse experience (Boon, Steele, & Van Der Hart, 2011). Masturbation can become a habitual means of calming in a way that is negatively impactful and compulsive. **Unhealthy masturbation and sex involves a pattern of self-soothing and mood regulation in the absence of adaptive coping skills.**

UNLEARNING PATTERNS OF AVOIDANCE IN A SEXUAL RELATIONSHIP

The following steps are part of a larger schema therapy treatment. Tim's formulation is represented below (Figure 1). We did extensive work on each of the identified modes and schemas in addition to the next steps outlined.



1. Building **awareness** of the DProt mode: Catching avoidance in the room and interviewing the mode in a different chair is an important part of building awareness. Awareness of this mode is a key treatment goal because the ability to observe the mode shift is an important antidote to the mode's function.

2. Identifying **what kind of relationship they have with the DProt** is an important part of reducing the power of the mode. In imagery, explore the childhood origins; what the protector is the protecting the client from the protector is protecting the client from – one of my favourite ways to describe the DSS is as a "cocoon ... it shelters you and creates a space where you don't have to think, or feel shame, judgement, loneliness. It's so good inside that cocoon, but then you come out of it and your critic is there to meet you." In this example the connection to the coping mode is as a protector. For many clients their only attachment is to this mode, for others their relationship with the mode is that is "seduces" them with promises, or lifts them out of numbness (detached self-stimulator mode)

3. Having Healthy Adult ways to soothe, connect and feel safe. Many clients who have been abused report that one of the key reasons why they want to keep their DProt mode is that it is "unsafe to feel". They have learnt that their feelings and their body experiences are overwhelming and the DProt keeps them safe. So in order to start to reduce their DProt they need "5 reliable ways to feel safe" that don't involve detaching. 5 is an arbitrary number, but it is also a method that they can remember using each finger.

4. Identify the costs of the mode – the following can be helpful ideas to help your clients start to see the impact of a mode that they feel very attached to:

   - I don't experience the closeness and intimacy I want to with my partner
   - I am unable to say "no" to things I don't like/want sexually
   - My vulnerable child doesn't know what time period I am in and sex can feel as out of control/distressing/unsafe as it did when the abuse occurred
   - t prevents me from taking charge of my sexuality as an adult and
   - reclaiming power that was taken from me
   - It blocks the growth of health neuroception that might prevent re victimization (more likely in survivors of CSA)
   - I get the "oxytocin (bonding hormone) hit" from an orgasm without the actual bond developing
   - The acceptance I crave from my partner that I could feel after sex is muted

BUILDING A HEALTHY ADULT SEXUAL SELF

When Healthy Adult can reliably bring safety and soothing, there will be capacity to build Healthy Adult Sexuality. I have provided 3 of my favourite techniques for this stage of therapy.

1. **Helping Clients get in touch with their body** – this set of questions helps clients to start to engage with their body in a variety of contexts (from Perel & Miller, (nd))

    - What's your favourite temperature of water?
    - What's your favourite temperature generally outside?
    - How do you respond to sun, wind, air?
    - Are you aware of what touches your skin, of what hovers around you? ▪ When you wash yourself, what's your relationship to the body that you're washing? ▪ Do you enjoy touching yourself? not genitals only, but pleasing and soothing yourself. ▪ When you drink coffee or tea are you just gobbling or savouring?
    - Are you aware of your experiences in sensory, sensual, and physical ways?
    - Which is the sense with which you make love the most?
    - Which sense do you barely notice or use?

2. Walking towards exercise – this can be done with a couple or with the therapist and client. Have the client be stationary and gesture with 1 hand for the other to take a step towards them. They can use a "stop" signal when there is the right amount of distance (as confidence grows, ask the client to invite and create distance nonverbally). Below are additional ways to use this technique, depending on the schemas involved.

    - **mistrust/abuse:** Notice where in the body I have feelings of safety or lack of safety. Practice having the walking person 'overstep' the boundary and the client reassert the boundary. Draw attention to how the HA mode can use voice, choice and power compared to the VC
    - **self-sacrifice/subjugation:** Practice being directive and asserting boundaries, while other partner practices being less dominant. Draw attention to the guilt or fear that comes up when a boundary is set and practice HA soothing that distress and staying present.
    - **emotional inhibition:** Learning how to express wanting Attuning internally to emotions and giving expression externally. Practice attuning to the body when triggers or feelings are active "notice what happens in your body if I say "you are strong" or if I say "you are not wanted"

- **defectiveness:** Do I deserve to have you want me? Can I tolerate being seen? Practice being seen and wanted in the safety of the therapy room. May need to start exercise without eye gaze and build up. Another option is to have a piece of paper represent the DProt: Initiate eye gaze and get the client to bring up the paper when they 'need to hide'. Work with them on being able to tolerate being seen.

3. **Catching the shift into detachment** – in the therapy room and outside of session in sexual experiences

Imagery re-scripting gives us powerful awareness of the kinds of touch, voice, location and emotion that have become paired with detachment through traumatic experiences so we can help clients unlearn those habituated processes. Get agreement from the partner to pause when detaching during sex. The couple can develop a grounding tool that they can use together or the partner might help ground "it's 2024 and you are with me, (name) and you are safe". When the client is feeling more present they can reengage sexually. Sensate focus can be a useful tool at this point.

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WENDY BEHARY

PSYCHOSEXUAL DYNAMICS: EXPLORING SCHEMA SEXUALIZATION AND NARCISSISTIC HYPERSEXUALITY

Relevant to this article, I am reflecting on some memorable times with Jeff Young. I'm reminded of a favorite place where we would engage in thoughtful chats about the beautiful schema therapy approach, at the New Jersey shore. Many a late afternoon we would sit on the beach together, long after the others in our group departed for the house. Here we would huddle in our beach chairs, talking all-things-schema-therapy. On one of those days, I recall pondering the question about the *"potential for schemas to become sexualized."*

~ This article delves into the mechanisms through which schemas become sexualized, the challenges of narcissistic hypersexuality, and the application of schema therapy in addressing these complex issues.

That day on the beach, Jeff and I discussed a client (Bill) who could only sexually perform when rooted in one specific fantasy: imagining his partner (Paula) being sexually satisfied by a stranger. Bill described the fear of losing her, the shame around his own sense of sexual inadequacy, his incapacity to fight for her... muted in silent restraint. He would also say it was the most exciting fantasy and the singular path to a satisfying orgasm. But at the conclusion of each sexual encounter, Bill felt angry and depressed; would withdraw from Paula and become critical of her. His excessive viewing of pornography and his responses to her distress, *"you're just so paranoid",* were intolerable to Paula. She was, of course, confused by all of this – not knowing about the underlying fantasy – recognizing Bill's pattern of silence during sex, accompanied by increasing escalations of anger. She ultimately insisted he seek help, *"or else."* Not wanting to face the shame of exposure, and a failed marriage, Bill entered treatment.

Unsurprisingly, Bill had a history that included abandonment by his mom, a general sense of defectiveness linked with that loss, along with the criticalness from a dad who was ashamed of his son's small stature and demanded outstanding competitive performance in academics and sports. One of Bill's chief coping styles, as a young boy, was subjugating his frustrations and detaching into superhero fantasies. As he entered adolescence, with an evolving sexual awareness, he engaged in fantasies that were more voyeuristic – watching others have sex and being a bit of what he called a "peeping intruder", hiding in the shadows. This fantasy, mingled with masturbation, was Bill's secret companion in his lonely teen times.

Along with an empathically attuned therapeutic stance, a comprehensive sex history, and a robust schema conceptualization, limited reparenting and imagery rescripting were the chosen strategies for identifying, connecting with, liberating, and meeting the needs of the lonely, burdened child. The fantasies lessened but did not disappear; they were no longer shame based, nor steeped in the threat of loss. The subsequent episodes of anger ceased. Bill could

(discretely) enjoy conjuring up the fantasy or share it with Paula in a mutually satisfying way. Intimacy was fortified as Paula became aware of and attuned to Bill's unmet need for feeling desired and loveable. And Bill could now reciprocate with present-moment awareness, and affection for Paula.

Early maladaptive schemas (EMS), deeply embedded cognitive, emotional, somatosensory *scripts*, developed through early life experiences, where emotional needs were not adequately met (combined with aspects of our innate structure), play a crucial role in shaping an individual's perceptions and behaviors. When EMS become sexualized, they can become the motivating instigators for sexual excitement, manifesting in (albeit an acute thrill) self-defeating consequences, compulsive sexual behaviors, and unhealthy intimate relationships. There is some evidence for the role of the hypothalamus, amygdala and other subcortical structures in sexual functioning and sexual arousal possibly being paired with schema activation. While not conclusive and not necessarily consistent for all, this would suggest a possible interplay between schema activation and sexual arousal, coming from brain-based-memory-linked structures.

The sexualization of schemas proposal also refers to how arousal systems can be influenced by early life experiences, cultural norms, and interpersonal dynamics. Early maladaptive schemas often develop in response to experiences of trauma, neglect, or invalidation, leading individuals to internalize distorted beliefs about themselves, their bodies, and their sexual worth. Common sexualized schemas may include beliefs of sexual inadequacy (defectiveness/shame) and overcompensating entitlement or avoidantly detached self-stimulating responses. But there are also less obvious schemas that can become sexualized, including: subjugation, abandonment, and mistrust/abuse, and the corresponding *surrendering* responses.

Schemas can become sexualized through a complex interplay of developmental, biological, interpersonal, and cultural factors. Early life experiences, such as sexual abuse, neglect, noxious family dynamics, and other attachment ruptures, can imprint distorted beliefs and perceptions about sexuality. Cultural influences, including media portrayals of sex and societal attitudes towards gender and sexuality, can further affect the sexualization of schemas. Additionally, interpersonal relationships and attachment styles can play a pivotal role in the formation and reinforcement of schema sexualization, with experiences of sexual arousal emerging from reenactments of rejection, betrayal, or invalidation, which may lead to overcompensating sexual responses, avoidance of sex, sexual secrecy, or sexual submission.

EXAMPLES OF EARLY MALADAPTIVE SCHEMAS AND HOW THEY MAY BECOME SEXUALIZED:

ABANDONMENT/INSTABILITY:

Individuals with this schema may experience sexual arousal when faced with a possible rejection or abandonment. They may engage in excessive sexual fantasy of a "chase" or in actual behaviors to keep a partner attentive and present, regardless of possible detrimental costs to them.

MISTRUST/ABUSE:

Those with a mistrust/abuse schema expect others to hurt, abuse, or take advantage of them. This can result in experiencing sexual excitement when engaging in abusive or exploitative relationships or using sex as a means of control or power, either by being submissive or dominant. It can be described as the attraction to, the irresistible and seemingly gravitational pull towards the "bad guy".

EMOTIONAL DEPRIVATION:

This schema involves the belief that one's emotional needs will never be met by others. Sexual arousal may be felt when with a partner who is distracted and disconnected, leading one to execute a flirtatious cat-and-mouse game designed to win attention and affection, often leading to frustrating, unsatisfying, or unfulfilling relationships.

DEFECTIVENESS/SHAME:

Individuals with this schema feel fundamentally flawed or unlovable. This can lead to using sex to gain validation or acceptance, often engaging in sexual activities they might not be comfortable with in order to feel desired or worthwhile.

SOCIAL ISOLATION/ALIENATION:

Those who feel different and isolated from others may find the challenge to fit in or connect with others sexually stimulating; using seductive behaviors, mimicry, and conforming to expectations... despite post-sex experiences of compromised identity, imposter syndrome; still on the outside looking in.

SUBJUGATION:

Individuals with this schema feel they must submit to the control of others and withhold their opinions, desires, wishes, and feelings to avoid negative consequences. They fear that unless they submit to others they will face rejection, judgment, anger, or humiliation. This schema can become sexualized creating a feeling of arousal when finding oneself in situations (or vicarious proximity) where one must be controlled and submissive.

NARCISSISTIC HYPERSEXUALITY

Schemas and narcissistic hypersexuality can be intricately intertwined, each reinforcing and perpetuating the other. Early maladaptive schemas may

contribute to the development of narcissistic hypersexuality by shaping the individuals' beliefs about their sexual worth, desirability, and entitlement to have what they want / do what they want, on demand. Narcissistic hypersexuality is amplified by schema sexualization, fueling compulsive behaviors, objectification of others, and a sense of entitlement to sexual gratification without remorse for transgressions and betrayals – betrayal trauma impact on partners. This pattern represents a fusion of narcissistic traits with highly preoccupied sexual behaviors, characterized by a relentless pursuit of sexual gratification, validation, and control. Individuals with narcissistic hypersexuality often view others as objects for their own pleasure, for admiration, and coercive control through sexual conquests. They may also seek relief from the demands of high-drive achievement through role-plays of sexual submission. Narcissistic hypersexuality serves to bolster the individual's ego, mask underlying insecurities, assist in avoidance of awkwardness with intimacy, and sustain a facade of superiority and specialness, the super-stud, the maverick. It also serves as an easily accessible companion to the unknown and underlying loneliness... often found in the narcissist's early narrative.

THE CASE OF KAREN AND PETER:

SEXUALIZATION OF SCHEMAS, NARCISSISTIC HYPERSEXUALITY, AND BETRAYAL TRAUMA

Karen and Peter have been married for 18 years. They have 1 pre-teen child. Karen has been charged with the burden of attending to Peter's relentless demands for on-the-spot attention and approval. And for most of their relationship, she simply complied with his expectations and demands, despite little reciprocity, lack of intimacy, a waning sexual life and growing criticalness toward her.

Following a "gut-feeling", along with some telltale signs, Karen discovered that Peter had been spending

multiple hours per day viewing internet pornography, chatting with women in cybersex chat rooms, and attending "happy-ending massage therapy". Predictably, Peter angrily denied the accusation, with *"How dare you spy on me!"*

Karen presented the evidence she found on his phone/laptop, and Peter shifted into a defiant-defensive and critical-attacking mode, with escalated shouting, *"It's not a big deal?! Most men do worse!"*.

Karen, weary from years of quiet desperation, now working to address her own schemas and lifelong self-defeating coping modes, was better postured to hold her ground and not give up her voice. She expressed a profound sense of hurt and betrayal, along with an unwillingness to share a future with Peter if this behavior persisted. Peter, unaccustomed to Karen's sturdy emotional stance, became further enraged and began to threaten her with, *"Don't tell me what to do, Karen ... you will be sorry... don't you dare threaten me!"*

Karen sustained a firm resolve and calmly expressed her right to express her feelings and to be respected, as Peter quickly engaged in a blame-shifting mode, rationalizing his actions as Karen's fault: *"You don't appreciate what I do for you... You are so ungrateful... Perhaps if you paid more attention to your appearance, I wouldn't feel the need to... Maybe if you showed more interest in sex and I wouldn't be forced to look elsewhere!"*

Karen was, of course, devastated by his cutting attacks. Seeing her distress, Peter became activated (for a fleeting moment) by a toxically shame-ridden schema – the defective "bad guy". But, just as quickly, he shifted into an overcompensating bully and attack mode, *"You are pathetic ... You are just too sensitive... Don't blame me for your issues with your alcoholic*

daddy ... Just back off!"

Karen, abundantly plagued with grief and despair, attempted a plea to be "seen", to have Peter's empathy and remorse, his accountability for betrayal and hypersexuality, and his aggressive reactions. But Peter was unbendable. And in many of the early encounters he would stomp out of the room, slamming the door behind him.

Silence and disconnection were loudly felt in their home for a period. They reassembled themselves with a typically uneasy and unspoken truce. Both decided they'd like to find a way out of the dark place they were in but struggled to take the torch in hand. For Karen, it was the fear of being played the fool and submitting again, and for Peter it was the stubborn unwillingness to be accountable for his actions, driven by fear of being shamed, rejected, or exposed as a deviant, as a failure.

Peter grew up in a home where the sole responsibility for his mother's joy and sense of worth lay with Peter being her puppet-boy, her trophy, her comfort, and her confidante. He sought pleasure in any stolen moment where he could "get away" with breaking a rule and not getting caught. He excelled academically and went on to achieve many accolades at university and then later in his professional life. He conducted himself with precision when attending to his work, but had no true friends, and poor interpersonal skills – given his constant need for center-stage attention, approval, and power. His (now adult) stolen moments were found in fantasies of sexual conquests, seeking sex from strangers, and pleasuring himself with sexual experiences in camouflaged massage parlors and sadomasochism clubs. He would report a feeling of being "off-the-hook" and unburdened, in charge, and enjoying the *high* of getting away with it. When shame or doubt would rear its head, he would launch into an entitled, self-justifying soliloquy of *"I do so much for my wife and child ... I am a very hard worker ... I deserve to have some fun ... I have a right to privacy ... it's not a big deal."* And then, it became a preoccupation, an obsession. Peter, himself, could see a pattern of need-versus-want and a deterioration in his mood and his capacity for sexual performance with Karen.

A WAY FORWARD:

Healing this relationship from its narcissistic hypersexuality and betrayal trauma would start with, ultimately, constructing a state of empathy and restoring a state of resilience, safety, and trust. To do this, both Peter and Karen would need to enroll in (facilitated) empathic attunement, narrative exploration, schema/schema mode conceptualizations, and emotional needs-meeting work.

For Peter this begins with an *inside-out* approach – forming a connection with "little Peter", to commence the process of eliminating the distractions of underlying shame and defectiveness, enmeshed and suffocated sense of self, and a demanding/shame inducing inner critic. This phase aims to free Peter to see and appreciate the impact of his actions on his partner. But this comes in the context of a comprehensive sexual history and a thoughtfully framed conceptualization, so that he might better understand the "part of him" that acted without regard for consequences; parts designed to disconnect him / medicate him from negative emotions, and elevate his self-concept.

Once Peter can fully appreciate the development of his schema profile and the accompanying self-defeating constructs – as well as the sexualization of his schema(s) and the state of arousal he reports when he is in an overcompensating (*"I'll show you ... I am a rebel"*) mode, his chance for resolving his defectiveness/shame (the bad guy, the disappointment) experiences could enable him to empathically connect with Karen's suffering. He would be freed from his wall of denial, defensiveness, devaluing, and disengagement.

Karen's work would include gaining a deeper emotional understanding of Peter's narcissistic hypersexuality and the challenges of his accompanying entitlement (the extra layer in sexual betrayals when the transgressor is narcissistic). She would also need to see her own activations\ linked with lifelong fears (hypothetically, abandonment) and a submissive coping style. She would need to be open to recognizing Peter's (eventual) capacity to demonstrate empathy and would need to offer (with cautious optimism) an appreciation for his efforts to communicate his empathy and remorse to her. Both parties would track the small victories to stabilize a new and healthy pattern of connection.

It takes a good deal of time, working with them individually and in intermittent conjoint sessions. But much of the time would be dedicated to Peter's covert hypersexual mode – healing the scorching toxic shame he carries via reparenting and imagery rescripting, mode investigations and mode dialogues, meeting early unmet needs and correcting the biased emotional experiences residing in his core.

CONCLUSION

In conclusion, sexualized schemas and narcissistic hypersexuality represent complex psychological phenomena with profound implications for individuals' well-being and interpersonal relationships. Schema therapy offers a nuanced and comprehensive approach to addressing these issues, providing a framework for understanding and modifying maladaptive themes and patterns. By targeting underlying schemas, challenging distorted beliefs, meeting unmet needs, and fostering adaptive coping strategies, schema therapy empowers individuals to reclaim agency over their sexuality and cultivate healthier, more fulfilling connections with themselves and others. The therapy relationship and the use of empathic confrontation will play a leading role in fortifying a sturdy and sustainable connection, especially with narcissistic clients who will squirm and storm when addressing the hypersexuality and betrayal. For more... https://www.schematherapytrainingonline.com/p/empathic-confrontation-wendy-behary

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Wendy Behary has co-authored several chapters and articles on Schema Therapy and Cognitive Therapy. She is the author of an international bestselling book, "Disarming the Narcissist..." translated in 16 languages. The Third Edition was recently released and was selected by Oprah Daily as one of the top books on the subject of Narcissism. Wendy has a specialty in treating narcissists and the people who live with and deal with them. As an author and subject matter expert on narcissism, she is a contributing chapter author of several chapters on schema therapy for narcissism for professional readers. She lectures both nationally and internationally to professional and general audiences on schema therapy, narcissism, interpersonal relationships, anger, and dealing with difficult people. She receives consistent high praise for her clear and articulate teaching style and her ability to bring the therapy to life through dramatic demonstrations of client interactions in the treatment room.

Her work industry business speaking engagements focus on interpersonal conflict resolution. Her private practice is primarily devoted to treating narcissists, partners/people dealing with them, and couples experiencing relationship problems.

DR LARS BANG MADSEN

SHADES OF GREY: A CASE STUDY OF SEXUAL SADISM & SCHEMA THERAPY

> *"Sadism is not an infectious disease that strikes a person all of a sudden. It has a long prehistory in childhood and always originates in the desperate fantasies of a child who is searching for a way out of a hopeless situation."*
>
> Alice Miller (Swiss Psychologist, Psychoanalyst, & Philosopher, 1923-2010)

Martin did not look like a sexual sadist as he fidgeted in his chair, avoiding eye contact and nervously re-adjusting the box of tissues on the adjacent coffee table. Well-groomed and dressed in smart business attire with designer Clark-Gable-like glasses, he would have looked at home in any contemporary men's fashion catalogue. Martin worked in the health sector and had self-referred for schema therapy because he knew *'things weren't right and hadn't been for some time.'*

CORE UNMET NEEDS & EMERGENCE OF SCHEMAS

In our first session, Martin had spoken openly about a difficult childhood. His family experienced instability, with periods of poverty interspersed with brief moments of extravagance, ostensibly for the benefit of others. A chaotic lifestyle driven by his father's unrelenting work ethic, grandiose entrepreneurial ambitions and desires to *'prove himself'* created a home environment devoid of warmth and genuine care, replaced instead by an oppressive intensity to achieve and an ever-present sense of impending collapse.

Martin's role in the family had been established early as a type of caretaker for his mother and a surrogate father figure to his older sister who had an intellectual disability. His parents prescribed his hobbies in line with their perceptions of what was most prestigious in their community and insisted that he speak only English at school and home rather than the native language of their country, largely to

showcase the family's supposed sophistication and status. These circumstances mostly left Martin feeling isolated and misunderstood, a target of constant ridicule and bullying by peers both at school and in the community. Early *diagnostic flashbacks* typically conjured up memories infused with stark themes of loneliness, over-responsibility, and powerlessness. Not surprisingly, on the YSQ, Martin's main schemas were *emotional deprivation* and *inhibition, defectiveness, social alienation, subjugation,* and, of course*, unrelenting standards.*

SEXUAL ABUSE, SEX ADDICTION & PORNOGRAPHY

The sexual abuse started early on with his older and physically larger sister, the perpetrator. It was a confusing time; whilst discovering sex and masturbation introduced a strategy for gaining relief from the chronic anxiety he experienced, the subsequent shame and guilt only amplified his sense of defectiveness and alienation. Paradoxically, this drove him further to pursue sexual gratification to regulate his distress. The discovery of pornography at around age ten intensified this preoccupation, and he recalled spending many hours alone, pursuing and engaging in sexual activity. It was, however, the pornography depicting abuse, humiliation, and the infliction of pain that was most compelling. From that time onwards, he described living a type of *'double life'*; to the outside world he was responsible, considerate and respectable (i.e. the "perfect son/brother"), whilst alone, he retreated to a world of sadist pornography and fantasy. Early on in our therapy, it was apparent the intensity of these sexual urges and sadistic fantasies were greatest during times of strong schema activation, particularly feelings of loneliness (*social alienation*) and emptiness (*emotional deprivation*), powerlessness and resentment (*subjugation*), and shame (*defectiveness*).

EMERGENCE OF SADISTIC MODE STATES

The trigger for coming to therapy for Martin had been an accumulation of discomfort, relating partly to his experience of his pornography use being '*out-of-control*' but mainly to a sense of the sadistic fantasies, desires, and urges having passed a type of threshold. He never disclosed having committed any physical violence or having deliberately hurt his partners. Yet , he recognised that he had become increasingly detached and emotionally cold in thinking about others. And, of course, there was the *anger*.

Martin had always considered anger '*off limits*.' Anger represented chaos and danger. Yet, this had not stopped him from feeling angry; it had just meant that he had suppressed and denied it. There was anger towards his mother—her haplessness, absence, and ineffectuality throughout his childhood. He was angry with his father, whose self-preoccupation and self-aggrandisement he experienced as perpetual abandonment, depriving him of the guidance he craved throughout his childhood and continued to crave as an adult. Then there was his sister, whose dependency on him and constant need for help had trapped him in an aversive and disempowering dynamic that continued to the present day. A sibling relationship stalked by the spectre of the abuse, a factor that served to magnify his feelings of powerlessness and resentment. Over time, however, a more insidious resentment also became apparent in our therapy.

A lifetime of watching pornography seemingly conditioned Martin to view some women through a heavily sexualised lens, an experience that was both automatic and involuntary. This elicited a dialectic of strong feelings, combining desire and powerlessness. He felt he was being deliberately taunted, then denied and rejected. This experience activated his sense of defectiveness, loneliness (*emotional deprivation*) and alienation (*social exclusion*), which, in turn, generated feelings of anger (*unfairness*) and then rage. It was a vicious cycle where his automatic cravings and sexual desires, which had been a source of self-soothing and escape throughout his childhood, became inextricably intertwined with feelings of *defectiveness*, *deprivation* and *alienation*, the 'hot' emotions of anger and rage, but most concerningly, a cold desire for retribution.

In our therapy, anger had increasingly started to surface during our chair work, initially manifesting as exclamations of injustice and unfairness in the *'angry/enraged child modes'*. Using limited reparenting, these angry modes were relatively easy to defuse and soothe. Martin also began to recognise another type of anger that was less chaotic, more entitled, and focused on power – a more challenging and disagreeable mode. Eventually, Martin would call this "the Scarecrow," based on the Batman universe (Langley, 2022), partly because of the character's backstory (i.e. bullying and isolation) but mainly because of its drive to control and the satisfaction it gained in causing pain. Over time, it became apparent that this mode was a suite of modes rather than a single one. The *bully and attack* and *predator* modes motivated to hurt and punish, and in fantasy, destroy others; and then, a *self-aggrandizer* that revelled in the power, control, and suffering inflicted. In each sadistic fantasy sequence, he would flip quickly between the modes. Afterwards, he would feel great shame (*punitive part)* and make promises to himself to 'stop' his behaviour, though inevitably, the cycle would repeat.

Tracing back the origins, he recognised that his pornography addiction took root early in life. Sex became an escape (*detached self-stimulator*), providing reprieve from a reality that felt bleak and joyless (*lost empty child mode*), feelings linked to *emotional deprivation* and *social alienation*. Unwittingly, sadistic themes held an inherent allure, feeding into this toxic cocktail with illusory sensations of control, vengeance, and power - experiences that stood in contrast to the powerlessness he felt in his daily life (*subjugation – emotional inhibition – defectiveness*). What initially began as a coping overcompensatory mechanism had gradually metastasised into the very shackles that imprisoned him today. The more he indulged, the more inured he became to intimacy and genuine human connection, and the emptier, lonelier and defective he felt in his general life. This is why he had come to therapy now—his addiction was a prison masquerading as an escape.

OVER-CONTROLLER MODES, HEALING THE CHILD MODES & MANAGING THE SURRENDERER MODES

Early on, Martin's over-controller mode was obvious in our sessions. He spoke precisely and slowly, carefully choosing his words like a litigation lawyer. He prepared for sessions with 'to-do' lists and requests for 'additional reading' and new 'coping skills' he could practice (though he was well versed in the usual therapy offerings). Therapy was not a collaborative process but a forum for negotiating transactions and treaties. We came to call this part of him 'Lord Business', from the Lego movie, a perfectionist and obsessional over controlling mode whose function seemed to be to ensure that everything was working 'fine' and 'in place' – an antidote to the chaos of much of his early childhood years. Disarming this mode was surprisingly easy. His neglected and lonely child modes were easy to access, and the imagery rescripting for these was relatively straightforward.

'Little Martin' craved love, stability, and safety; opportunities to be listened to, validated, and comforted. The most powerful rescripts usually involved messages about 'not being responsible for everybody else', being free to be a child, playing, and being spontaneous. Martin learnt and accepted that he craved genuine emotional connection, empathy and understanding with others. Taking small risks in his daily life by being vulnerable in his relationships and asking for support and help when he needed it (i.e. pattern breaking) also improved his experience of his relationships with others and reduced his sense of isolation. However, despite this progress, pornography use remained a problem.

The recognition (and acknowledgement) of his 'anger' appeared pivotal in his schema journey. The anger he worked so hard to suppress or deny never went away, and the acknowledgement of it changed his experience of it. It was less frightening and an understandable reaction to his childhood experiences and *unmet childhood needs*. More generally, Martin also started to recognise that he struggled with identifying and labelling emotions and typically did not know what he 'wanted' (or needed) from people. Only through imagery rescripting with his child modes, could he recognise what it felt like to be validated, emotionally safe, and empathised with. These experiences, over time, inoculated in him the idea that his *'needs (also) mattered',* which helped him be more genuine in his relationships but, importantly, also express anger in healthy ways when he was treated poorly.

Martin noted that when he was 'on top' of his schema reactions and engaging his healthy adult, the 'strength' of his anger reduced, as did the frequency of accessing pornography and his indulgence in sadistic fantasies. Nonetheless, progress in therapy was slow and, inevitably, a process of small steps forward followed by relapse.

With a lifetime of relying on these coping strategies, it is perhaps unsurprising that there would be 'sides' of Martin ambivalent about change. His *surrenderer* modes would tell him that he *did not need others*, that *it was too dangerous*, and that *he could not change anyway*. In sessions, these surrender (or enabler) modes stifled progress through long-winded trivial stories, being 'too busy' for regular sessions, or having a superficial crisis that needed to be unpacked in our session. Invariably, a focus of therapy became the management of these coping modes through the use of empathic confrontation and limit setting.

CONCLUSIONS

Few studies have explored the emotional lives of sadists, but the existing research highlights themes similar to Martin's childhood experiences. These themes often involve overcontrolling and emotionally depriving parental figures, leaving children feeling powerless and unable to connect emotionally with others (e.g., Brittain, 1970; Dietz, et. al., 1990; MacCulloch, et. al., 1983). In response, these individuals retreat into a fantasy world where sadistic fantasies provide a sense of control and power absent in their real lives. One case study by Madsen and Bernstein (2023) identified a similar pattern in a sadistic child sex offender, reinforcing these findings. Martin's experience of controlling and emotionally neglectful parents aligns with these observations, suggesting his sadistic sexual fantasies served as a coping mechanism for his lack of control and emotional deprivation.

Working with Martin regarding his sadistic fantasies was undoubtedly challenging. He found it extremely difficult to be honest about these issues in therapy, and it took him a long time to acknowledge and discuss them openly in our sessions. However, by utilizing schema therapy (i.e., Bernstein, et. al., 2007; 2019), we were able to understand and make sense of his fantasies and urges, which helped to diffuse some of his shame. Recognizing the vulnerable child mode and understanding its needs proved to be a powerful tool in changing the behaviours that had troubled him so much.

Although Martin has continued to struggle with relapses, this is a normal part of the therapeutic process. He tends to revert to using pornography and sadistic material during times of challenge and stress. Nevertheless, he now has a much greater awareness of the mechanisms that trigger these coping modes and knows what he needs during these times. This awareness has been instrumental in helping him manage his behaviours more effectively.

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ANDREW B. PHIPPS

SEX AS A 'PLAY STATE': IMPLICATIONS FOR SCHEMA MODE CONCEPTUALISATION

Traditionally, schema therapy associates consensual and pleasurable sex with the healthy adult mode. This article proposes a re-evaluation, suggesting that sex is more appropriately conceptualised as a happy child mode activity. It is argued that we embody the happy child mode when we are in the 'play state.' This state is characterised by active engagement in an activity that provides a sense of pleasure or enjoyment, diminished self-consciousness, and diminished sense of time. As sex provides an opportunity to enter the play state, it appears reasonable to conceptualise this as a happy child mode behaviour. Consequently, the article recommends reconsidering the word 'child' when referring to this mode. It is suggested that the word 'child' may limit our understanding of adult play activities, including sex. Instead, the term 'happy/playful mode' is proposed as a more inclusive alternative. The implications for clinical practice are also explored.

WHAT IS MEANT BY THE TERM 'SEX'?

In this article, the term 'sex' refers specifically to consensual and pleasurable sexual behaviour. This includes a diverse array of conventional practices, such as masturbation, kissing, genital touching, as well as oral and penetrative sex among adults of any gender. Additionally, this encompasses less conventional activities such as those occurring within BDSM (consensual bondage and discipline, dominance and submission, and sadism and masochism), and group-sex. This understanding of sexual behaviour is consistent with Brown (2013), with a focus on behavioural interactions. It is important to emphasise that all participants are presumed to be consenting and legally competent. Furthermore, it's understood that individuals engaging in sexual activity do so with the aim of experiencing pleasure.

HOW DOES SCHEMA MODE THEORY TRADITIONALLY VIEW SEX?

Traditionally, schema therapy identifies consensual and pleasurable sex as a behaviour related to the healthy adult mode. Our most popular treatment manuals (e.g., Arntz & Jacob, 2012; Farrell, Reiss, & Shaw, 2014; Roediger, Stevens, and Brockman, 2018) suggest that a healthy pursuit of sexuality falls under the domain of this mode. This assertion aligns intuitively with our understanding of sexual behaviour. Primarily, we expect sexual interactions to occur between consenting adults. Also, there are many aspects of a healthy sexual interaction that require the skills of a strong healthy adult mode. One example of this may be the capacity to assert personal boundaries, as well as respect the boundaries of others. Despite the obvious need for a healthy adult mode to facilitate sexual activity, the playful nature of sex may suggest that conceptualising it as a happy child activity may be more accurate.

WHAT IS THE HAPPY CHILD MODE?

The happy child mode is the part of us that has the capacity to engage in play activities and engage playfully with the world. This article sees the happy

child mode as in-line with Edwards (2022). Edwards (2022) describes the happy child mode as an active state that has the potential to engage spontaneously with the world, and experience positive emotions such as joy and optimism. The happy child mode is synonymous with play and playfulness (Edwards, 2022; Farrell, Reis, & Shaw, 2014; Lobbestael, van Vreeswijk, & Arntz, 2007). Given this, it is pertinent to define 'play', before sex is discussed.

WHAT IS PLAY?

Despite the numerous definitions of play that appear in the literature (e.g., Brown & Vaughan, 2009; Henricks, 2010; Van Vleet and Feeney, 2015), several themes are generally present. Firstly, is the notion of the 'apparent purposelessness' of play. Play has no immediate survival function and is done purely for its own sake. Secondly, play is an activity that creates a pleasurable affective experience; we do it because it feels good. Thirdly, play is an activity that frequently results in a diminished sense of time; we're more 'in the moment.' When engaged in play, we tend to experience diminished self-consciousness. That is, we tend to be less concerned about our appearance and impression on others and more focussed on the task at-hand. Finally, play is an interactive behaviour, rather than passive. Van Vleet and Feeney (2015) review various commonalities to arrive at the following simple definition of play.

> *"Play is an activity that is carried out for the purpose of amusement and fun, that is approached with an enthusiastic and in-the-moment attitude, and that is highly-interactive".*
>
> (Van Vleet and Feeney, 2015: pp. 632)

It has been argued that play is better understood as a 'state', rather than a certain set of behaviours (Brown & Vaughan, 2009; Grey, 2013). Part of the motivation for this is to avoid the limiting nature that definitions of play can have on what we might define as play. When considering the commonalities in the definitions above, the 'play state' may be experienced as: a sense of pleasure or enjoyment, a diminished sense of time, a diminished self-consciousness whilst engaging actively in an activity. Table 1 outlines the key affective and behavioural characteristics of the play state.

Table 1:

KEY CHARACTERISTICS OF THE PLAY STATE
1. Sense of pleasure/enjoyment
2. Diminished sense of time
3. Diminished self-consciousness
4. Active engagement

This notion of a 'play state' is particularly useful for us as schema therapists as we see modes as behavioural and affective states. To this end, this paper proposes that the experience of being in the happy child mode is synonymous with the play state. If this is the case, we are in the happy child mode when we are in the play state.

IS SEX A TYPE OF PLAY?

Modern writers in sexuality argue that sex is best understood as a form of play (Bem and Paasonen, 2021; Harviainen & Frank, 2018; Paasonen, 2019). Paasonen (2018) argues that the nature of most sexual practices being: voluntary, non-utilitarian, absorbing and pleasurable meet sufficient criteria to be defined as play. Interestingly, Paasonen (2018) describes the play state when referring to the pleasurable and absorbing nature of sex. Harviainen & Frank (2018) liken the ability to master the complex rules that occur within organised group sex to that of skilled 'players' of more conventional complex adult games. Sihvoven & Harviain (2023) identify obvious features of play in BDSM such as fantasy and role-play. As the overwhelming majority of consensual and pleasurable sex is engaged in for its own sake, and allows us to enter a pleasurable play state, it should be regarded as a form of play. As play is a happy child mode activity, it appears logical then, to conceptualise sex as occurring within this mode.

SEX AS 'HAPPY CHILD' OR 'HEALTHY ADULT' ACTIVITY

It is suggested that sexual activity itself is attributed to the happy child mode. As discussed above, sex is indeed a play activity. Sex is also an activity that allows us to enter the play state, where we can experience pleasure as well as a diminished sense of time and self-consciousness.

It is evident however that sex also involves a range of skills that we readily attribute to the healthy adult mode. For example, sex involves embracing vulnerability (e.g., obtaining consent, making requests that may be denied, and nakedness). We must be able to be attentive to the needs and safety of others. We must also be able to demonstrate emotion regulation capabilities such as responding respectfully if consent is withdrawn, or a partner(s) sets unexpected boundaries. In short, sex involves a range of mature and sophisticated functions in addition to participating in the play itself.

It appears that both modes are involved in the process. It may be that the sexual activity itself allows us to enter the happy child mode, while the healthy adult mode performs a range of facilitative functions. These healthy adult functions would no doubt increase the likelihood of a pleasurable and successful experience.

DO WE REALLY NEED THE 'CHILD' IN HAPPY CHILD?

To continue to broaden our awareness of individual play preferences, including sexual play preferences, it may help us to re-think the name of the happy child mode. The overwhelming majority of adult

sexual behaviours are clearly not child activities. Use of the word 'child' in reference to sex is clearly problematic; likely to make therapists and clients feel unnecessarily uncomfortable and potentially unsafe. Furthermore, the use of the world 'child' when encouraging more broader forms of adult play, may be inhibiting for adults. Deterding (2018) and Walsh (2019) both discuss the importance of a relatable adult 'frame' when facilitating adults to play. They argue that language and 'frames' that reinforce commonly held beliefs about play being the domain of children, are more likely to be inhibitors to adult play (Deterding, 2018; Walsh, 2019).

Due to the potentially limiting nature of the term 'happy child', this article suggests 'happy/playful mode' as a suitable alternative. This term allows for a clear link to our original concept, while also focuses on play and playfulness as the main feature of this mode.

WHY IS THIS IMPORTANT AND WHAT ARE THE IMPLICATIONS FOR CLINICAL PRACTICE?

Conceptualising pleasurable and consensual sex as occurring within the happy child or happy/playful mode has important implications for attunement with our clients and validation of sexuality. This positive shift in seeing sex as play, which therefore has infinite variations may reduce therapists' personal biases and unintended prejudice. This is particularly important as we still see diversity in sexuality (e.g., Polyamory and BDSM) being over-pathologized by clinicians as a way of coping with trauma and resultant distress (Fern, 2020; Pitagora, 2013).

This also provides a framework to help clinicians differentiate sex that is play, and sex that is a maladaptive coping strategy. In short, our aim as clinicians is to understand whether the function of the behaviour is to allow us to enter the play state, or whether the function of the behaviour is to allow us to escape from emotional distress. BDSM is a useful example to demonstrate this. In BDSM, roles are often delineated between dominant and submissive parties (Thomas, 2020). These roles appear to resemble 'overcompensating' and 'surrendering' coping states that we refer to in schema therapy. For some individuals, this may indeed be the case. Adopting a dominant role may allow an individual to rise above feelings of fear by holding power over another. Conversely, a submissive role may serve as a form of 'schema surrender' for some survivors of trauma. For the overwhelming majority however, BDSM does not serve as a strategy to escape pain. Rather, most BDSM practitioners experience it as a form of play (Thomas, 2020). Interestingly, levels of emotional distress/impairment in BDSM practitioners have been found to be no different to non BDSM practitioners (Richters et al., 2008). Similarly, lifetime exposure to trauma does not differ between BDSM practitioners and non BDSM practitioners (Richters et al., 2008). In the common case of BDSM as a form of play, we are likely to see practitioners entering the play state. This involves the experience of pleasure, diminished self-consciousness, and diminished sense of time.

Conceptualizing sex as a potential play activity provides a framework to support clients grappling with understanding their sexual preferences, an important aspect of sexuality. Broadly speaking, being attuned to the play state is key to understanding inherent preferences for play (Brown & Vaughan, 2009). When we experience the play state during any activity, we tend to repeat this activity, reinforcing a coherent sense of preferences and identity (Brown & Vaughan, 2009). Sex has the potential to allow us to enter the play state. Recognizing this state alongside specific sexual activities helps us better discern our preferences. This concept aligns with Alan Downs' idea of discovering authenticity (Downs, 2005). Drawing from DBT principles, Downs (2005) describes a process of allowing oneself to: be open to the experience of joy, engage in a behaviour, and repeat the behaviour if it results in joy. The role of the therapist is to assist our clients to recognise the play state when they engage in any potential play activity, including sex.

The idea of attuning to the play state as a guiding principle for preferences and identity is fundamentally simple: if something brings pleasure, continue with it. However, this premise hinges on the assumption that we can achieve a pleasurable play state when engaging with potential stimuli. For individuals who have endured prolonged lack of safety or 'play deprivation,' this may not be immediately possible (Brown & Vaughan, 2009). These individuals are likely to experience considerable difficulty accessing the play state. Schema therapy strategies to recognize and address barriers to the play state extend beyond the scope of this paper. It is hoped that this will be a focus for a future publication.

CONCLUSION

The core message of this article is quite simple: pleasurable and consensual sex is best conceptualised within what we currently call, the happy child mode. It is suggested that this mode be renamed to reduce limitations on the range of adult activities that can be considered play. Happy/Playful mode has been suggested. The experience of the play state is suggested as synonymous to the happy/playful mode. It is hoped that this concept can assist our community to better understand our clients experience of healthy sexual behaviour.

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RACHAEL CHATHAM, LCMHC

THE COMPLIANT SURRENDERER IN THE BEDROOM: HOW OTHER-DIRECTED SCHEMAS CAN LEAD TO EXPLOITATIVE SEXUAL RELATIONSHIPS

For most adults, sexuality is a basic human need. It can provide experiences of profound passion, pleasure, and deep human connection. Sex can be used psychologically, as a way to manage emotions and reduce stress. Additionally, "clinical experience and research findings... attest to how often sexual activity and fantasy are used defensively to master anxiety, to restore self-esteem, to offset shame, or to distract from a sense of inner deadness." (McWilliams 2011).

When our core schemas compel us to place the needs of others above our own, we may unconsciously set ourselves up for manipulation and exploitation. At worst, in cases where the compliant surrenderer mode is a key coping strategy for other-directed schemas, the potential for abuse becomes a real possibility. This can manifest in sexual relationships that are both psychologically and physically dangerous.

Schemas in the domain of other-directedness include subjugation, self-sacrifice, and approval-seeking. These patterns of belief and behavior occur as the result of early experiences with caregivers that were invalidating, highly controlling, and undermining self-trust and self-confidence.

When a child must face a subjugating parent's wrath, whether in the form of seething silence, outright anger, or rage, the intensity of those adult-sized emotions can feel overwhelming. The only recourse for the terrified child is submission and surrender. Walking on eggshells, anticipating the parents' moods, and taking responsibility for their parent's possible stressors become the child's new norm. Since this preoccupation is prohibitive to cultivating a sense of self, compliant surrenderers end up without a solid sense of self-trust. They tend to defer to others who seem to possess the confidence and self-assuredness they lack.

In *The Dance of Anger*, Dr. Harriet Lerner described how self-sacrifice is perpetuated for women through the "Nice Lady Syndrome," of not expressing our authentic feelings for fear of making someone else uncomfortable. Lerner stresses that we preserve "the harmony of our relationships at the expense of defining a clear self" (2014). When we flex the compliant surrender defense, we fail to attune inwardly. The clarity of who we are, how we feel, and what we want all suffer. This is particularly costly in relationships that call for vulnerability, namely romance and sexual connections, which will often trigger the other-directed schemas.

In her book *Children of the Self-Absorbed*, Nina Brown described "sufficient basic approval" which conveys to a child that they are liked and accepted just as they are. Brown goes on to say "If you did not receive (this) basic approval, or received it only for meeting other people's needs, then you may have developed a belief that you must meet other people's needs, wants, and desires to count on their support for your survival. When you don't get their approval, or it appears that you don't have it... this tells you that you are not good enough" (2008). Parents who withhold their support, only to be doled out for their children's acts of obedience, teach them early that approval equals love.

Of all of the coping modes in Schema Therapy, the compliant surrenderer is a mode hell-bent on preservation. Through passivity, surrenderers seek to keep tension and conflict at a minimum and maintain their relationships at all costs. In *Adult Children of Emotionally Immature Parents,* Lindsay Gibson captured the early predicament of so many compliant surrenderers: "Emotionally immature parents don't know how to validate their child's feelings and instincts. Without this validation, children learn to give in to what others seem sure about" (2015).

I have worked with several cases in which the compliant surrenderer has led to sexually manipulative dynamics. These include a client who reluctantly agreed to open a monogamous marriage into a polyamorous one out of fear of upsetting her husband and another client whose partner consistently took advantage of his patience and generosity yet withheld the affection and physical contact he needed and desired.

Of all of the clients I've seen with this dynamic, the case of Olivia best illustrates how other-directed schemas coupled with a compliant surrendering mode can result in exploitative sexual dynamics.

* * *

Olivia entered into psychotherapy with me shortly after separating from her husband. The two had been college sweethearts and married shortly after graduating. Now, in her late twenties, Olivia found herself on her own for the first time in her life. She reported feeling wracked with guilt and self-doubt in addition to a long history of lacking confidence in her ability to make decisions. The fallout from her separation was extensive, and it bled into her relationship with her parents.

"My dad's just someone who's always said 'The right thing to do is to keep your commitments, no matter the cost.' He's not happy in his marriage to my mom. They constantly bicker. But he's willing to sacrifice happiness for marriage, and expected me to do the same." Olivia described her mother as a doting peacekeeper, always trying to appease her husband, who could be a fierce and formidable opponent.

As we discussed Olivia's relationship dynamic with her parents, I learned how they had fashioned a life trajectory for Olivia that looked strikingly similar to their own, replete with the traditional gender roles and lack of fulfillment that Olivia found repellent. Her father had a "save the marriage at all costs" mentality and vehemently shared his belief that divorce equated to a personal failing.

In our work together, we explored the history of her parent's discouragement when she made her own choices and the chronic self-doubt that manifested in Olivia. She had developed approval-seeking, self-sacrifice, and subjugation schemas as a result of her father's controlling and invalidating behavior.

Olivia adopted a compliant surrenderer mode to keep the peace in her family of origin. Her agreeable adaptation kept her out of the firing line with her father. After spending years trying to make her marriage work, she'd finally conceded that it was the wrong relationship for her. While that choice felt right to her, it came at the high cost of losing the support from her parents. Now, she struggled to make the transition to reclaim her life and determine what she wanted.

"I just don't feel like I can trust my own decisions," she confessed through tears.

* * *

In the months since her separation, Olivia had met someone new and started a relationship. Chad was

fifteen years older and had a worldly confidence that instantly attracted her to him. The two had a fiery sexual chemistry, a quality that Olivia hadn't ever experienced before.

Their relationship quickly became sexual and Chad introduced Olivia to the world of kink, bondage, domination and submission. Olivia liked playing the sub role and relished when Chad took control.

Shortly after their first few intimate encounters, Chad suggested that they take their sub/dom dynamic out of the bedroom and incorporate it fully into their relationship. This included Chad's taking an authoritarian role in Olivia's life. He required that she fulfill obligations he set forth around her eating, exercise, and work schedules in addition to meeting his sexual needs regardless of her mental or emotional state or desire. When she failed to meet his demands, he swiftly punished her with the silent treatment. Olivia was tasked with recovering communication between them and reigniting his interest in her which could take days or weeks.

Over the next year, their dynamic took on an even harsher quality. Chad increasingly found opportunities to humiliate and degrade Olivia both publicly and privately. He also introduced other people into their sexual repertoire, which was not Olivia's preference, but she agreed to it to please Chad. She was crestfallen by his treatment overall but found herself conflicted about ending the relationship.

* * *

During our work together Olivia realized her pattern of looking for direction outside of herself. She made the important connection that she'd sought out another strong personality that would tell her what to do, just like her controlling father had always done. Olivia became aware that, despite imbuing them with confidence and wisdom, neither Chad nor her father always knew what she truly needed.

As Olivia became more conscious of her compliant surrender, reinforced with a demanding critic mode, she noticed a feeling of heaviness in her body when it was activated.

Through behavioral rehearsal, we prepared Olivia for challenging conversations with her dad. Using imagery, we reparented the vulnerable child by expressing curiosity and affirming her feelings and instincts. Olivia and I reviewed the cycle of abuse and she was able to recognize how her dynamic with Chad was part of a larger pattern of mistreatment.

Over time, Olivia understood how she'd come to equate approval with love. As we disentangled these concepts, I also introduced loving-kindness practices from the Buddhist tradition designed to cultivate self-love and self-compassion.

Through exploring her feelings, she realized how her relationship with Chad had depleted her, leaving her feeling guilty, wrong, and bad for not catering to his demands. Olivia realized that it was okay for her to have preferences and that having her own needs was both normal and healthy. Eventually, she discovered how good it felt to be with people who expressed genuine interest and curiosity about her thoughts and feelings.

Olivia articulated her newfound self-awareness and a spark of hopefulness during one of our sessions together:

"I've always relied on external approval and criticism to let me know if I was doing the right thing or the wrong thing… and I don't want to do that anymore. I'm finally starting to know what I want, and I want to be in relationships with people who really care and are curious about me. Do you think there are people like that out there?" She smiled and let out a laugh.

"Yes," I smiled back. "I'm certain that there are."

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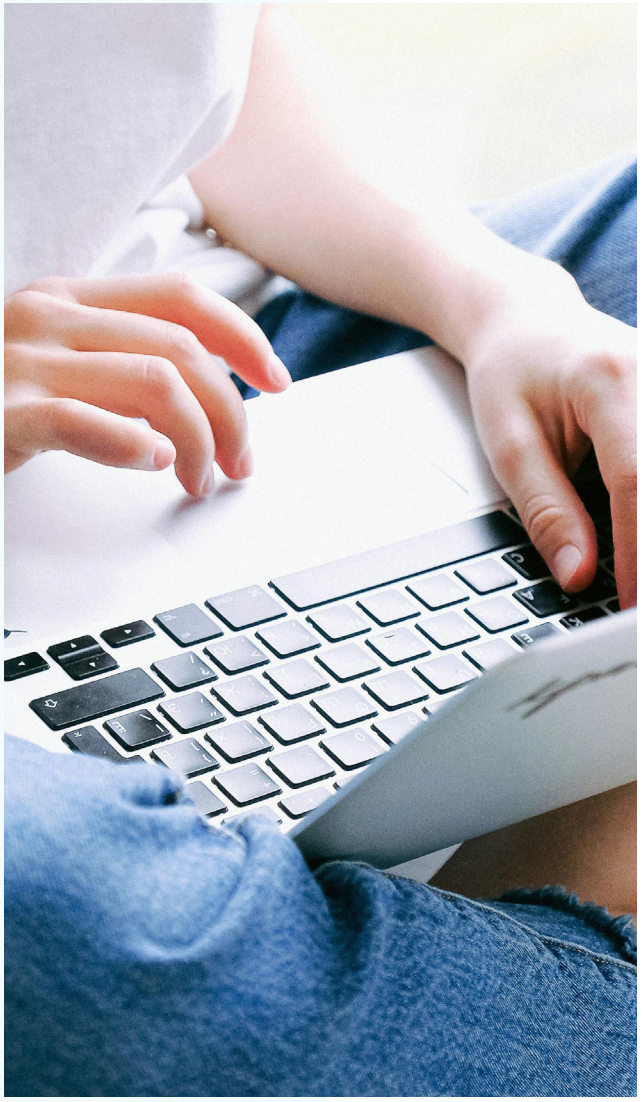
ISST SEXUALITY & GENDER SPECIAL INTEREST GROUP

Sexuality and gender are two psychologically central and intertwined topics. Both run deep and have far-reaching influences for all human beings' lives. To date, the Schema Therapy formal literature and informal discourse have both left these issues largely unexplored. As a consequence, the ways in which needs, schemas, coping styles and modes are implicated in people's sexuality and gender are still very much unknown. Our special interest group focuses its discussions on questions pertaining to sexuality and gender through a Schema Therapy lens.

The sexuality and gender special interest group meets once a month (excluding July and August) 8am UK time. We are yet to determine the day/date for the next meeting in September. Our meetings over the past year have been a mix of case studies and presentations, with a particular focus on trans and non-binary presenting clients. We have also delved into literature and readings that can be translated through a schema model and assist clinicians in their work.

Should you have an interest in joining our group, which is well attended by people all over the globe, please contact Dr Nicole Manktelow via email nmanktelow@gmail.com and we will be sure to add you to the group and notify you of meetings and any other resources likely to be of interest to schema therapists with an interest in Gender and Sexuality.



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Working in the Dark? Exploring the Relationship Between the Dark Triad and Early Maladaptive Schemas

S. Judith Ray, K. Fritzon

Judith Ray, S., Fritzon, K. Working in the Dark? Exploring the Relationship Between the Dark Triad and Early Maladaptive Schemas. *Trends in Psychol*. (2024). https://doi.org/10.1007/s43076-024-00374-3 https://link.springer.com/article/10.1007/s43076-024-00374-3#rightslink

Intervention on Trauma in Developmental Age

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Schema therapy for cluster C personality disorders. Treatment of the Dependent, Avoidant, and Obsessive-Compulsive patients

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