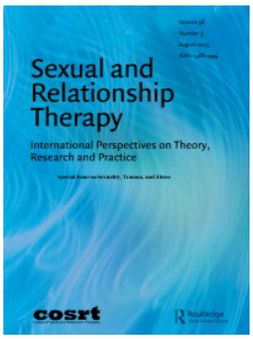

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Introducing compassion focused psychosexual therapy

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ABSTRACT

Psychosexual therapy has undergone numerous developments since the introduction of behavioural therapy for sexual difficulties by Masters and Johnson in the 1960s. We argue that theory and practice from Compassion Focused Therapy (CFT) offers a novel and relevant development to existing approaches to psychosexual theory and practice. CFT presents a theory driven, flexible, trans-diagnostic and integrative way of understanding, formulating and treating general mental health problems. In this paper we propose that the underlying theory from CFT integrates well with existing approaches to psychosexual therapy, and offers some helpfulways of formulating sexual problems to present a coherent rationale for treatment strategies. We also argue that some additional CFT treatment strategies already used in general mental health settings are appropriate and helpful for those experiencing sexual difficulties. This paper outlines how CFT can be theoretically integrated with existing psychosexual therapy.

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Introduction

Sex can be a highly pleasurable, connecting and motivating experience for many people. There are many reasons for moving towards sex, including procreation, pleasure, to gain power or to express love for someone (e.g. Meston & Buss, 2007). Whatever the case may be, sex can be rewarding, affirming and fun. However, sex can also be source of significant difficulty and distress for others. Sexual difficulties such as pain with penetration, erectile difficulties, low desire, early ejaculation and difficulties with orgasm are fairly common (Mitchell et al., 2016). Recent UK population research estimates that approximately a third of people experience one of these difficulties, however when other morbidity factors (e.g. significant distress) are accounted for, estimates reduce to approximately 3–4% (Mitchell et al., 2016). As well as impacting sexual pleasure, sexual difficulties can affect many aspects of people's lives and can

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contribute to difficulties in relationships (Christopher & Sprecher, 2000), shame, embarrassment, low self-confidence, anxiety and depression (Ayling & Ussher, 2008; Laumann et al., 2005; Sotomayor, 2005). There is also considerable shame and stigma related to sexual difficulties, which can inhibit professional support seeking (Gott & Hinchliff, 2003; Sheppard et al., 2008).

Given this, there is great interest in psychological approaches for sexual difficulties. This paper introduces the theory of Compassion Focussed Therapy (CFT; Gilbert, 2009, 2014; Gilbert & Irons, 2005) and how it may be used in understanding and formulating sexual difficulties. The paper begins to introduce some of the practice of CFT and how it may be beneficial in psychosexual therapy, with a view to expanding on this in later publications. We propose that the underlying theory from CFT offers a transdiagnostic, flexible and integrative approach to formulating sexual difficulties. CFT coherently integrates theoretical and empirical work from a range of fields including evolutionary psychology, neurobiology, attachment theory and clinical psychology, alongside existing theory from psychosexual therapies and sexology. We argue that CFT could be integrated with traditional psychosexual therapy to help people take a more compassionate stance towards their difficulties and take steps to improve their sexual wellbeing. This paper focuses on the theory of CFT, psychosexual difficulties and formulation, providing a starting point for developing the therapeutic technique in the future.

Existing approaches to psychosexual therapy

The most well-known and widely used form of psychosexual therapy was initially proposed by Masters and Johnson (Linschoten et al., 2016; Weiner & Avery-Clark, 2014). They introduced a behavioural approach to psychosexual therapy in which various behavioural strategies are practiced to reduce avoidance of sex and re-introduce sexual and sensual touch in a graded way. Examples of the behavioural interventions include sensate focus (where couples progressively introduce or re-introduce sensual touch) and vaginal trainers for pain with penetration.

Since Masters and Johnson's behavioural approach, numerous integrations and adaptations have been developed including cognitive therapy approaches (e.g. Ford, 2005; Hawton, 1985; Payne et al., 2005), systems and couples' approaches (Clement, 2002; Gehring, 2003) and critical and third wave approaches (Atwood & Dershowitz, 1992; Barker, 2011). More recently, mindfulness approaches have been promoted and researched (Brotto et al., 2008; Stephenson, 2017; Stephenson & Kerth, 2017). Integration has been argued to be the new paradigm in sex therapy, with theory and practice constantly developing in line with theories and therapies in general mental health (Weeks, 2005).

In terms of efficacy, reviews of existing psychosexual therapy approaches indicate mixed effect sizes, for example for female sexual difficulties (Frühauf et al., 2013; Pereira et al., 2013), erectile difficulties and early ejaculation (Althof, 2006; Melnik et al., 2008; Metz et al., 1997). A more recent review of mindfulness-based therapies suggested emerging evidence for the effectiveness of this approach for female sexual difficulties (Stephenson & Kerth, 2017), and there is increasing interest and evidence

for Eastern approaches (e.g. yoga, acupuncture and mindfulness; Brotto et al., 2008). A review of the current evidence around compulsive sexual behaviour noted few treatment studies and continued debate around categorisation of the difficulty (Derbyshire & Grant, 2015). Thus, the current evidence for existing approaches to psychosexual difficulties suggests that they are effective for some people, but not everyone. Moreover, benefits are not always maintained. This supports the need for continued integration and development of therapy and models. It is also important to note that many trials tend to exclude participants where there may be complexities (e.g. comorbid mental health difficulties), potentially reducing their applicability to populations seen in typical National Health Service (NHS) clinics. McCarthy and McDonald (2009) emphasise the importance of understanding why some people do not find psychosexual therapy helpful and discuss sex therapy "failures" according to psychological, biological and social/relational factors. They note motivation, systemic patterns and shame as being important factors to consider. Sheppard and colleagues (2008) note that some people can experience shame simply through being referred for psychological therapy and may never attend their first appointment.

CFT may have the potential to address some of these issues for some people. A starting point of CFT is to present the formulation in a way that promotes non-judgement, affirmation and challenges shame. Coherent and normalising psychological formulation has been argued to be a key factor in recovery for those with psychological difficulties (e.g. Johnstone, 2018**).** It plays an important role in de-shaming problems and supporting clients to connect and collaborate with the therapy process. A collaborative and shared understanding of the difficulties can help clients to engage with therapeutic techniques and homework tasks, increasing the likelihood that the therapy will be effective (e.g. Rees et al., 2005). Although there are no published studies in the field of psychosexual therapy that directly explore clients' experiences of formulation, it is likely that formulation of psychosexual problems also plays a key role in the therapeutic process. CFT provides a way of formulating difficulties in a normalising and coherent way, which in itself may be therapeutic. In psychosexual therapy the need for an individualised approach has already been argued (e.g. Irwin & Pullen, 2019), and the flexibility of CFT certainly allows for an individualised formulation approach. Additionally, within the formulation, CFT can also include comorbid mental health problems, and allow for a coherent and joined up treatment plan where sexual difficulties and mental health difficulties are experienced together.

As noted by McCarthy and MacDonald (2009), shame can be an important factor in sex therapy failure. As well as providing a de-shaming formulation, CFT typically works directly with shame and self-criticism, looking in detail at the manifestation and function of the inner critic (e.g. Andersen & Rasmussen, 2017; Irons & Beaumont, 2017). In sex therapy, where someone's self-criticism is inhibiting their progress with the behavioural strategies introduced (e.g. dilator use in painful sex), working with the inner critic first may be very beneficial and lead to improved motivation for behavioural strategies.

An additional barrier experienced in psychological therapy for mental health problems is the experience of rational-emotional dissociation (e.g. Stott, 2007), where clients understand cognitively that a thought is irrational, but don't *feel* this

emotionally. In terms of psychosexual therapy, this may also play a part in the therapeutic process for some clients, and may inhibit fully engaging with some of the behavioural strategies suggested. Some of the therapy processes in CFT explicitly aim to facilitate emotional shifts using non-verbal strategies (e.g. soothing rhythm breathing and imagery strategies; Gilbert, 2009; Irons & Beaumont, 2017), rather than targeting thoughts or behaviour alone. For some clients this may be an important step in making changes.

In summary, the dynamic integration of relevant therapy models in psychosexual therapy continues to address the mixed evidence for effectiveness of psychotherapeutic approaches. We propose that this presents a rationale for exploring the theoretical and practical integration of ideas from an additional novel, transdiagnostic, integrative and flexible therapy model: CFT (Gilbert, 2009).

Compassion focussed therapy

Compassion Focussed Therapy (CFT; Gilbert, 2005, 2009a) was developed initially following observations of people experiencing high levels of shame and self-criticism, and the inhibitory impact of these on the therapy process. These observations led Gilbert to develop psychological theory and practice, which integrate ideas from Cognitive Behavioural Therapy, however expand out to also include evolutionary psychology and attachment theory, neurophysiology and neuroscience and Eastern philosophy along with ideas and interventions from various evidence based therapies to assess, formulate and treat psychological difficulties. Therapeutic techniques from a variety of different therapy models are integrated, for example, breathing work and cognitive challenging typical of CBT, imagery work typical in trauma focused therapies (as well as others), chair work typical of Gestalt and Emotion Focused Therapy, as well as relational and process work more typical in psychodynamic approaches (Bell et al., 2020; Gilbert, 2005; Irons & Beaumont, 2017). Since its introduction, CFT has been increasingly used for a variety of presenting difficulties, including depression (Gilbert & Irons, 2004), bipolar disorder and psychosis (Heriot-Maitland et al., 2014), eating disorders (Goss & Allan, 2010), and persistent pain (Penlington, 2018). A systematic review in 2015 concluded that there is emerging evidence for CFT, particularly amongst people with high self-criticism (Leaviss & Uttley, 2015).

A CFT approach to sexual difficulties

A description of a CFT approach to sexual difficulties is presented in the next sections of this paper, including an evolutionary approach, social mentalities theory and a model of affect regulation known as the Three Systems Model. A definition of compassion used in CFT and a model of a compassionate response, using competencies of compassion are then presented. Potential clinical applications are presented subsequently to link theory with practice in psychosexual therapy.

CFT, sex and evolution: the tricky brain

One of the underlying principles of CFT is to challenge shame and self-criticism by using evolutionary theory to argue that many of our difficult experiences are to be

expected given the way our brains and bodies have evolved. Rather than pathologising difficulties, evolutionary theory is used to normalise and explain why humans struggle with many aspects of life. Our brains and bodies have evolved to survive various threats to existence and to procreate our genes (Dawkins, 1989). CFT emphasises that the process of evolution does not result in "perfect" systems, but systems that have adapted to various different environments at different times. Some of our emotional responses have been adaptive in fight, flight or freeze situations, but are less adaptive, and often not helpful for us when feeling challenged or threatened in other situations (for example, during sex). Sexual function has also evolved over millions of years, and adapted to a variety of different environments (Dawkins, 1989). Therefore, a CFT approach would argue that it is not surprising that some adaptations *feel* less helpful in modern contexts.Adaptations in the evolution of sexual function typically use existing systems in different ways. For example, oxytocin and vasopressin are both neurotransmitters important in sexual function, connection and bonding in humans (as well as other species who form monogamous pair bonds or use sex for social bonding; e.g. Young & Wang, 2004). However, these neurotransmitters are involved with other social functions, such as mother-infant bonding and territory guarding (Holley et al., 2015; Kendrick, 2000; Neumann, 2008), with the implication that sex is complex and tricky on a neurobiological level, and is not a perfect and neatly organised system.

CFT argues that the continual evolution of our brains has led to a tricky brain rather than a perfect brain. In CFT a way of highlighting evolved processes is to make a distinction between the old brain and new brain (Gilbert, 2009b). Old brain systems include areas such as the limbic system, which is involved in immediate emotional reactions to stimuli (e.g. fight/flight/freeze), with motives to survive (resources and safety) and to reproduce (sex). The new brain refers to frontal areas, which are involved in complex reasoning and social cognition. With the addition of newer frontal areas of the human brain, the limbic emotional response to threat or challenge can be triggered by internal thoughts, images, worries and memories. Whilst adaptive in some circumstances (preventing against future threats to safety), this temporal mismatch can also lead to emotional responses being continually activated in the absence of actual or real external threats. For example, worrying about sex going wrong before one is even in a sexual situation.

In the case of sexual difficulties, our ability to create representations, meanings and ideals about sex (new brain) which then activate older brain areas (feelings of arousal or feelings of fear, shame and deactivation), can lead to considerable distress. As far as we know, no other species can deactivate their sexual arousal with worries about their body shape or whether their partner is enjoying themselves during sex (Gilbert, 2009b). This potential for unhelpful loops between thought and emotion are prime examples of the tricky brain.

The evolutionary model also highlights the potential for survival motives to conflict or clash against each other, whether they are within the old brain or between the old brain and new brain (Gilbert, 2015a). For example, the motive for safeness seeking (affiliation and connection with others) and sex (reproduction and/or connection) are both old brain motives. However, in the context of a sexual difficulty, an old-old

brain conflict may be that there is a strong impulse to connect with another or reproduce, but a strong fear/anxiety (safety motivation) reaction to sex, if there have been previous sexual difficulties triggering shame or sexual trauma. Old brain motives may also conflict with new brain motives of morality (for example, religious chastity or no premarital sex). Motivations are usually inferred by their associated emotional reactions (e.g. motivation for safety may be visible by the emotion of fear when safety is challenged) and If motivations start to contradict and/or compete against each other, one can expect a complex emotional reaction that can become difficult to resolve (Gilbert, 2015a).

Where other species may use sex for procreation, bonding and pleasure when our thinking brain gets involved there can many more reasons and motivations for sex. One study found that 237 reasons were identified as motivators for sex, from relational, to spiritual and simply passing the time (Meston & Buss, 2007). Social reasons for sex were very commonly reported, in terms of bonding, power, vengeance and mate guarding. For humans the complexity of motivations for sex certainly fits with the idea of a tricky brain.

Within CFT, normalising common experiences (e.g. changes in desire, quicker than preferred ejaculation) as a function of how our brains and bodies have evolved has the potential to de-shame and demystify common sexual experiences, whilst allowing for conscious change where there is a desire to engage in action. For women, theory and arguments informed by evolutionary psychology (including The Dual Control Model, Janssen & Bancroft, 2007) have already been used to formulate and normalise sexual difficulties (Nagoski, 2015). The Dual Control Model is a theoretical neurophysiological model of sexual responsiveness and sexual behaviour (Janssen & Bancroft, 2007). The model fits well with the CFT model of emotional regulation, where complex patterns of upregulating and downregulating of different emotions throughout the day are likely to impact on sexual arousal. The model's focus on biopsychosocial influences and the focus on evolutionary adaptiveness compare well with the underlying theory of CFT, which also normalises differing emotional and behavioural responses as adaptive in nature rather than abnormal. For example, according to the Dual Control Model, sexual inhibition would be adaptive in an environmental situation of high stress, where concerns other than procreation or forming new social/pair bonds are of higher importance (Bancroft et al., 2009). The old brain – new brain model of CFT fits well with some aspects of the Dual Control Model; which also proposes both conscious and automatic pathways to inhibiting arousal on a physiological level, (Bancroft et al., 2009). The similarities and links between the Dual Control Model and CFT lends support to using the underlying theory in CFT to understand and formulate sexual difficulties. However, as CFT is a more general theory than the Dual Control Model, it provides more flexibility in formulating a variety of different problems, along with therapeutic strategies and techniques that may benefit clients in therapy.

Social mentalities

Social mentalities are the cognitive, affective and behavioural patterns activated when a person is in a social (or potential social) encounter with another (or an imagined

other; Liotti & Gilbert, 2011). They serve to link the relevant motives and basic emotions within social (and sexual) roles. Unlike many other species whose sexual social mentality may be switched on and off automatically at certain times of the year, humans drift in and out of various social mentalities throughout the year: sexual, caring, competitive and receiver of care. Where a certain pattern of social mentality has become more fixed (e.g. competitive or caring) it may become very difficult to quickly and automatically switch motives and re-regulate the basic emotional system. For example, if someone is characteristically in a competitive social mentality, the motive for achievement, success and excellence may inhibit responses that could lead to more enjoyable, free-flowing and unconstrained sex.

Existing theory on sexual difficulties has highlighted the particular difficulty faced by humans around managing long term relationships where numerous roles are required, for example managing the holding roles of a lover, co-habiter, co-parent, and sometimes co-worker all within one relationship (Perel, 2007). Within CFT, this would be formulated as moving between social mentalities with different motivations and different patterns of cognitions, emotions and behaviour. Considering social mentalities offers a way to integrate CFT with alternative therapeutic approaches to sexual difficulties that are more social in nature, e.g. systemic or couples' approaches (Carr, 2014; Gehring, 2003). CFT strongly emphasises the role of relationships in how we function, where difficulties can arise due to patterns in our social functioning.

Three systems model of affect regulation

A key part of CFT is to use an evolutionary functional perspective to understand emotional and mental health difficulties, emphasising the function of emotional systems and affect regulation. A heuristic is used to describe how emotions can be clustered into three distinct systems, based on how they have evolved to help us navigate our complex world (see Figure 1):

- threat detection and protection
- drive and resource seeking
- rest and affiliation (Gilbert, 2009a; Panksepp, 2010)

These systems have evolved to keep us alive and safe in harsh environments. The Threat system alerts us to danger, whereas the Drive system propels us to seek food, territory, and sexual opportunities. The Soothing/Affliative system promotes rest and food digestion, in addition to nurturing bonds (e.g. parent infant attachment or group bonding; Gilbert, 2009b, 2014, 2018). The interaction between these systems is mapped out in terms of each system's capacity to down-regulate another system. Ideally, these systems are flexibly active, each being triggered when appropriate to environmental triggers. In a situation where threat is high, a sense of safeness and down-regulation of threat may happen when there is a group or caregiver for safety. Individuals who struggle to create a feeling of safeness and contentment within relationships may develop a reliance on the Drive system to down-regulate Threat (e.g.

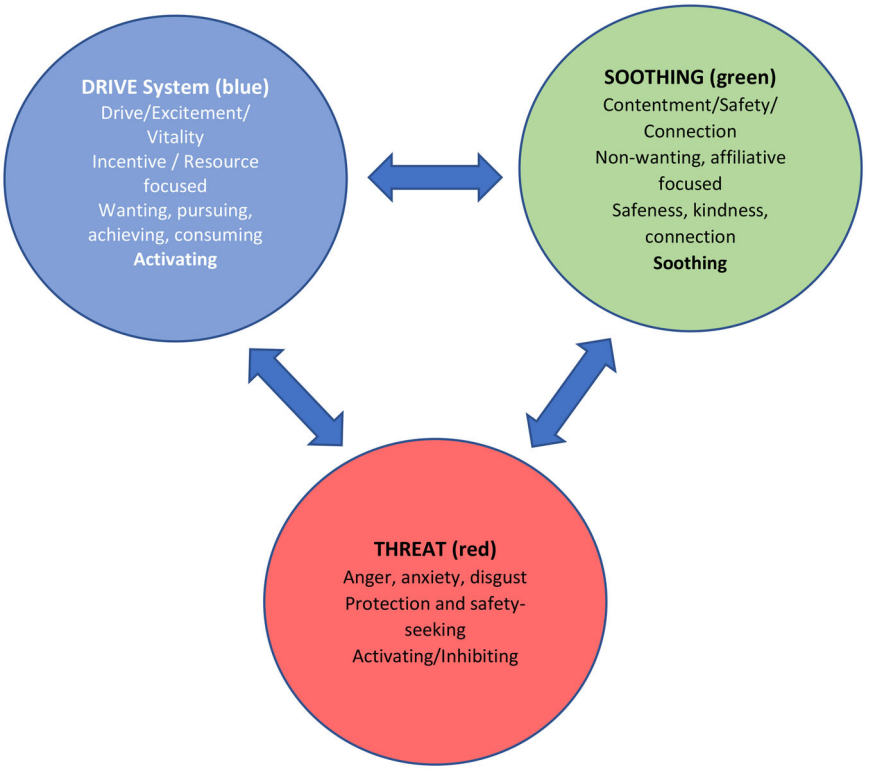

Figure 1. Three Systems Model. (From Gilbert, 2009b, The Compassionate Mind, reprinted with permission from Routledge.).

working hard to achieve goals or compete). In doing so, the emotional regulatory systems become unbalanced, or dominated by one or two systems instead of a flexible interplay between all three systems (Depue & Morrone-Strupinsky, 2005; Gilbert, 2009b; Panksepp, 2004).

Three systems and psychosexual functioning

Like emotions, sexual responses are a set of evolved drives (motives), feelings and behaviour, with a strong relationship with emotional responses (both primitive and social). On a neuropsychological level, sexual responses involve similar areas in the brain as the emotional centres; in the limbic system, in particular the accumbens (Young & Alexander, 2012). Therefore, interaction between sexual and affect systems is inherent and inevitable in our neural anatomy and functioning. The Three-systems model described earlier to model the interplay between some basic emotional states (Drive, Threat and Soothing systems) may also offer a way of looking at how sex and emotions are regulated, and how an imbalance between these systems might lead to sexual difficulties.

Drive system

The Drive/Excitement system described in CFT includes the drive to seek out sexual opportunities (Gilbert, 2009b). The energetic pleasure, excitement and reward of

seeking and engaging in sexual behaviour is common across a variety of species from primates to certain kinds of slugs (Pfaus, 2009; Young & Alexander, 2012). Indeed, our contemporary culture promotes sex as a recreational pursuit in which one can gain or achieve pleasure, fun and affirmation. The dopaminergic reward systems have been systematically and repeatedly studied with relation to sexual behaviour amongst a variety of species for over 50 years (Pfaus, 2009). The drive to find a mate and copulate appears to be strongly related to the limbic system and hypothalamus (medial preoptic area (MPA), nucleus accumbens, amygdala and ventral tegmental area). This Drive system is activated in our brains when something is wanted, regardless of what is wanted, from food to territory or sex. When these areas are stimulated, the MPA then selects environmental cues that lead to behaviour (if food – then eating would be the behaviour; if sexual partners then sex is the behaviour). In other words, the sensation arises of wanting – then meaning is given to the sensation (Pfaus, 2009; Pfaus & Scepkowski, 2005). This links to the cue-response sexual excitation aspect of the Dual Control Model (Janssen & Bancroft, 2007), where the sexual excitation system is triggered by attention to environmental cues. When thinking of the impulse toward finding and/or initiating sex, it is the Drive system which is active. This forward moving motion has been argued to be one of the oldest parts of our brain (Fisher, 1998), and linked to the sympathetic (action) arm of the autonomic nervous system (alongside the Threat system; Porges, 2009). Although sexual function is often linked to the parasympathetic system, the sympathetic system is also active and necessary (Meston, 2000; Motofei & Rowland, 2005).

From an evolutionary perspective, when considering the Drive system with regard to sex, the principle aim of all activity is reproduction. Like all species, we have a drive to reproduce and continue the lineage of our genes (Dawkins, 1989). Of course, human sexual activity is driven by additional motives, such as competitiveness, dominance, prestige, control and power. All of these motivational states of "wanting" can have a complex relationship with sexual desire and arousal.

When discussing a sex "drive," it is often the Drive system (cued to sex) which is referred to, with an emphasis on spontaneous desire. When sexual difficulties relating to desire are experienced, often it is the Drive system that is considered as over or under active. There is considerable criticism of the idea that there is a certain level of sexual activity that is normal (Barker, 2011; Basson, 2000), as this depends on what culture defines as normal. From an evolutionary perspective, it could be proposed that it would be more or less beneficial to have high or low desire at varying times. That is not to say that having low or high desire may not be causing someone considerable distress. However acknowledging that our sexual and emotional systems are *partly* guided by a brain that has evolved over millions of years to help us and our genes survive (not to behave perfectly as we would like it to), may be a non-shaming starting point for therapy.

Threat system

Young and Alexander (2012) argue that the Threat system (fear, anger, aggression and disgust) is highly related to sex and love on a neurobiological level – with sex

activating systems also involved in territory guarding (vasopressin) and leading to heightened anxiety and aggression.

There are numerous examples where the Threat system can inhibit sexual arousal and behaviour (Bradford & Meston, 2006; Fleischman et al., 2015; Grauvogl et al., 2015; Malamuth et al., 1977). There is also evidence that the Threat system can promote sexual behaviour for some individuals in some contexts (Barlow et al., 1983; Bozman & Beck, 1991; Grauvogl et al., 2015; Howells et al., 2004), as well as some situations where sexual arousal can down-regulate the Threat system, for example in the case of disgust (Stevenson et al., 2011). Reviews tend to suggest a very mixed picture regarding sexual arousal and the Threat system, indicating a multidirectional interaction dependent on individual differences and context (Iannuzzo et al., 2014; Kane et al., 2019; Malamuth et al., 1977). It has been argued that whether the Threat system promotes or inhibits sexual activity depends on the environment (Wallen, 2001). We have evolved to react in a multitude of ways if it is beneficial for a given specific situation. For example, in theory a social threat may trigger one individual to display sexual dominance to maintain their status, whereas another may retreat and switch off sexual responses to maintain their safety from dominant others. This would account for the mixed findings on the impact of anxiety and other Threat system emotions on sexual arousal noted earlier. Studies on rodent behaviour have indicated that infants who receive less nurturing from their mother experience generally higher anxiety levels *and* tend to be less discriminating about sexual partners (Cameron, Corpo, et al.; Cameron, Fish, et al.). From an evolutionary position, stress and social behaviour are "deeply intertwined" (Beery & Kaufer, 2015, p.116). For example, to maximise the chance of passing one's genes on, there may be evolutionary advantages to having a greater number of sexual partners in a high stress or threat environment. Understanding how situational threat may potentially activate or deactivate sexual arousal and behaviour may offer a normalising function to people who blame and judge themselves negatively in terms of their sexual functioning and behaviour. The function of the threat system to activate or inhibit sexual excitation according to environmental cues links with the Dual Control Model, as discussed earlier (Janssen & Bancroft, 2007). Depending on the context Threat may trigger drive and the sexual excitation system, or may trigger the sexual inhibition system and switch off drive.

It is proposed that the Threat system is highly adaptive in terms of immediate threats to physical safety (e.g. attack by a predator). However, due to our tricky brains it is also activated when there is a social threat (exclusion), where often the fight/flight/freeze reaction may be less appropriate or helpful. For example, in a situation where someone experiences anxiety about how they will perform sexually, their Threat system is activated by the potential for shame, rejection and social repercussions (very real threats for humans and other group species), which may result in a freeze response, which is not helpful in this social/sexual situation. This is one example given of the function of evolution over time having produced a tricky brain (Gilbert, 2014). The Dual Control Model also proposes that interpersonal threats can activate inhibitory process, whether on a conscious or unconscious level (Bancroft et al., 2009).

Although, importantly, CFT emphasises understanding that our difficulties are not our fault it also emphasises that once we have awareness of the difficulty it is our

responsibility to act compassionately for ourselves and others (Gilbert, 2009a, 2014; Irons & Beaumont, 2017). The evolutionary position is not used as an excuse for behaviour that causes harm to self or others. Instead, an evolutionary position provides a compassionate way of understanding ourselves with the aim of allowing and promoting action that reduces or prevents distress.

In summary, the bidirectional relationship between Threat and sexual systems appears to be complex. As a flexible theoretical approach, CFT may help to describe and formulate how these emotional/motivational systems interact for individuals who are experiencing sexual difficulties.

Shame and self-criticism. A particularly salient threat experienced by humans is shame. A variety of research findings have suggested that shame and self-criticism may inhibit the effectiveness of therapy (Gilbert, 2010, 2014; Löw et al., 2020; Rector et al., 2000). Similarly, shame and self-criticism are both factors which can lead to and maintain sexual difficulties. CFT emphasises that humans, as a social species, have historically needed to make and retain social bonds to survive. From an evolutionary perspective, a human was at greater risk if rejected from their social group. It follows that our brains will have adapted to send us strong signals to help us maintain our social status and avoid rejection (Gilbert, 2015a). This is achieved by receiving positive feelings when social bonds are established (both Drive and Soothing/Affiliative systems). However our brains also flood us with negative signals if there is a chance of being rejected.

An individual's sexual status has long been a source of social taboo. The amount of sex an individual engages in, with whom they are having sex, the kind of sex they are having and their ability to please their partners have all been subjected to judgements (Barker, 2012). Those experiencing sexual difficulties are often highly ashamed of their difficulty, and report that they would find it difficult to talk about with family or friends. The fear of rejection by partners, as well as losing status amongst friends feeds this sense of shame, leaving individuals at risk of heightened anxiety and/or lower mood. Feelings of embarrassment have also been associated with difficulties in sexual functioning (Cyranowski et al., 1999), and results from a number of studies have illustrated how women who experience pain during sex feel ashamed (Ayling & Ussher, 2008; Ellison, 2000), embarrassed (Donaldson & Meana, 2011) and unable to discuss their difficulties with their health provider (Berman et al., 2003). Studies have found that embarrassment can be a barrier to men discussing erectile difficulties (Perelman et al., 2005) and early ejaculation (Sotomayor, 2005) with their doctor. Older people also report shame and embarrassment if they experience sexual difficulties (Gott & Hinchliff, 2003).

As well as feelings of shame, the experience of sexual difficulties often leads to high self-criticism and a sense of feeling abnormal or not good enough in comparison to others (e.g. Ayling & Ussher, 2008). People may develop an "inner sex critic"; a self-critical voice related to sexual difficulties. Self-criticism is a "new brain" activity which can activate the limbic emotional response to threat (Gilbert, 2009b) and can perpetuate sexual difficulties as well as increase feelings of shame, low mood and anxiety. Traditional sex therapy (e.g. Masters & Johnson, 1966) is behavioural in focus

and does not address shame and self-criticism specifically. Although shame is acknowledged by other therapies, it is not always formulated in a detailed way. However, within CFT, shame and self-criticism can be central aspects of a formulation, with therapeutic interventions designed specifically to address these areas (Gilbert, 2009a, 2010, 2014). Within the context of psychosexual therapy, normalising difficulties and presenting a strongly de-shaming approach is key. In therapy groups for women experiencing painful sex, identifying and addressing the secrecy and shame associated with their difficulties in a compassionate manner were amongst the most valued activities in the group (Vosper & Gibson, 2016). Existing critical systemic approaches to sex therapy do target shame associated with sexual difficulties and challenge whether they are problems at all (Atwood & Dershowitz, 1992; Barker, 2011). CFT could offer a way of taking this critical approach and integrating it into a coherent therapeutic model. Although the underlying theory may be from a different epistemological approach compared to critical systemic approaches, the deshaming function may be similar.

Soothing/affiliative system

Like other species who nurture their young for an extended period of time, and species who keep safe by living in groups, humans have developed an affiliative system that promotes attachment and bonding behaviour between individuals. This system creates a feeling of safeness when activated (e.g. an infant feeling safe when next to their mother, or an individual feeling safer when part of a group). The affect generated in such affiliative behaviour is a positive one. However, it is subjectively different from the positive feelings associated with achievement (Drive system), and activates the parasympathetic arm of the ANS (Porges, 2009). The Soothing/Affiliative system relates to attachment systems between parent and infant, or group cohesion. Therefore, attachment behaviours also activate this system; signals of kindness and care generate feelings of safety (Gilbert, 2009b). The parasympathetic arm of the ANS is also highly involved in sexual arousal. As well as rest and digest, this system facilitates feed and breed (Purves et al., 2001).

In species who use sex to form pair bonds or social bonds, the Soothing/Affiliative system also appears to be particularly active and important in sexual contact. Similarly to mother-infant bonds, oxytocin (associated with the accumbens in the limbic system) appears to be important for species who use sex for bonding or connecting with others (Young & Wang, 2004). As a *partially* monogamous species, humans use sex for reproduction, but we also use sex for creating connection and affiliative bonds with other people (Morris, 1967). Some evolutionists argue that it has been adaptive for certain species in certain environments to adopt a monogamous or partially monogamous approach to mating and bonding as this maximises the chance of survival for offspring (Reichard & Boesch, 2003; Rutberg, 1983; Schaik & Dunbar, 1990). For humans (as well as prairie voles and a number of other monogamous species), sex often triggers a release of oxytocin and/or vasopressin in specific regions of the limbic system, triggering a bonding effect or feeling of connection between individuals (Fisher, 1998).

When describing their enjoyment of sex, many talk about its pleasure, excitement and reward (Berridge & Kringelbach 2015; Georgiadis & Kringelbach 2012). However, many also report feelings of warmth and connection with their sexual partners – whether their relationships are short or long term (e.g. Birnbaum & Reis, 2019; Fletcher et al., 2004). This pleasant feeling associated with sex may be activating a different positive emotion system compared to the Drive system described earlier – the Affiliative/Soothing System. McCall and Meston (2006) found that women consciously identified cues for love and bonding as activating their sexual desire (as well as more explicitly erotic cues)

In Masters and Johnson's description of "normal" sexual function (desire – arousal – orgasm – resolution), there is a presumed initial spark of seeking and wanting sex (e.g. desire) which appears linked to the Drive system. However, there has been considerable criticism of this model as many people do not report this simple linear experience. From a great deal of research and clinical experience, Basson (2000) describes a more complex pattern for women, taking into consideration many other concerns including a desire for closeness with partner and desire triggered in response to sexual arousal in the body. This model of sex corresponds to that of a CFT approach, where sex can involve the Soothing/Affiliative system as well as the Drive system. For example, Masters and Johnson's model emphasises how desire initiates everything else in sex, which relates to the Drive system (a focused dopaminergic response and motivation for sex). However, according to Basson, the motivation for sex for many women (particularly in a longer term relationship) is more aligned with the Soothing/Affiliative system. She argues that a neutral and potential state is needed, which can then move into desire with the appropriate cues and stimulation. The motivation is then to maintain a social/partner bond which can then lead into physiological (Drive system) desire, once the Soothing system is activated (Basson, 2000).

The manner in which the Drive, Threat and Affiliative/Soothing systems interact in sex is complex and multidirectional. The Three Systems model of emotional regulation offers a way of understanding the various aspects of sex in general, in addition to sexual difficulties. Although this model is a simplification of the complex nature of emotional (and sexual) evolution – it can assist us in considering and flexibly mapping out the numerous bidirectional relationships that occur between different emotional systems and sexual behaviour.

CFT: theory to practice

CFT is a multi-modal therapy that uses a variety of therapeutic interventions, to encourage change on emotional, behavioural, cognitive and social levels. A key part of CFT if to help build one's capacity to accept and acknowledge the functions of their emotional systems and develop ways of regulating them. For example, if someone struggles to generate feelings of safeness and calm contentment, then a therapist may use a number of strategies to foster this capacity (e.g. use of imagery, two-chair conversations, voice tone and compassionate letter writing; Gilbert, 2010; Irons & Beaumont, 2017).

What is compassion?

Compassion within CFT emerges in part from a caring motivation. Compassion is defined as "the sensitivity to the suffering of self and others, with a commitment to relieve and prevent it" (Gilbert, 2014, p. 19). This definition is described as encompassing two psychologies; *engagement* and *action* (Gilbert, 2015b; Gilbert et al., 2017).

First psychology of compassion - engagement

- The first psychology of compassion involves awareness and understanding of distress, and an ability to tolerate turning towards it. It is linked to six core competencies – care for well-being, sensitivity to distress, sympathy, distress tolerance, empathy and non-judgement (see inner circle in Figure 2 below). In the case of a sexual difficulty, this implies being able to acknowledge that something is causing distress with regard to one's sex life (or one's sexual partner), and turning towards and exploring it. However, sexual difficulties commonly involve blocks or difficulties with one or many of these compassionate competencies. For example, shame can be a block to turning towards a difficulty and, as noted in the literature described earlier in this paper, many people can experience significant shame or self-blame regarding sexual difficulties. This may make it very difficult to take a non-judgemental stance towards the difficulty. Little knowledge around sexual difficulties, alongside experiences of difficult, dismissive and shaming pathways to care (e.g. Shallcross et al. 2018) can all contribute to making it very difficult to *engage* with a sexual difficulty.

In therapy, to build on compassionate engagement, the therapist's non-judgemental, warm and encouraging stance when talking about sex, as well as detailed knowledge around sexual difficulties may well be a starting point for the client to feel able engage with their difficulty. The therapist may then use a normalising and de-shaming CFT formulation to help the client turn towards their difficulty and look at it with understanding.

Second psychology of compassion - action

The second psychology of compassion involves developing wisdom and skilful means to alleviate suffering and where possible, to prevent it emerging in the first place. This also involves six core competences which therapy interventions may target – attention, reasoning, behaviour, sensory focus, emotion and imagery (Irons & Beaumont, 2017). In the case of sexual difficulties, this would involve learning ways to alleviate the distress caused by the sexual difficulty, improving sexual wellbeing and potentially improving the difficulty itself. For example, *compassionate attention* might involve learning what and how to guide attention when it comes to sex (e.g. on the here and now sensations, rather than tracking with the thought "am I doing this right?"), or on sexual cues throughout the day (Nagoski, 2015). Compassionate behaviour may involve helping people to engage in behaviours that expose themselves in a helpful way to their difficulty, and often involve courage (e.g. tolerate shame/discomfort/fear of negative evaluation). Sensate focus is one of the strategies that moves towards compassionate attention and behaviour. *Compassionate reasoning* might involve developing an understanding that this is not our fault; that many others

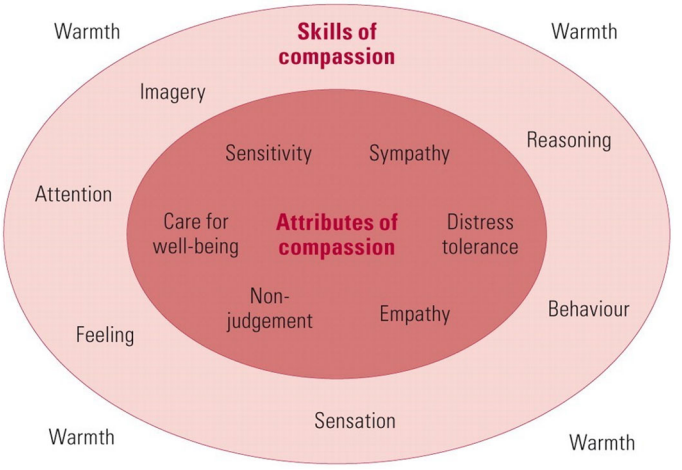

Figure 2. Competencies of Compassion. (From Gilbert 2009b, The Compassionate Mind, reprinted with permission from Constable.).

struggle with similar difficulties, and that there are many ways to engage in and "have" sex. Understanding and challenging an inner sex critic may also be part of compassionate reasoning in psychosexual therapy.

Competencies of compassion

CFT uses a concentric circles diagram to model the competencies of compassion that are the focus of the therapeutic work (see Figure 2). Table 1 presents the competencies of compassion in relation to psychosexual therapy, with suggestions of how each may be strengthened through the therapy process. As emphasised throughout this paper, the model offers a framework to integrate some existing methods and techniques of psychosexual therapy within a coherent and integrative theoretical framework.

Clinical applications: formulating problems with CFT

As CFT facilitates a flexible and transdiagnostic approach to understanding difficulties, it could be used to understand, formulate and assist in working with a number of sexual difficulties. The following section outlines some possible formulations and understandings of a few common sexual problems using the Three Systems Model and New-Old Brain Loops. Whilst Table 1 provides some examples of how therapeutic techniques fit with CFT theory, we do not present detailed examples of CFT practice in this paper as published case studies will be a clearer way of describing the process of therapy.

We present how the model can offer the potential for formulating sexual difficulties in relation to the interaction between the basic emotion systems, as well as the interaction with higher level brain functions, to outline how the theory links to problems seen in practice. The Three Systems Model is flexible and allows for exploring with the client which systems are active and may be up-regulating or down-regulating

Table 1. Example of engagement and action competencies for psychosexual difficulties.

Competencies of psychosexual compassionate engagement	
Non-judgement	Non-judgement of sexual performance/mistakes/difficulties Affirmative stance Seeing difficulties as part of being human (evolutionary based formulation)
Distress tolerance	Ability to tolerate difficulties experienced during sex/awkwardness/difficult sensations/ embarrassment/anger/frustration
Empathy	Ability to consider/understand distress or difficulties of self and/or partner during sex
Care for wellbeing	Care for sexual distress and wellbeing/acknowledgement if important in life
Sensitivity	Noticing own/partners distress reactions or difficulties during sex
Sympathy	Being emotionally moved (e.g. sorrow/sadness) about the distress that might be associated with the sexual difficulty
Competencies of psychosexual compassionate action	
Imagery	Fantasy/positive sexual imagery/using alternative imagery to explore different sexual interests, using imagery to help bridge between self-practice/masturbation & contact with partners.
Attention	Paying attention to reactions during sex/foreplay/masturbation, mindfulness.
Sensation	Sensate focus, exploring different sensations, graded practice (women), stop start (men), mindfulness of sensation.
Behaviour	Scheduling self-practice/practice with partners. Courage to move towards and experiment with sexual contact even if anxious
Feeling	Allowing, acknowledging different feelings during sex; excitement, connection, as well as managing some more difficult feelings if they arise.
Reasoning	Understanding and challenging the "inner sex-critic," creating positive sexual discourse / compassionate discourse regarding sexual difficulty (understanding sexual difficulty as part of being human with human brain, who is also shaped by own life experiences)

each other. Old brain-new brain loops can be used to draw out how new brain functions (such as thoughts, images or beliefs) can trigger or maintain the old brain systems. The social aspect of the theory can be used to highlight the impact social context has on both old and new brain systems, integrating the impact that evolution and specific life experiences have on individuals' difficulties

As mentioned previously, one of the key aspects of the intervention is to provide a normalising and non-shaming formulation, to help people build a compassionate stance towards the difficulties they experience. The evolved nature of the brain is often a part of this formulation, emphasing the message "it's not your fault." However, alongside this message, the compassionate stance also emphasises action and a stance that whilst our brains and bodies are not our fault, they are our responsibility. Evolution is not used as an argument to allow hurtful behaviour (to self or others) just because we believe we're evolved to do so. This stance is particularly salient when considering an evolutionary stance to sexual behaviour, as some authors have argued there may be an evolutionary advantage to coercive sexual behaviour (as discussed by Rose & Rose, 2010). This must not be taken as an excuse to behave in this way. CFT offers a non-shaming way of understanding desires and behaviour, but emphasises the need to use this understanding to behave in a compassionate way to self and to others.

For brevity, we have focussed on five of the common sexual difficulties that we encounter frequently within our clinical practice; low desire, pain during penetrative sex, ejaculation quicker than preferred, sex that feels out of control. We also present an example case study of a client experiencing erectile difficulties and how this would be understood using CFT principles. We believe, however, that CFT is also applicable to other sexual difficulties not outlined within the following section.

Low desire

Low desire is a common sexual difficulty (Mitchell et al., 2013). For some people, it can cause considerable distress, particularly in the context of a relationship where there is a mismatch in levels of desire. As with other approaches, CFT would start with building an understanding exactly what is meant by desire, exploring whether "low desire" represents little spontaneous desire (Drive system), but enjoyable arousal and sexual contact in particular contexts. This may be normalised as a common and adaptive approach, with no evolutionary reason for everyone to experience spontaneous desire throughout their lives and in the context of a long-term partnership. Old brain-new brain loops may be challenged, particularly where the "inner sex critic" is present (i.e. self-criticism and/or opinions about the desire people "should" have) which will keep the Threat system active and cause distress. Within this there would be space to acknowledge how ideas about desire may have been shaped by cultural messages about sex.

Alternatively, if there is no enjoyable arousal and sexual contact and the person would like this, we may look at the balance of the emotional regulation systems, and then consider which emotional systems to target. For example, we could encourage clients to target the Drive system by engaging curiously in fantasy or erotic imagery. If the Soothing system is underactive, we could consider targeting this system with strategies that build the skills of psychosexual compassion, for example attention and sensory focus (such assensate focus or mindfulness skills). Our rationale is that when the Soothing system becomes more active, the Threat system will diminish, which can allow the Drive system to be triggered (resulting in a perceptible experience of desire and arousal). Figure 3 shows how a Three System Model could be used to demonstrate low Drive, low Soothing and high Threat in a sexual context can result in low sexual desire.

Pain with penetrative sex

CFT is already being applied in chronic pain conditions (Penlington, 2018). The initial indications are that it may also be a beneficial integration to CBT-based psychosexual therapy for pain with penetration (Vosper & Gibson, 2016). People who experience pain during penetrative sex can experience considerable shame, self-criticism and challenges to their identity (their social mentality as a partner) around their condition (Ayling & Ussher, 2008). This can significantly contribute to their experienced distress, on top of the pain experienced when trying to engage in penetrative sex. Research is now emerging linking self-compassion and pain with penetration. For example, Santerre-Baillargeon and colleagues (2018) found associations between self-compassion, lower anxiety, lower depression and lower sexual distress in women with sexual pain. However, they did not find more direct associations between self-compassion and pain. This may be due to the self-compassion scale used in this study as it conceptualised and measured compassion related to general mental health difficulties rather than compassion focussed on sexual problems. More recently, Vasconcelos et al. (2020) found that cis women with sexual pain or sexual problems

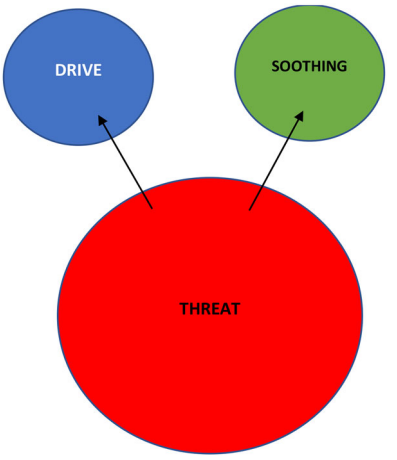

Figure 3. Low desire Three Systems model; where both Soothing and Drive are low.

reported lower self-compassion and more difficulties with emotional regulation compared to women without these problems.

For people experiencing pain with penetration, it could be hypothesised that their Threat system is likely to be highly active in the context of sex, and their Soothing and Drive systems may be down regulated (see Figure 5). Therefore, established CFT methods which focus on increasing the skills of psychosexual compassion would be helpful. For example, for people with vulvas, graded practice with vaginal dilators, mindfulness and sensate focus (alongside a medical examination with a compassionate health professional). As above, the theory would argue that the Drive system would potentially be activated once the Threat system is less active. A new brain-old brain loop can also be used to illustrate how worries of future pain, memories of previous pain and the inner sex-critic contribute together to activate the Threat system, which impacts on pain sensations (see Figure 4). Alongside the standard psychosexual interventions, compassion-based interventions of challenging self-criticism and shame, understanding the role and function sex might have at different times in life, in addition to fostering self-compassion may be useful. Work is currently underway to evaluate an NHS-based psychosexual therapy group for women with pain with penetration that includes such CFT theory and interventions (e.g. working with an inner sex critic).

Ejaculation quicker than preferred

When a person with a penis begins to struggle with ejaculating quicker than preferred, the CFT perspective could formulate the Drive and Threat systems as being very active at the same time (see Figure 6). We can take an evolutionary functional perspective by arguing that the body is not dysfunctioning. When Threat is high, there may be an evolutionary advantage to ejaculating quickly, as this would have ensured reproduction and allowed the individual to quickly return to dealing with the perceived threat. We could also argue that even when threat is not high, ejaculating rapidly may well be a helpful physiological strategy for reproduction. Social shaping

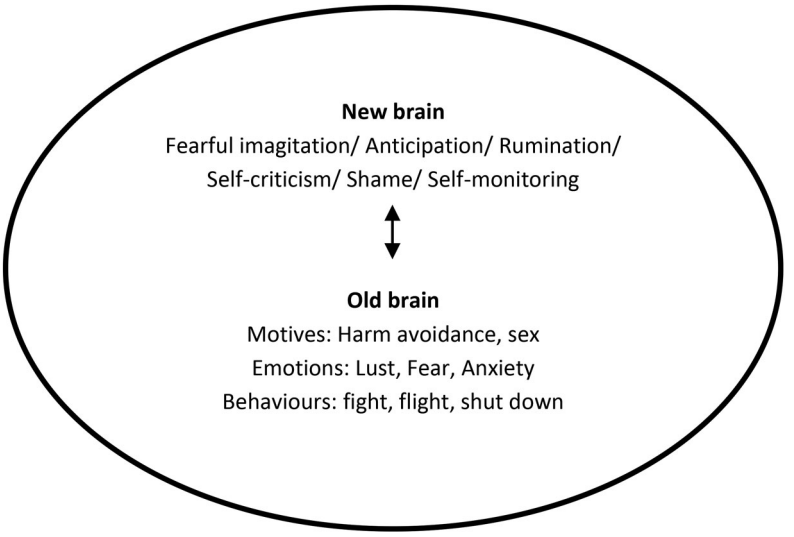

Figure 4. Example of new brain-old brain loop in pain during sex.

may also have deemed ejaculating quickly as adaptive, for instance if masterbating in contexts which do not feel safe for instance for fear of being interrupted in shared households. According to the evolutionary perspective, the advantages of ejaculating quickly might outweigh the advantages of taking longer to ejaculate. It may have become socially desirable for men to last longer as we started to focus on pleasure with sex. According to the CFT perspective, if an individual felt frustration, shame or embarrassment about ejaculating rapidly we could hypothesise that their Soothing/ Affiliative system (parasympathetic response) is less active during sex (potentially reducing any down regulation on Threat and Drive). Many individuals who experience rapid ejaculation usually want to last longer so they can enjoy more pleasure and connection with their partners. However, individuals may also be negotiating a variety of relational and situational factors when having sex, which then activate alternative and competing emotional systems. This all adds complexity to the CFT formulation. For example, an individual may not be aware of and/or understand their partner's motivations or expectations for sex (e.g. may not want to engage in it for very long as they are tired).

Taking a compassionate stance may involve creating an understanding with the therapy client that their current reaction/behaviour of the body is not dysfunctional. It could be helpful to challenge the belief that their body should be behaving differently. A compassionate stance would also assert that if the individual wants to increase enjoyment of sexual pleasure, it is often necessary to practice using masturbatory techniques (stop-start technique) to develop greater awareness of their sexual sensations and when they approach the point where they will inevitably ejaculate. Success with such practice may be enhanced if the individual can work towards establishing a balance between their three emotional regulatory systems. Strategies may include those to help extend time to ejaculation at a behavioural level (e.g. stop-start technique), strategies to reduce Threat (by normalising and challenging the inner sex-critic, and attending to other sources of potential threat in the environment).

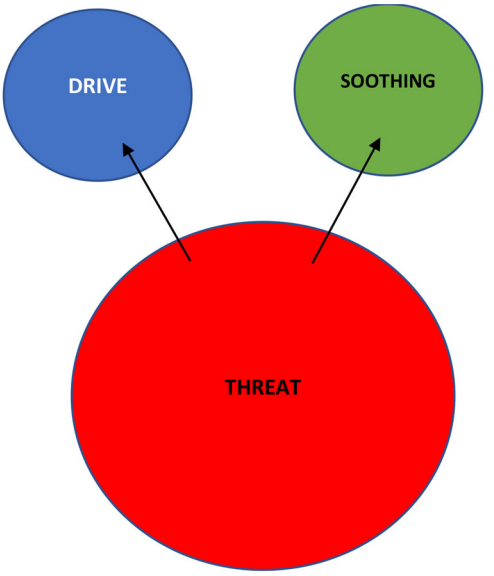

Figure 5. Example Three systems model for pain during sex.

Strategies may also focus on up-regulating the Soothing system (e.g. working on sensation and attention through sensate focus,mindful masturbation or practicing how to relate to times when ejaculation happens quicker than desired).

Sexual behaviour that feels "out of control"

In some circumstances individuals can experience significant distress while engaging in more sexual activity than they want and find it impacting on their daily functioning (American Psychiatric Association, 2013). From the CFT perspective the Drive system may be overactive as an individual seeks sexual encounters in the pursuit of sex, or that the person has a general dysregulated Drive system that constantly seeking novelty/excitement (see Figure 7). However, the Threat system may also be highly active, and an individual may have learnt to use sex (Drive) as a means to down-regulate Threat because sexual encounters may help them to feel some momentary relief from stress and/or enhanced acceptance from others. If the individual is seeking help, it may be due to consequences of the imbalance (e.g. potential losses or shame/self-criticism) which serves to increase Threat, which could be maintaining the cycle of Threat – sexual encounters – shame - Threat.

Alternatively, it could be the case that the activation of the Soothing system when feeling safe and connected with another individual inadvertently triggers anxiety, especially if there have been difficult attachment patterns with neglect, trauma or hardship in childhood (Gilbert, 2009a). This can lead to an over-reliance and dysregulation of the Drive system, with a constant need for novelty or excitement that accompanies sex. In this instance, the imbalance might be a result of both the Drive and Threat systems being highly active, with an underactive Soothing/Affiliative system.

Figure 6. Three systems model for early ejaculation.

Therapeutic approaches may look at introducing ways to up-regulate the Soothing/Affiliative system as an alternative way of down-regulating Threat. Again, strategies designed to build the skills of psychosexual compassion and thus activate the Soothing system, would be utilised.

Case example: Steve

To begin to link theory to practice we present a case example below, using some of the CFT ideas discussed in this article (based on a variety of clinical clients' experiences)

Steve is a 31-year old gay man who has been living in London for 3 years after graduating from university in the North of England. One of the reasons for moving to London was for Steve to live more openly in a gay community where he could become more confident and comfortable with himself within a network of gay friends. Steve is the only son of his married parents. His mother has tried to talk to him about his "personal life" on occasion, but Steve has tended to avoid such conversations. Steve has experienced his father as very critical, demanding and rejecting of others who do not meet his high standards in life. Steve can also remember his father making homophobic comments, cruel jokes about "poofs" when he was younger. Steve and his family grew up influenced by the legacy of Section 28 within a cultural context which did not question the dominance of heteronormative ideas. All the sex education Steve received was focused on heterosexual sex, and how to avoid threat (e.g. HIV or unwanted pregnancies) within sex, and he was used to hearing homophobic slurs between peers. He grew up with ideas from the media about men needing to satisfy their partners sexually to sustain a relationship, and that a satisfied life includes a monogamous sexually active relationship.

Before Steve moved to London, most of his sexual life centred around regular masturbation with gay porn. However, he did enjoy a couple of casual sex hook-ups from dating apps, usually on weekends after consuming considerable alcohol. For the

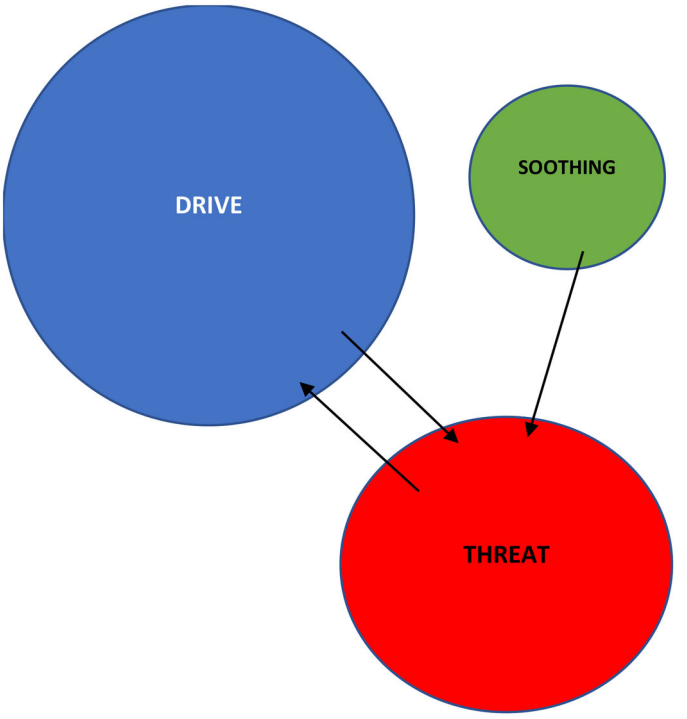

Figure 7. Three systems model for sexual behaviour that feels "out of control".

most part, these sexual experiences were pleasurable and fun, with no concerns. However, Steve did not tell anyone about these experiences as he believed others might judge him for engaging in an activity that he believed was "dishonourable" or "seedy."

After a couple of years in London, Steve joined a gay men's badminton club where he met another young man and they started to date. While this was initially exciting for him, Steve soon started to struggle in gaining and maintaining erections during sex together (but not during solo masturbation). Erectile difficulties were something that he had never experienced before, and Steve found himself worried with fears of "sexual inadequacy." He also became very frustrated with himself, as Steve valued the opportunity to start a relationship with someone special, but he felt his body was "failing." Steve soon started to fear evenings when he was supposed to meet up with his partner, as he would worry that his erectile difficulties would ruin everything. Even though his partner denied any problems with their sex life, Steve felt he was only being polite and would soon break up with him if things did not improve. Steve found himself comparing himself unfavourably to the images of men's erections within porn, and thinking that he was "less of a man."

From a CFT perspective, it appears that Steve's punitive "inner sex critic" was activating his Threat system as he feared his erectile difficulties were going to "ruin everything." He felt considerable shame about his perceived sexual inadequacy, with heightened self-criticism for not being "good enough" at sex. He seemed to judge himself negatively compared with cultural ideas of what it meant to a successful man

and sexual partner. Perhaps feelings of shame and self-criticism with fears of rejection were quite familiar to Steve, given that he struggled for many years with his sexual identity in a hostile and homophobic context. It also appears that Steve was exerting excessive pressure on himself, with his Drive system, to excel at sex. He believed he needed to "make up for lost years" of dating and sex, given that he "held himself back" during his university years. Steve also consumed considerable porn over the years in the context of not having access to other relevant sex education, possibly creating unrealistic expectations of sexual prowess as this was his reference point for what sex should look like for gay men.

Given these driving pressures for "wanting" and his anxieties, Steve could help himself by developing a more compassionate stance of reassurance, encouragement, warmth and kindness towards himself. However, he struggles in soothing himself. His family background of exceedingly high expectations with threats of ridicule and rejection for failure had left Steve lacking in opportunities to develop such self-compassionate skills or attributes.

In CFT-informed psychosexual therapy, Steve could learn more about the "tricky brain" and how it may have been shaped through evolution and his specific life experiences, with a view towards developing more adaptive and compassionate ways of responding when anxiety about sex, erection difficulties or homophobic messages occur. At the beginning of therapy, he could learn more about the universal nature of struggling with sexual difficulties. The non-judgemental and affirmative formulation could help him engage compassionately with his difficulties. An integrated formulation of the difficulties would indicate which therapeutic activities (compassionate actions) would be most useful. He could work on developing an inner "compassionate sex coach" to counteract his longstanding tendency to be critical about himself, which was shaped through his experiences growing up. By developing self-compassionate skills he could learn how to relate to messages about sex, including those within different cultural contexts, in a more self-compassionate way. As part of this he could now develop his wisdoms through psychoeducation tailored for the type of sex he is interested. A compassionate action might be to practice mindful masturbation Steven and build on his skills of "being in the moment" and focusing on sensation. Sensate focus with a partner might help focus on the connection aspect of sex as well as attending to his own sensations.

Further directions in CFT

The example formulations and case example above show initial ideas about how CFT may be used to formulate different sexual difficulties, with a focus on the Three systems model and the tricky brain. These represent a theoretical framework which has been shown to be useful in clinical practice. Further development through more systematic evaluation and clinical work to explore which ways they are a helpful and a theoretically coherent way of understanding difficulties experienced is now needed.

Other formulations can also be used in CFT, for example looking specifically at how self-criticism emerges and understanding this from a functional perspective. Whether self-criticism is being used to self-correct and keep an individual socially

safe, or being used to punish, will influence how a therapist may work with this (Gilbert et al., 2004). In the context of a sexual difficulty, an individual may be very critical of their performance or body shape, which serves to increase threat and reduce sexual enjoyment. On a cognitive level, understanding that the function of the self-criticism is to protect, but the outcome is not protective, may help some people work towards building a more compassionate response to their sexual difficulty or their sexual self-image.

Future exploration of CFT for psychosexual problems could also consider some of the complexities around experiences of compassion and self-criticism for some people. For some people compassion from others can be experienced as unfamiliar or even aversive (potentially due to childhood adversity; Gilbert, 2010). For these individuals, a compassionate stance from a practitioner and/or encouragement to build on compassion may be extremely difficult. Some people can find it very difficult to give up their inner critic, as they may have found it protective (albeit with unintended consequences) (Lawrence & Lee, 2014). Typically a CFT approach would work in a medium term way with people, gradually exploring and building compassion and giving time to consider the advantages and disadvantages of compassion (e.g. Kolts & Gilbert, 2018). For psychosexual therapists introducing CFT to clients, this potential should be acknowledged and considered in supervision.

Summary and final thoughts

This paper has introduced the principles and therapeutic interventions of Compassion Focused Therapy (CFT) in the field of psychosexual difficulties. We argue that this integrative framework allows for a transdiagnostic and flexible formulation for a variety of sexual difficulties. The theoretical underpinnings of CFT offers the possibility of utilising theory and research from important areas in sexology and clinical psychology. This includes comparative and evolutionary perspectives, attachment theory, cognitive behavioural models of therapy and social/system models. These psychologically informed approaches, in addition to the de-shaming Eastern philosophical principles of universality allows for a non-judging and normalising stance that fits with critical approaches to psychosexual therapy (despite the different epistemology).

CFT often emphasises that the way our brains and bodies work is not our fault, whilst encouraging the act of taking responsibility to understand, manage and improve ourselves. Evolutionary theory is used alongside cognitive and social theories. In doing so, evolutionary theory is not used in CFT to offer a reductionistic account of how sexual behaviour has developed, but to acknowledge adaptations and adaptiveness of our brain systems to our changing environments over thousands of years and thereby offer us options of how to respond to these. The focus and formulation of shame and self-criticism may have a particularly important role for some individuals experiencing sexual difficulties. Where shame or self-criticism may block engagement with existing approaches, CFT may offer a complementary therapy option. The model of compassion, involving its defining attributes and skills applies easily to psychosexual therapy, and some of the therapeutic methods (e.g. identifying the inner sex-critic

and building on a compassionate response) offer some new directions, or develop further existing directions, for practitioners. Indeed, a compassionate stance is already integrated into mindfulness and Eastern approaches to sexual difficulties. CFT may offer an additional way to consolidate the compassionate stance, particularly for people who tend to struggle with generating feelings of warmth and kindness for themselves in relation their sexual self, or more broadly. In this way, CFT also offers a way of integrating attachment theory into the formulation of sexual difficulties, with a practical approach in focussing on the Soothing/Affiliative system.

In some NHS psychosexual services, these CFT ideas have been introduced and trialled in female sexual pain, with some initial positive feedback (Vosper & Gibson, 2016). There is considerably more work to be done to pilot a range of services for other psychosexual difficulties to explore how the model is received by service users. Formal evaluation of pilot projects are needed to consider important constructs (e.g. shame, self-criticism, self-compassion), as well as the acceptability of CFT formulations and therapeutic interventions in psychosexual therapy. More detailed formulations and case studies for specific sexual difficulties would be a helpful way of assessing CFT's potential in offering a useful coherent framework in this specialised field. Whilst this paper has focused on detailing the underlying theory of CFT in relation to psychosexual problems, further papers focusing on the therapeutic method and technique are needed. Published case studies are a helpful and appropriate way of describing detailed formulation and intervention strategies (e.g. Ribeiro da Silva et al., 2019), and are an important next step in developing compassion focused psychosexual therapy.

We have focused on an individual approach to therapy, however psychosexual problems are often a systemic difficulty; whether in the system of a couple, group, or where an individual compares themselves to a perceived norm in society. CFT has the potential and flexibility to be used in couples therapy (Karris & Caldwell, 2015), as well as theoretical underpinnings that allow for understanding shame and stigma in the context of social shaping. CFT has already been piloted in groups who face discrimination (whether due to sexual orientation or HIV diagnosis; Pepping, Lyons, McNair et al. 2017; Skinta et al., 2015), and has the potential to offer a genuinely affirmative stance within psychosexual therapy. Whilst sex has been discussed in the context of evolution and reproduction, we have also made it clear that sex for humans has a variety evolutionary functions; in particular *connection* between individuals (independent of the gender of individuals, how many individuals are involved and how long that connection may last). Evolutionary psychology has been highly criticised on a number of dimensions, including making biologically deterministic claims about sex and gender (e.g. Gannon, 2002; Rose & Rose, 2010). However, there are also arguments that evolutionary psychology and very different epistemological paradigms such as social constructionism can co-exist (e.g. Mallon & Stich 2000). CFT uses evolutionary theory, but also strongly emphasises the role of social shaping and does not present a deterministic view of human behaviour. The inclusion of evolutionary theory is aimed to promote non-judgement, and is certainly does not aim to determine which behaviours are normal for whom. An important future direction for compassion focused psychosexual therapy would be a theoretical exploration of

the CFT theories of social mentalities and social shaping with reference to psychosexual problems in minority and marginalised groups. Further work exploring how models and formulation guided by evolutionary theory are appraised by different client groups would also be very beneficial in exploring whether and how CFT for psychosexual problems.

There is considerable work to be done in measuring the impact of CFT informed psychosexual therapy, especially in considering the role of compassion in sexual difficulties. Whilst general self-report measures of compassion exist and are widely used (Gilbert et al., 2017; Neff, 2003), they may need to be adapted so they can directly measure compassion in relation to sexual difficulties.

In conclusion, we believe that CFT has the potential to offer a useful integration to existing psychosexual therapies, with a rich and inclusive theoretical background as well as a wide variety of therapeutic interventions that have the potential to relieve the distress associated with sexual difficulties as well as help individuals to develop enjoyable and satisfying sex lives.

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Stuart Gibson has been working in sexual health and HIV for more than 20 years. He has been applying CFT theory and principles in his therapeutic work since first reading Gilbert's *Compassionate Mind* nearly 10 years ago. Working with clients to develop a more compassionate stance towards their sexual difficulties, with an aim to promoting their sexual wellbeing has been at the core of his clinical work for many years.

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