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A Person-Centred Approach to Psychosexual Therapy: Theorizing Practice

Sexual and Relationship Therapy

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Abstract

There is little explicit referencing of the Person-Centred Approach in the psychosexual therapy literature and clients who experience sexual difficulties seem seldom to be discussed in publications on person-centred therapy. These 'silences' might suggest that there is little interest in establishing a greater dialogue between these two therapeutic approaches, yet there is, we would suggest, considerable value in doing so. Drawing on developments in person-centred theory and practice, we outline and extend in this article the 'theorization of practice' that has supported the development of a more person-centred approach to time-limited psychosexual therapy. While acknowledging the tensions that exist between the philosophical tenets underpinning the Person-Centred Approach and the practices that constitute psychosexual therapy, we suggest that the experiential therapies of Gendlin and Rennie provide useful meeting points between the Person-Centred Approach and psychosexual therapy. We argue that in addition to facilitating a more idiographic approach to psychosexual therapy, the Person-Centred Approach helps to widen the scope of practice within psychosexual therapy by placing greater emphasis on the promotion of sexual potential.

[word count = 172]

Key words: psychosexual counselling; psychosomatic; experiential; person-centred theory

Introduction

Despite humanistic approaches to sex therapy (Kleinplatz, 1996, 2007; Armstrong, 2006; Tiefer, 2006), and descriptions in some of the foundational texts of person-centred therapy of work with clients experiencing sexual concerns and difficulties (Rogers, 1951/1973, 1961/2004), there is little mention in contemporary person-centred therapy literature of clients presenting with sexual function problems. This may, in part, reflect the perception that sexual difficulties constitute the province of the 'specialist' practitioner. There is, however, also little explicit referencing of the person-centred approach (PCA) in the psychosexual therapy (PST) literature, which emphasizes a scientific model of sexual behaviour and functioning, and a therapeutic approach which is more technique-driven than theory-driven (Berry & Barker, 2015). Writing in the 1990s, Kleinplatz (1996) observed that the concept of a humanistically-oriented sex therapy was almost 'unintelligible' in sexual science. By contrast, the traditional emphasis in PST on interventions being guided by diagnosis (and formulation), is typically eschewed by many person-centred therapists (Rogers, 1951/1973; Gillon, 2013). PST may also be seen by person-centred practitioners as being preoccupied with the restoration of normative sexual performance at the expense of understanding the subjective experience of clients and the meaning they give to such experience (Kleinplatz, 1996, 2012a&b). Also, until relatively recently, person-centred therapists have generally not attempted to tailor either their theory or their practice to particular groups of clients, as the same set of conditions provided in person-centred therapy is seen as being of value to all clients, irrespective of their presenting issues (Cooper, et al., 2013).

Recently, we described an approach to delivering brief psychosexual therapy (PST) in a specialist sexual health service that is more closely aligned to a PCA than many traditional models of PST (Irwin & Pullen, 2017). Given that PST tends to be more closely associated with the clinical/medical model, and that some person-centred theorists and practitioners consider time-limited therapy to be fundamentally incompatible with the ethos of the PCA, the emergence of a PCA to PST in this setting might seem surprising. Yet the requirement to provide therapy in six sessions

(necessitating significant modifications to the process of PST) and a greater number of service users with complex and chronic health problems (who have often experienced repeated medical consultations for their sexual difficulties) were important factors in developing a more idiographic, PCA to PST. Having been struck by the relative silence in each of the respective literatures (PST and PCA) about the other, in this paper we explore the possible ‘fit’ between PST and PCA, with the aim of encouraging greater dialogue between these two therapeutic traditions.

PST and the PCA are not natural bedfellows. However, the integration of seemingly diametrically opposed therapeutic approaches has been part and parcel of the development of PST, an early notable example being Kaplan’s (1974) ‘new’ sex therapy that sought to integrate behavioural and psychoanalytic principles in the treatment of sexual problems (Wiederman, 1998). A more recent example of this is multidimensional open-minded sex therapy (MOST), which seeks to integrate a systemic social constructionist approach to therapy with sexology (Markovic, 2017). Indeed some now question the status of PST as a distinct area of clinical practice citing its lack of a distinctive theoretical foundation and the fact that its practitioners typically use techniques deployed in other therapeutic approaches (Wiederman, 1998; Wincze & Weisberg, 2015).

Thinking about theory – why bother?

In an era when technical eclecticism appears increasingly to underpin practice in psychological therapy, it is legitimate to ask whether there is any need to bother with theory. Ensuring the optimal match of client and treatment – the central premise of technical eclecticism – is guided primarily by research on what has been found in the past to work best for others with similar characteristics, who were experiencing similar problems (Lambert & Norcross, 2017). As Lambert and Norcross (2017) note, with technical eclecticism the foundation of decision-making and practice is not theoretical but actuarial. A number of difficulties exist with this actuarial approach to practice. First, the presenting issues of clients in PST are typically complex (with multiple possible biological, psychological and social

contributing factors potentially interacting in a variety of ways) and are often experienced in particular relational/social contexts. Such issues cannot always be neatly 'matched' with existing research findings, reminding us of the limits of propositional knowledge when it comes to therapeutic practice (Schön, 1983; Donati, 2016). Second, the published 'evidence-base' for PST is not particularly robust when judged by the criteria currently used for establishing empirically supported psychological interventions (Roth & Fonagy, 2005), although some within the field of PST question the appropriateness of the research paradigms typically employed to establish empirically validated therapies (Kleinplatz, 2012a).

According to Lewin (1943-44, p. 169), there is 'nothing so practical as a good theory', and in the context of therapy, a therapist's formal theory base supports their reflective functioning by providing them with a reference point for thinking more objectively about their experiences of working with clients (Donati, 2016). Theories directly inform the working hypotheses of practitioners and indicate not only the various contributing factors in a given situation that should be considered but how such factors might best be addressed (Bekerian & Levey, 2012). Critical engagement with theory is therefore important for both practitioners and their supervisors. Facilitating awareness of the (often tacit) theories, which inform the supervisee's decision-making and practice is one way in which supervision supports critical reflection on practice. Supervision, however, also provides a formal space for 'theorizing practice', that is, drawing on a professional knowledge base (such as person-centred theory) to think critically about what has happened (and might happen) in a supervisee's practice (Thompson & Thompson, 2018). This article outlines and extends some of the theorization of practice that has occurred in our work together over a number of years.

Theory and the person-centred approach: a thumbnail sketch

The work of Carl Rogers (1951/1973; 1961/2004) provides the theoretical underpinnings of the PCA. Rogers believed that each human being has an inherent biological drive towards growth, the actualising tendency, which, given the right

facilitative conditions can be trusted to guide human development in a constructive direction. The functioning of the actualising tendency is facilitated by an organismic valuing system that allows individuals to appraise experiences that are necessary to maintain or enhance their personal growth and development. And arising from the actualising tendency is the need for positive regard from others. If the responses of others to an individual's experiences are empathic and accepting, then that person develops a sense that their organismic values are positively regarded without condition. If, however, certain experiences generate negative reactions in others or are simply ignored, the individual begins to evaluate these self-experiences accordingly. It is through this process of introjecting the values of others that 'conditions of worth' are acquired. As a result of the association of positive self-regard with such conditions of worth, some aspects of an individual's organismic needs and experiencing are acknowledged and incorporated into an individual's emerging self-concept, whereas other aspects are not.

To manage the inevitable discrepancy that arises when experiences occurring at an organismic level are inconsistent with a person's self-concept, the psychological mechanisms of denial and distortion are employed. Denial refers to the non-perception at a conscious level of experiences felt at an organismic level, whereas distortion refers to the inaccurate perception of experiences to resolve the threat they pose to the self-concept. This means that experiences that challenge an individual's self-concept are not fully or accurately symbolised into awareness. Rogers referred to the mis-alignment that develops between an individual's actual experiencing and their perceived self as 'incongruence', which he considered to be the basis for all psychological distress (Rogers, 1957, p 222).

Severe distress is therefore most likely to occur in those individuals who have encountered a large number of conditions of worth, leading to a greater level of denied and distorted organismic experiences. Such individuals have what Rogers (1951/73, p. 150) termed, an external 'locus of evaluation', that is, they tend to make decisions on the basis of conditions of worth rather than their inner

experiencing. In such circumstances, any failure of the processes of distortion and denial can lead to the individual feeling anxious and vulnerable.

A person-centred perspective on the causes of sexual function problems

To suggest that all sexual function problems are caused solely by incongruence that is the result of conditions of worth acquired in earlier life is clearly untenable. Sexual experience is 'par excellence psychosomatic' (Bancroft, 2009, p.55), involving a complex interplay of psychological and somatic processes. Numerous organic factors, many associated with injury and chronic health conditions, may impact adversely on sexual function (Bancroft, 2009; Wylie, 2015), indicating the importance of a biopsychosocial perspective when considering the likely contributing factors to sexual difficulties (Wincze & Weisberg, 2015).

Where psychosocial factors contribute substantially to the development and maintenance of sexual function problems, it is possible, however, to hypothesise how certain conditions of worth may be implicated in the development and maintenance of such sexual difficulties. For instance, if one of the values introjected in early life is that one should always try to please others, it is feasible that 'performance anxiety' may contribute to the development and maintenance of sexual function problems (McCabe, 2005). Conditions of worth may underpin guilt and shame that contribute to the onset and perpetuation of some people's sexual function problems (Hawton, 1985; Markovic, 2017). Indeed, 'restrictive upbringing', that is, a child's experience of negative attitudes within their family towards sexuality and personal relationships, has long been recognised as impacting on a person's psychosexual development, and as a predisposing factor for experiencing sexual function problems later in life (Hawton, 1985, p. 58). Conditions of worth may be highly gendered, for example, 'real men...', creating expectations about sexual experiences and sexual relationships that are not only unrealistic but inimical to the individual's inner experiencing and personal growth.

In one sense, this type of re-formulation of contributing factors to sexual problems is consistent with recent developments within the PCA, in which various 'presenting issues' and forms of mental distress have been reconceptualised using person-centred concepts (e.g. Joseph & Worsley, 2005; Tolan & Wilkins, 2012). Such reformulations have also led to developments in person-centred theory and practice, a notable example being Margaret Warner's (2005, 2007) 'process-sensitive' model of psychological distress. Warner's model retains Rogers' emphasis on incongruence, but suggests that the life difficulties a person faces at any moment in time and the extent to which they have developed a capacity for processing their experience, influence a person's ability to resolve such incongruence. This allows for the interplay of various contributing factors, both distal and proximal, in the development of psychological distress. Among the factors that Warner identifies are: the 'press of life', which may temporarily overwhelm even the most well-developed processing capacities; limitations in processing capacities that are the result of the lack of care provided in early childhood and/or impairments (congenital or acquired) in the organic systems required for processing experience; and the level of available relational support of processing (Warner, 2005, 2007).

Another key concept in the PCA literature is the 'self-structure', which is considered to be unique to each individual and an outcome of their life experiences and the level of unconditional positive regard they have received during their life. A person's self-structure is the model of the world around them (and themselves) that provides the basis for explaining and making sense of their experiences (Tolan, 2017; Tolan & Wilkins, 2012). It is possible to make links here to the research literature on cognitive schemas, particularly sexual self-schemas, which have been suggested as important contributing factors to sexual function problems (Peixoto & Nobre, 2015). Person-centred perspectives on adverse life events, such as loss and bereavement (Haugh, 2012), trauma (Turner, 2012) and childhood sexual abuse (Power, 2012) have also recently been formulated, as well as reactions to such life events, such as anxiety and depression (Bryant-Jeffries, 2012; Rundle, 2012). These events and experiences are often associated with sexual function problems (Brotto et al., 2016).

Those involved in developing more person-centred perspectives on specific life events emphasize, however, that it is important that theory is 'held lightly' in practice (Haugh, 2012, p. 16). This is because each client is a unique individual with unique experiences of the world, therefore every effort needs to be made to understand the world of the client as she or he perceives it, rather than trying to 'fit' the person and their presenting issues to theory (Wilkins & Tolan, 2012).

That said, a core theoretical construct of person-centred therapy is the actualising tendency, which, it is hypothesised, expresses itself in human beings as an inclination towards safety, growth and wellbeing (Haugh, 2012). Where sexual function problems are predominantly the consequence of psychosocial factors, the concept of the actualising tendency suggests that such problems can be understood as having some purpose for that person at that moment in their life. This idea is not as unusual as it might at first seem as the potential 'positive functions' of sexual problems have long been recognised in PST (LoPiccolo, 1994). In the context of a person's biography and their current relationships and circumstances, the sexual difficulties reported by clients can often be seen as an understandable reaction to issues such as the anticipation of pain or a lack of trust or safety in the relationship with their current partner(s). From a person-centred perspective, it is as if the client's body seems to be trying to keep the client safe, signalling aspects of the client's experiencing that either have not been symbolised fully or accurately into his or her awareness, or are not possible to 'voice' directly.

Although recent developments in person-centred theory may help to reformulate some of the contributing factors to sexual function problems in a PCA to PST, it is the emphasis in the PCA on personal development and growth that is most likely to make the greatest contribution to PST in terms of promoting sexual wellbeing and fulfilment.

Optimising sexual potential

Kleinplatz (2012a) suggests that rather than optimising sexual potential, PST seems to have settled for the fixing of problems, and, as a result, tends to offer clients little choice in terms of therapy options other than the reversal or palliation of sexual symptoms. A PCA emphasizes the importance of listening carefully to the client and trying to remain 'unknowing' in order to develop, in conjunction with the client, an understanding of what it is that the client is seeking. Studies that have sought to understand the meaning of sexual function support this approach. For instance, Mitchell et al. (2011) identified three 'sexual scripts' in the meanings attached to sexual function by 34 respondents who were interviewed about their sexual experiences: a 'biomedical script'; a 'relational script'; and an 'erotic script'. Although respondents' accounts usually contained elements of more than one script, often one of these three scripts was predominant. In respondents' accounts where a biomedical script was prominent, the emphasis was very much on genital function and the importance of penetration and orgasm. A more common script, however, was the relational script and respondents for whom this script was more in evidence, valued emotional connection and security, focusing on the relational aspects of their sexual experiences. Sex was considered to be an intimate act that required both partners to make themselves vulnerable, therefore considerable importance was attached to protecting one's own self-esteem and that of one's partner. Finally, an erotic script was prominent in the accounts of some respondents, which were characterised by an emphasis on pleasure (rather than penetration), novelty and excitement. This suggests that while some individuals and couples will be seeking symptom reversal, others may be looking for outcomes from PST other than the restoration of the sexual status quo.

Noting that the spectrum of sexual potential is less well understood in PST, Kleinplatz and colleagues have developed an empirically-based conceptual model of optimal sexuality, by studying it from a phenomenological perspective (Kleinplatz et al., 2009). Their findings suggest several components of optimal sexuality, including (Kleinplatz, 2012b, pp. 113-114):

- Being present, focused and embodied
- A sense of connection/being in synch with one's partner

- Deep sexual and erotic intimacy, characterised by mutual respect, acceptance and caring
- Extraordinary communication, including heightened empathy and sensitivity
- Interpersonal risk-taking, experienced as on-going exploration and adventure
- Authenticity, i.e. being genuine, uninhibited and transparent
- Letting oneself be vulnerable, revelling in sensation, being 'swept away' and surrendering to one's partner
- A sense of transcendence and transformation

These components were identified from data gathered in semi-structured interviews with 56 people who self-identified as regularly experiencing optimal sexuality and 20 sex therapists who had a professional familiarity with optimal sexuality (Kleinplatz, et al., 2009). Two further minor components were mentioned by some participants, but were not emphasized to the same degree as the other components already indicated; these were: 'intense physical sensation and orgasm' and 'lust, desire, chemistry, attraction' (Kleinplatz, et al., 2009, p. 9). The individuals who identified these two elements, however, did not consider them sufficient in and of themselves for optimal sexual experiencing. With the exception of the sex therapists (who believed that optimal sexuality was dependent on sexual functioning and was different for men and women), there was surprising agreement in the descriptions provided of optimal sexuality by the diverse groups of participants in Kleinplatz's study (Kleinplatz, et al., 2013). Supporting the development of sexual potential implies a shift away from PST's traditional goal (the elimination or reduction of symptoms of sexual dysfunction), and the growth-oriented theory underpinning the PCA is arguably well suited to support psychosexual therapists in this aspect of their work.

Rogers (1961/2004, pp. 183-196) suggested that the attributes of a 'fully functioning person' are: (1) openness to experience; (2) living in the moment without having to shoehorn experience or behaviour into frameworks predicated upon a particular view of self or the world; and (3) trusting in one's organismic experiencing, i.e.

arriving at decisions about what to do on the basis of one's inner reactions. He viewed the process of change in therapy as a journey from 'fixity' (where experience is either made to fit into rigid preconceptions about self, others or the world, or is not acknowledged) to a growing openness to all experiencing. He also observed that the penultimate stage in this process, (where clients are fully aware of their moment-by-moment experiencing), is often accompanied by a 'physiological loosening' (Rogers, 1961/2004, p. 147), which is associated with muscular relaxation and improvements in physiological functioning. This observation has particular significance in the context of PST. However, it is also possible to see many common themes in Rogers' observations concerning the journey to becoming a 'fully functioning person' and the development of sexual potential over time described by respondents in the study by Kleinplatz and colleagues (2009). The emphasis on 'being present', acceptance, empathy and genuineness in descriptions of optimal sexuality provided by respondents in the Kleinplatz study also resonate with aspects of the six conditions Rogers (1957) proposed to be 'necessary and sufficient' for personal growth to occur.

Putting theory into practice *carefully*

Person-centred therapy helps clients to become aware of their inner subjective experience, to symbolise it, to reflect on it and develop new ways of living which are based on their own inner experiencing (Watson, 2006). Rogers saw the relationship between the therapist and client as central to this endeavour and proposed six 'necessary and sufficient' conditions for constructive change to occur in therapy. These are: psychological contact; the client being in a state of incongruence; therapist congruence (or genuineness) in the relationship; unconditional positive regard; empathic understanding; and communication of the therapist's empathic understanding and unconditional regard to a minimal degree (Rogers, 1957). The presence of such conditions, according to Rogers, helps to counteract conditions of worth and supports the client in contacting and processing their own organismic experiencing, thereby reducing incongruence and facilitating the work of the client's actualising tendency. Constructive change in therapy is therefore attributed to the

client's own actualising tendency rather than the therapist's expertise. The 'sufficiency' of these six conditions implies that no additional intervention on the part of the therapist is required, indeed, that the non-directivity of the therapist is a *sine qua non* of therapy. Person-centred therapists who subscribe to this view are typically considered to be working within the 'classical approach' in person-centred therapy (Gillon, 2007).

Some person-centred practitioners do concede that specialist knowledge of the types of presenting issues that clients bring may be helpful (Wilkins & Tolan, 2012). Such knowledge may help a therapist to better understand the client's frame of reference and stay alongside the client when the therapist's own insecurities are triggered (Haugh, 2012; Tolan, 2017). However, the approach to PST we described in our previous article, does not sit within the 'classical approach' in person-centred therapy. The therapeutic conditions suggested by Rogers certainly underpin many of the 'common factors' associated with positive outcomes for clients in PST and other forms of therapy (Donahy & Miller, 2001; Sanders, 2013; Wampold & Imel, 2015). The importance of empathic understanding, acceptance and congruence in work with clients who present with sexual difficulties should also never be underplayed, especially given the continuing sex-negativity in society and the unease many in the helping professions experience when discussing the sexual concerns of service users (Stevenson, 2010; O'Donovan, 2017). But, we would argue, sometimes a level of directivity is required in PST in order for therapists to fulfil their duty of care to clients and practise ethically. An example of this is recommending that a client seek a medical opinion to exclude the possibility of medical conditions contributing to their sexual difficulties.

Within the PCA, there are practitioners who do not consider the provision of the six conditions identified by Rogers to be always sufficient for all clients to experience constructive change. While sharing the same goals as their 'classical' colleagues, person-centred therapists working within more 'experiential' approaches often use specific interventions to assist their clients to contact and process their organismic experiencing (Gillon, 2007; Sanders, 2013). Among the many experiential therapies

associated with the PCA, the focusing oriented therapy of Eugene Gendlin (1996) merits particular attention in the context of PST. A key premise of focusing-oriented therapy is that when experiencing becomes 'stuck', direction can be obtained by attending to what Gendlin terms the 'bodily felt sense', that is what is sensed in one's body. An important component of focusing oriented therapy is teaching clients 'focusing', a strategy for enabling their 'felt sense' to come into focus (Fleisch, 2016). Noting that 'somatic awareness', is a meeting point between humanistic therapies and many other therapeutic approaches, Turp (2001, p. 42) observes that many clients in differing psychotherapy contexts often suffer an impoverishment of somatic awareness and sees the restoration and enhancement of this as being essential in the therapeutic process. But she also cautions that many clients have had to reduce their level of somatic awareness in order to defend against psychological pain that would otherwise be unbearable. We would also add that for some clients, a reduced level of somatic awareness may enable them to continue to function in certain areas of their life (for instance, in certain occupational settings), despite contributing to difficulties in other areas (such as sexually intimate relationships). Great care is therefore required when facilitating greater somatic awareness is the focus of work with clients.

A second experiential approach that supports a PCA to PST is that outlined by David Rennie (1998). Rennie's approach to person-centred therapy is organised around the concept of reflexivity, which he considers to be not only an important aspect of consciousness, but integral to action: our ability to reflect on our own experiencing as well as experience it, enables us to think intentionally and to enact personal change, albeit within certain constraints. In Rennie's approach to therapy, the attention of clients may be drawn to aspects of their experiencing that may, or may not, be in their immediate conscious awareness, thereby offering them the opportunity to reflect on such experience. In addition to promoting the client's awareness of their inner subjective experiencing through communicating empathic understanding, therapists may also offer clients 'process identifications', that is observations that are intended to draw the client's attention to what they are doing, cognitively or behaviourally. Such activities tend to reside in the background of the

client's awareness when they are focused on their feelings and the meaning of their experience. Drawing the attention of clients to what they are doing therefore provides clients with an opportunity to reflect on the intentions behind their actions and also their own agency. What perhaps makes Rennie's experiential approach to therapy most challenging for classical person-centred therapists, is that he also suggests that some clients, on occasions, may need 'process direction', that is guidance provided by the therapist concerning certain activities, for instance, doing more of less of a present activity, or how to go about doing something differently. Although in Rennie's experiential therapy, process directiveness is less technical than that which typically characterises the tasks negotiated with clients in PST, Rennie's approach does provide a bridge to such task-work.

The process directive activities mentioned in our previous article included psycho-education, mindfulness-based activities (such as body scans) and relaxation exercises (Irwin & Pullen, 2017), but many other forms of 'process direction' may be used in PST, including the use of sensate focus tasks. On one level, these activities may appear completely incompatible with a PCA, crossing the 'dividing line' between the PCA and more 'authoritative' forms of therapy that are grounded in different types of therapeutic relationship (Warner, 2000, p. 34). However, even sensate focus activities may have a place within a PCA to PST, if as Linshoten et al., (2016, pp. 233-234) suggest, they provide opportunities for individuals to develop their capacity 'to be present and aware of their own personal experience of sensations'. There is also much in the PCA to relationship counselling (see, for instance: Tudor, 2008; O'Leary and Johns, 2013), including the more 'active' stance of the therapist in providing structure to sessions, that many psychosexual therapists who provide conjoint therapy would recognise.

Cain (2013), an advocate of integration in person-centred therapies, suggests that person-centred therapists cannot on one hand maintain that clients know what is best for them, while on the other define, *a priori*, what specific conditions are sufficient for clients to experience constructive change. Cain further argues that clients may need and benefit from different things at different times during therapy.

Remaining absolutely non-directive may restrict the availability to the client of the therapist's personal and professional resources.

Given that sexual function and fulfilment can be affected by both psychosocial and physical factors, a question inevitably arises about the role of assessment and formulation in a PCA to PST. These processes are central in many other psychotherapeutic approaches, but are problematic in the PCA. This is largely because, no matter how collaboratively they are undertaken, assessment and formulation are considered to be indicators of an 'expert-oriented' approach, which places the expertise of the therapist and psychological theory and research findings over the lived experience of the client, thereby reinforcing an external locus of evaluation (Rogers, 1951/1973; Gillon, 2013). This brings into question how therapists should then proceed in their work with clients whose difficulties are essentially psychosomatic. Writing in the early 1950s about the how best to approach clients presenting with psychosomatic problems, Rogers (1951/1973, p. 226) acknowledges that he was unable to provide any definitive answer. As sexual problems may sometimes be symptoms of serious pathological processes, a detailed assessment informed by a biopsychosocial perspective would seem essential. In our previous article, we described a less-structured, client-led approach to assessment, but medical practitioners typically refer clients to this service, after possible organic factors contributing to clients' sexual difficulties have been either excluded or identified and treated.

Given that the focus of this article has predominantly been on theory and its links to practice, it seems apposite to end by considering the role of formulation in a PCA to PST. The term formulation can be used to refer to the process of sense-making and the 'explanation' that arises from this process (British Psychological Society, Division of Clinical Psychology, 2011). Formulation is a key process in psychological therapy (Johnstone & Dallos, 2006), but one that is inherently problematic from a person-centred perspective. Gillon (2013) suggests, however, that the tentative use of theoretically-informed formulations is possible providing the priority given in the PCA to the client's frame of reference is never compromised and the therapist

remains open to whatever happens in the here-and-now of the therapeutic relationship. He also observes that in the person-centred therapies, formulations typically reside within the therapist. But, as Hawton (1985, pp. 118-119) notes, in addition to linking assessment to intervention, sharing formulations with clients serves a number of other important functions in PST, such as enabling the therapist to check that they have interpreted correctly the information clients have given them, encouraging optimism about the possibility of change, and helping clients to further understand their difficulties. The latter in a PCA to PST may entail sharing 'process identifications' and bringing material into the relationship from the therapist's own frame of reference (specifically, the therapist's specialist knowledge of human sexuality and sexual functioning). Offering such material (for example, information about the physiological changes that occur during pregnancy and how these may sometimes impact on sexual functioning following childbirth) may enable clients to make more sense of their experiencing.

While the formulation process in psychological therapy may be a positive experience for clients, it is not invariably so and can result in distress for some (see Redhead et al., 2015). Formulations are open to revision and re-formulation, and when formulations are shared with the client, this should always be done tentatively rather than presented as expert pronouncement (Johnstone & Dallos, 2006). The place occupied by formulation in a PCA to PST is likely to differ to its traditional position in PST process, where sharing and reviewing the formulation acts as a 'bridge' between the assessment and 'treatment' phases of therapy. In our previous article we noted that there was no such specific formulation 'session' in the brief approach to PST we outlined (Irwin & Pullen, 2017), but, as Gillon (2013) notes, this does not preclude the sharing of the formulation if this is done tentatively and when it supports the core conditions of empathy, acceptance and congruence in the therapeutic relationship.

Conclusions

Significant differences do exist between the PCA and more diagnosis-driven approaches to PST. While PST often seems preoccupied with solving 'problems', the ethos of the PCA is on growth and helping clients to become aware of, give 'voice' to, and reflect on their experiencing in order to develop new ways of feeling, thinking and being (Watson, 2006). No doubt some person-centred therapists and psychosexual therapists would consider a PCA to PST to be a contradiction in terms. However, it is easy to overlook evidence that suggests a level of integration already exists: it is hard to conceive of a psychosexual therapist who would not acknowledge the centrality of the core conditions of empathic understanding, acceptance and genuineness in the therapeutic relationship or the importance to the therapeutic process of understanding of their clients' subjective experience and the meaning they give to such experience.

This article has suggested that a PCA to PST is possible, resulting in a more idiographic approach to PST (Berry & Barker, 2015). While recent developments in person-centred theory make it easier to re-formulate some psychosocial factors in ways that are consistent with a PCA, the psychosomatic nature of sexual function problems requires practice to be informed by a biopsychosocial perspective. However, the emphasis on growth in the PCA can help to restore a more equal balance, in terms of focus, between sexual problems and sexual potential in PST. Finally, we have indicated that a PCA approach to PST is likely to be more closely aligned with experiential therapies (such as those developed by Gendlin and Rennie) rather than the classical approach to person-centred therapy, which emphasizes the sufficiency of the six conditions proposed by Rogers and non-directivity on the part of the therapist. In a PCA to PST, the process-expertise and specialist knowledge of sexuality and sexual functioning of the psychosexual therapist can be very useful resources for clients, but ultimately it is clients who know what is best for them.

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