



Historical and Contemporary Psychoanalytic and Bioenergetic Perspectives of Sexuality: Lets Bring it Back into the Therapy Room

Sannes HR*

Psychologist in private practice, California, USA

*Corresponding author: Helen Resneck-Sannes; Psychologist in private practice, California, USA, Tel: (831) 777-2035; Email: helenrs@aol.com

Opinion

Volume 5 Issue 1

Received Date: February 10, 2020

Published Date: February 21, 2020

DOI: 10.23880/pprij-16000235

Abstract

In the late 60s and 70s sexuality occupied center stage in psychoanalysis and then retreated as a focus of inquiry. The increase of claims against therapists for sexual violations, as well as the emergence of more relational analytic therapies, contributed to the avoidance of addressing sexuality in the therapy room. During this time, the psychoanalytic definition of "normal" sexuality was evolving, as well as our notions of gender. Reichian psychotherapy, and its offshoot Bioenergetic Analysis have always seen sexuality as integral to the healthy functioning of the individual. This paper translates current psychoanalytic concepts of healthy sexuality into its somatic counterparts in bioenergetic theory. A case is presented illustrating how these concepts manifest in practice. Exploring sexual fantasies and clients' preferences for certain types of pornography is viewed as helpful for understanding the dynamics of parenting, and for clarifying transference and counter transference issues.

Keywords: Sexuality; Psychoanalysis; Reich; Bioenergetic Analysis Sexual Abuse; Shame; Pornography; Gender Identification

Introduction

Wilhelm Reich is the only person whose books were burned by the FDA. And as one psychoanalyst asked me when I was presenting Bioenergetics to an analytic group: Do you really believe that orgone energy was that threatening?" Freud believed that sex and aggression were the two most threatening drives, and the culture's role was to manage and control them. "It was Freud who first bravely placed sex at the heart of psychic development and highlighted its destabilizing power in our psyche and hence the defenses brought into play to manage it. As one contemporary psychoanalyst has stated: "His corpus of work might even be described as the result of an internal need for regulation of the sex drive.

Reich also saw the danger of the sex drive. As we know

from, Reich discovered his mother having sex with his tutor and told his father of the affair [1]. His father began treating his wife badly, and Reich's mother was driven to committing suicide. However, Reich believed that the problem was repression of sexuality, rather than it needing to be more controlled.

Bioenergetic analysts view that how we organize ourselves sexually plays a key role in our feelings of aliveness and in our somatopsychic organization. In *Fear of Life*, Lowen states: "Sex is the most intense manifestation of the living process [2]. By controlling sex one controls life." Two factors have the greatest impact on our attitudes regarding sexuality: cultural attitudes and our attachment histories. In this talk I trace what has happened in the field of psychotherapy regarding sexuality from the 60s when sexual attitudes began to be more open, to the present. Focus is on

the necessity to be alert to feelings of shame, the importance of grounding especially in relation to the pelvis, and the role of sexual fantasies in revealing attachment histories.

The following concepts are key when discussing sexuality from a Bioenergetic perspective:

1. Reich's' concept of orgasmic potency is a yardstick for health in that it describes the capacity for aliveness and pleasure in life.
2. Lowen's [2] addition of the concept of grounding enables a person to take a stand to feel his bodily separateness.
3. Bodily boundaries enable the client to merge and recover his separate bodily integrity.
4. Opening the blocks in the body in the presence of a highly skilled Bioenergetic therapist reveals to the person his needs and emotions that he has cast out, enabling him to be in as much contact with his deepest self and to experience as much as he can of his partner's emotions. has elucidated the requisites for creating the optimal environment for this deep work. Bioenergetics therapists are skilled in knowing how to support the diaphragm through the terror of the heart and pelvis opening and flowing together, enabling feelings of passionate love, which is sometimes a roaring train and other times a sweet melting.

History

Let's go through a little history about how Bioenergetics, with its emphasis on emotional expression and sexuality came to be popular and then retreated from a prime position on the therapy stage. By the mid 1960s the Kinsey Report had been published and its findings disseminated. Birth control was widely available, as well as mind altering drugs, great music, economic prosperity, and feminism. Without the fear of pregnancy or HIV, cultural attitudes regarding sexual expression loosened. Reich's ideas were attractive because they promised freedom to discover our real selves, separate from the culture's restraints. However, the culture was still saying that sexuality was dangerous and women's role was to create boundaries.

I remember when I told my parents my sophomore year of college, that I wanted to move off campus and needed their signature, my father first accused me of wanting to put a red light in front of my door, and then the next day offered to help me get birth control pills. I was in love but not certain I was ready to have sex yet. Fifteen years later I entered Bioenergetic therapy and training. I remember when I first felt the sweet vibrations emanating from my pelvis, trying to work its way through the block at my shoulders. My therapist told me that this was my energy, and that it belonged to me. I had been masturbating since the age of 4 and enjoying orgasms, had been active sexually since the age of 21 years,

and had been married 5 years and had given birth. However, I began to cry, as for the first time, I really felt that this energy was mine. Of course, there lies the danger. If I felt that this was my sexual energy, how was I to control it, and to keep it from being expressed when it shouldn't? After all, the culture had told me that I am a woman and I must set boundaries. There was that ominous red light problem. As the sexual charge increased, the more shame I felt with my desire not to manage it. I asked my therapist what she thought about shame and she replied: "that it was just a racket that parents run on their children". My parents did not want to shame me, but there it was. I felt terrible, so, I decided to explore it: How it was held in my body? What were its early manifestations? In 1981 I published my article: "Shame, Sexuality, Vulnerability". Shame had not been explored much before then in the psychological literature, so other authors began calling me, wanting to talk about it.

In 1988, my friend, Ellen Bass published the book: *The Courage to Heal* (which I helped edit, but only the body work section) [3]. It alerted the culture to the widespread occurrence of sexual abuse. She has a statement in the book, which sounds innocent enough:

If you don't remember your abuse, you are not alone. Many women don't have memories, and some never get memories. This doesn't mean they weren't abused. If you think you have been sexually abused, you probably have."

This became the sentence that caused a public outcry. During those subsequent years, many women and men for the first time began to tell people about their sexual abuse histories. Even before the book had been published, I was interviewed by a magazine and asked how many of my clients reported sexual abuse. I went through my notes. It was 80% of women. I was asked if that seemed disproportionately large. I had never even thought about it before then. Interestingly, if I look at my cases now, it is probably only 35% of women and 10% of men.

After the book was published, therapists were alerted to the sexual abuse they had been missing. I had clients coming in reporting that previous therapists were telling them that they had been abused and as a somatic therapist, perhaps I could help them recover their memories. No memory of a sexual abuse incident emerged, although somatically the clients were experiencing the same bodily sensations and emotional fears of clients who had a memory of at least one specific incident of sexual abuse. Two parenting events were a parent, who was also violently punishing them. Now, we know from working with the body that two things flood the pelvis: Sexuality and aggression. And as I mentioned previously, Freud believed that these were the two most difficult and potentially dangerous drives to control.

I then published the article: "A Feeling In Search Of A Memory", which was immediately picked up by the Utne Reader. I state in that article:

The current debate in the field of psychotherapy and child abuse is a difficult one. The question is: Can therapists know about a client's sexual abuse before the client is aware of it? Several of my clients have seen therapists who decided that they had been sexually molested. The therapists began to work toward enabling the clients to retrieve the abuse memories. One client produced memories for the therapist. Later, in therapy with me she admitted that these events could never have really happened. For the others, no memory ever emerged. All of the clients became more and more confused and ashamed of their sexual feelings.

No memory of sexual abuse ever emerged because there was no incident. These clients had all grown up in families in which boundaries weren't respected. Many of them were emotionally flooded by one of the parent's needs. The threat of violence was present, often from a parent who was also seductive. They grew up in an atmosphere of emotional and sexual abuse, but there was not a physical incident of sexual abuse to be remembered. There was no memory because there was no incident [4].

The culture, especially the therapeutic field had become hyper vigilant to issues of sexual abuse. Therapists were being reported to licensing boards for sexual violations and day care centers were being closed due to charges of sexual abuse. The False Memory Association was formed. Bob and Virginia Hilton published the book: *Therapists at Risk* to help us navigate this territory [5].

Current Views

Alan Schore's writings [6,7] and the findings from neuroscience directed the field to focus on the non-verbal events that happen during the first three years of life. Many therapists took refuge here, for now the focus was infantile issues rather than adult sexuality. And as Mann warns us: "When sexuality is too hot to handle, therapists may resort to mentally de-sexualising their own and their patient's bodies, thereby compounding problematic body-mind splits and heightening the danger of acting out erotic desires [8]. Awareness of the effects of shock trauma, flooding, and disassociation became hot topics, and many of us studied treatment modalities for working with trauma. Treating shock trauma is now included in our training curriculum.

Self Psychology (1) and Object Relations (2) became of interest, along with Martha Stark's analysis of a One person, One and a half person and Two person therapy. (3)

Self Psychology is a modern psychoanalytic theory. Its clinical applications, were conceived by Heinz Kohut in Chicago in the 1960s, 70s, and 80s, and is still developing as a contemporary form of psychoanalytic treatment. In Self psychology, the effort is made to understand individuals from within their subjective experience via vicarious introspection, basing interpretations on the understanding of the self as the central agency of the human psyche. Essential to understanding Self psychology are the following concepts: empathy, alter ego/twinship and the tripolar self. Though Self Psychology also recognizes certain drives, conflicts, and complexes present in Freudian psychodynamic theory, these are understood within a different framework. Self Psychology was seen as a major break from traditional psychoanalysis and is considered the beginnings of the relational approach to Psychoanalysis.

Object relations is a variation of psychoanalytic theory that diverges from Sigmund Freud's belief that humans are motivated by sexual and aggressive drives, suggesting instead that humans are primarily motivated by the need for contact with others—the need to form relationships.

One person therapy: The therapist as expert, separate from the relationship and interprets the client's feelings and behaviors. **One and a half person therapy:** The therapist empathically mirrors the client. **Two person therapy:** The therapist is an active participant in the relationship.

Classical bioenergetics is a One person therapy, with the analyst as expert offering interpretations and techniques. With a Two person therapy, the therapist is a part of and deeply affected by the process. Many of us were working with personality disorders and our clients were feeling ashamed and flooded by the Bioenergetic work. We had already begun to reshape our interventions, so that the analyst openly acknowledged her part in the process. However, to work this way has its risks, especially if you are working with sexuality. You are no longer an unmoved observer of someone's energy opening.

It appears that psychosexuality retreated from analytic focus at about the same time and rate that transference issues started to occupy the centre ground. Possibly sexuality was easier to focus on when the treatment was shorter, when the relationship with the therapist was not the central focus, when the patient's attachment to the analyst was most easily understood to be part of their illness, and the therapist behind the couch did not expect to get involved.

Therapist Stance Working with Sexuality

It behooves you then as the therapist to be more aware of your own sexual energy, and to work on yourself, to be as open and conscious as possible. This is especially true, as we now know from Alan Schore's writings, that what transpires

between the therapist and the client is often unconscious and non-verbal. Our comfort with our own bodies and sexuality is a pre-requisite to work with another's sexuality.

So after all of this: Again, what do we know of as healthy sexuality? For Reich the measure of health was to achieve orgasmic potency, "The Big O". One definition of healthy sexuality could be a body that has a capacity to slowly vibrate into finer and finer movements until they become like subtle electricity and the body is enveloped in streaming, "The big O". For a brief period of time the body/mind split is healed.

Although Reich believed that the charge begins in the pelvis, he was writing about more than genital arousal. He was talking about an energetic charge that is first manifest as vibrations or a tingling sensation, which travels up the spine through the shoulders freeing the arms to reach for connection and to push away to create boundaries. It travels up and down the legs, like a balloon needing a string and a hand to hold it, seeking for a way to move down and up from the ground in a wave pattern, moving our head back as the lower spine seeks contact with the ground and our legs seek a boundary to hold them. It comes up the front of the belly and chest and up to the jaw and out the eyes, freeing the eyes to be soft or hard, to push away or pull back, to show love, passion, longing, hurt, anger and sadism. Yes, we need to take responsibility for our sadistic impulses, feel the pleasure of our anger, to feel it in our bodies, and to have a choice whether to contain it or express it and to decide how we wish to do that.

The "big O" isn't only about sex. These vibrations or tingling sensations are important for regulating our arousal system. Reich believed that we have more energy than is needed, in case of fight/ flight. If that energy isn't discharged, it becomes anxiety, sometimes so intolerable that physical symptoms and illness occurs. We know how valuable it is to release that energy, especially in dealing with trauma. Levine [9] and Berceles's [10] somatic interventions for the treatment of trauma are based on Bioenergetic theory and techniques, which they both studied.

However, it is not that easy to reach the Big O and certainly difficult to sustain. My experience is that I have achieved it rarely and for only brief periods of time. I notice that my clients and I unconsciously stop the flow. Even though the sensations are pleasurable, familiar muscle tensions and holding patterns reassert themselves. Our attachment history has informed our bodies that it is not safe to be this open. It is too painful to have the expression of our needs and impulses denied again and again, so our bodies contract so that we are unaware of these frightening emotions, our desires for connection and the need for boundaries. To re-experience that rejection again and again would be intolerable, so we

prevent ourselves from consciously knowing of them. We may be in state of chronic hyper- or hypo-arousal without awareness that another way of living in our bodies is possible. Not knowing our needs, we aren't able to take care of them. Lack of awareness of our anger can cause it to burst through explosively. Chronic muscular tensions cannot only make it unpleasant to feel our bodies but also lead to health problems. Of course this is a very shortened minimal description. To see how they apply in Bioenergetic therapy, see Angela Klopstech [11].

However, lying on the floor and streaming isn't sufficient for healthy sexuality. The "Big O" is an experience of a person alone, not in relationship. Healthy sex is relational, for as Lowen A [12] says, "It is illogical to write about sex without discussing its relationship to love". Our relationship to sex and love are formed in our early attachment relationships.

Target M [13] lists the following attributes as necessary for what she refers to as "normal" sexual relationships.

First the relationship must allow opening one's mind to another's projection, an experience of safe attachment interactions allow each partner to accept being both separate and fused with one another...Secondly, normal sexuality requires a reliable sense of the boundary of the physical self. This is blurred in intense sexual pleasure, in which the bodies may feel merged or interchangeable, and there must be confidence that the sense of self can be restored. Thirdly...genuine desire on both sides is essential. Fourthly, heterosexual excitement may be underpinned by an unconscious fantasy of also possessing being the gender of the partner.

Target mentions an experience of safe attachments as necessary. We know that to rear children with healthy sexuality, we must provide a positive mirror, beginning in infancy and throughout childhood. Children must neither be favored nor victimized by either parent, but must be the third, separate from the parental unit. Tucillo [14] states that the relational dynamic between the parents has a profound impact on the child's sexuality and, in particular, on her eventual sexual relationship.

Children learn to relate to others through their parents relationships. Much of this trauma and pathology becomes imprinted, embedded in the unconscious and, although a young adult may vow never to repeat the mistakes of her parents, nevertheless, she often finds herself mired in similar relational traps.

For healthy sexuality it is necessary to be separate, to feel the charge and to take possession of it. If not, the person remains in a symbiotic merger with the other. As I quoted

Target previously, you can't merge and lose your boundaries with another unless you are separate.

Bioenergetic Work on Sexuality

One of the principles of Bioenergetics is to first help the clients find their ground, to feel stable standing on their own two feet. As Lowen states in *Fear of Life*: "One's feelings of security and independence are intimately related to the function of his legs and feet. These feelings strongly influence his sexuality." It follows then that for clients to experience separateness, they must be able to stand, feeling supported by their own legs. It is often necessary to assist them in finding where the pelvis should be held in relation to the rest of the body. The client often needs support from the therapist to be able to manage this new stance.

Case Presentation

The pelvis needs to be allowed movement to provide charge and energy. Sometimes it is cocked back and held in the charged position, and tensions block the full swing of the pelvis into the discharge position. It is as if the person has one foot on the gas and one on the brake. Recently, a male, I'll call him Joe came to therapy reporting ongoing panic attacks that had begun after his wife separated from him. He couldn't sleep and a psychiatrist diagnosed him as bipolar. However, he had never had these symptoms before. When I began to ask him to focus on the sensations in his body, he described feeling intense activation beginning in his chest and rising up his back and up to the top of his head. The area of his heart felt tight and ached. I told him that he was describing the pathways opened in kundalini yoga. He then told me that he had attended a kundalini retreat a couple of years ago, and it seemed that these either were, or had become habitual pathways for the energy in his body. First, of course, I helped him ground, finding the support that his own legs could give him. As Baum S [15] says: "Modifying the stance, like the effect of considering a new way of looking at something about which one has always had a particular attitude, creates the possibility for new experience, new ideas, new images, and new solutions."

After Joe found his legs and grounded, we did some simple boundary-setting exercises. Next, I encouraged him to move his pelvis. It was arched back, and he found it difficult to let go of the tension. He held a fully charged pelvis, but couldn't release during the thrust. All that charge created a great deal of anxiety, confirming Reich's theory. When trying to release his pelvis, he lost his ground and needed support from my hands on his upper back and on his chest to keep centered. While standing there, he reported a memory. One time, when he was 18-years-old, someone spiked his drink at a party with a hallucinogen. He came home and was very frightened. His

father was generally passive, and his mother let him know in many ways that Joe was superior to his father. My hand on his upper back reminded him of that time when his father was providing support and calming him. His mother came home and found them together. She yelled at his father, grabbed Joe and dragged him upstairs to his bedroom, locked the door and climbed into bed with him. As he told me this story, he became aware of how enraged he was with his mother and how frightening it was to feel that. I removed my hands from his chest and back and stood in front of him. I offered him the palms of my hands and encouraged him to move his pelvis and push against me with his hands, enabling him to feel the power to set boundaries. I continued the contact with my hands while he pushed, since without the contact, he lost his ability to ground. His mother encouraged his sexuality. In fact she flooded him with so much charge, that it became difficult to ground. Also, there was no safe release.

Joe could not report an incident of sexual abuse but was caught between his mother's use of him to meet her own narcissistic needs, including sexualization of him, and the negation of his father as an idealizing object. He was caught in an Oedipal triangle that charged his pelvis in a way that was frightening to him.

After that session, he was able for the first time to take a stand during the mediation sessions with his wife and set limits on how she was treating him. He also began having his first good nights of sleep in months. This was important as he said his anxiety was about not being able to sleep and not being able to sleep led to more anxiety. So being able to sleep offered him a great deal of hope.

Joe did not enter therapy with sexual issues but the somatic interventions were useful in enabling him to recover feelings regarding his mother, which in turn enabled him to be more assertive, to set boundaries, and discharge some of his anxiety. However, like most of our interventions, this was not a one-session cure. Several weeks later he had trouble sleeping again and was experiencing anxiety about his relationship with his current girlfriend. He reported frightening nightmares of being held sexual captive by his girlfriend and her father. Joe still has a tendency to lose his ground, especially with women to whom he becomes attached. He will need to lose and recover it many times before that learning solidifies. However, under stress, Joe like the rest of us will return to his defensive position. But he now is aware of it and is able to find a solid ground for himself. After 21 sessions, he no longer needs the Ativan medication to sleep.

Shame and Sexuality

Not all clients enter therapy ready to stand on their own

and be separate. As infants we need a caretaker to survive. If that caretaker doesn't respond contingently to the infant's needs or threatens abandonment when the child tries to individuate, the child will be unable to separate from the introjected mother. To do so would mean death. In this case infantile issues need to be addressed before opening the sexual charge.

Another pitfall of opening sexual feelings prematurely is the following. When sexuality is opened before the person has dealt with feelings of shame, he or she either self attacks or attacks the other (the therapist) to protect against the "bad self". You may be working with infantile blocks as the patient lies on the mat, encouraging a full pelvic release. But later the adult is frightened by the charge and the sexual impulses that have emerged and may have feelings of shame. This is especially true for issues regarding sexual abuse. Sexual abuse often opens the genital charge before the victim can contain it. The charge is over-whelming and frightening; and to make matters worse, the victim usually blames him or herself for the abuse, and experiences intense feelings of shame.

Shame is an emotion that is not readily shared.

Rather the person wants to hide and cover the feeling to prevent further exposure of inadequacy. Because of this reaction, the person may internally separate from the therapist [16].

This is a critical moment because if the shame is not immediately addressed the client will be left feeling that he or she is bad, which may lead to a self attack, i.e. cutting, over-eating, drugs or attack on the other (the therapist) to protect against the "bad self". The therapist who opened these feelings must be bad. He or she is the perpetrator over-stimulating the client.

Empathy, mirroring, supporting, challenging and analyzing the therapeutic relationship are needed to treat sexuality. Lowen emphasized to always support sexuality. We need to support it because of the shame and feelings of inadequacy that surround it. It is such a sensitive part of ourselves that we need to bring to the therapy all of our therapeutic skills, including our knowledge of how energy moves through the body, especially through the pelvis Resneck-Sannes [17].

Developmental Charge and Sexual Expression

Another important contributing factor that Bioenergetic theory brings to the therapy process is the analysis of how developmental charge is held in the body. The belief is that the charge comes into the pelvis in a more differentiated way

between 18 months to 3 years.

Reich W [18] made it a point to investigate his clients' fantasies during masturbation. So, at some point, when the relationship is solid and I'm fairly certain that the question will be received well, I ask my clients what they fantasize about when having partnered sex or masturbating. I do this, because I want to know how they were parented during this time. As I have said, physical aggression charges the pelvis. Children who were physically punished during that time (not necessarily beaten, but swatted on the butt), or harnessed, or confined to a playpen, often have sado/masochistic fantasies during sex or masturbation. One client was literally tied to his crib when he was young, as his parents were afraid he would wander through the house and hurt himself. He liked being tied up during sex, and deep inside, he felt his charge was too much for others. When he had a therapist who avoided discussing his sexual practices, it confirmed that belief. Another client's father spanked her very hard. He also dressed her in a French Maid costume when she was 8 years old, so physical aggression and sexuality were merged. She had fantasies of being spanked during sex. She was over-stimulated by her father and entered therapy wanting treatment for alcoholism. Once the drinking was under control, she became a compulsive eater, and then finally she became a sex addict. After three years of therapy, she could take a stand and ground on her own. She was able to differentiate her own body's arousal from her father's sexualization, which had flooded her. She was free from the need to use alcohol, food, or sex to calm herself.

If women are told that their sexual feelings might be over-whelming and that men might have a difficult time containing them, i.e. leading to rape, they report fantasies of being irresistible and captured, so that they aren't responsible for what follows and can avoid feeling ashamed for wanting sex.

There are as many variations on themes as our wonderful fantasy life will allow. I include Internet videos to be an important part of a client's fantasy life that also need to be investigated. I have treated many men who have come to therapy suffering from secondary impotence. The men I treated were all able to masturbate successfully, which I encourage. It is always good to keep the equipment in working order. Each of them experienced harsh rejection and criticism from their partners during sex. The pelvis was tucked under, like a dog with its tail beneath its legs, muting both the charge and specifically the aggression that would follow the resentment at being treated badly.

As Murray E [19] says in her article: The necessary therapeutic intervention was when she helped her client see "his impotence as an expressive act by his body, through

which he told his wife how he felt about her behavior.”.

Some of these men turned to Internet sexual videos, which the culture has labeled as pornographic. When questioned about what they were watching, the story line was clear. The women in these videos were all enjoying receiving and giving sexual pleasure. Fantasies are a rich resource of material and I encourage them not to be overlooked when working on attachment issues.

Culture and Sexuality

Along with our early relational experiences with our caretakers, cultural attitudes impact how sex is experienced in the body/mind. The definition of normal sexuality has gone through many changes. In the last few years homosexuality and transgender identification are no longer considered sexual perversions. In fact, transsexuals have shown us that gender and sexual attraction are fluid. A woman may be attracted to women and find that the lesbian community provides a safe mirror for connection to her self. When her partner decides to become a man is she still a lesbian or is she now heterosexual? Does she have to give up her lesbian community, in which so much of herself is identified? In this context the labels lose their meaning. Gender is no longer a two-option choice. It also means that the ideal couple doesn't necessarily need to be represented as a heterosexual unit. But then again, how many of us hold our parents' unions as ideal standards of relatedness?

Homosexuality is no longer considered perverse. It does bring some problems of its own in terms of marginalization by the culture, homophobia and shame. In fact homophobia impedes the ability to have normal sex, as it interferes with the capacity for imagination during sex of being the gender of the other. Normal sexuality is about being grounded and separate enough in your own body and sense of self that merging and losing body/mind boundaries is pleasurable. For healthy sexuality, we must be able to move from passive surrender (reception) to assertive aggression (thrusting). We need to take on both roles in our imagination. As we receive the penetration in our body/minds we also hold the role of the penetrator, feeling welcomed inside, imagining being touched while touching the other and reveling in the sensation.

Conclusion

In the last year I asked several Bioenergetic male therapists if they work with sexuality. Many said that they stopped because they were afraid of litigation. De-sexualizing our clients is often shaming to them, encouraging them to turn away and negate the very part of them that provides the life force, a sense of joy and power in the world. Therapists who

are unaware of how sexuality functions in their own psyches are unable to effectively mirror their clients' sexuality and are in danger of acting out in the therapy room. However, working with such an integral vulnerable part of the self has its dangers. Virginia Hilton [20-25] has written: How can we, who haven't resolved our own conflicts, offer those who come to us an ideal relationship for working through their Oedipal/sexual problems? We can't. Hopefully, we can be aware enough of our own issues and how they may impinge on the relationships, so as to keep them out of the way, and clear enough about the nature of the task so as not to simply recapitulate the initial trauma. We can acknowledge our limitations, and seek help for ourselves through therapy and supervision, accepting the fact that we never outgrow the need for such help.

References

1. Sharaf M (1983) *Fury On Earth: A Biography of Wilhelm Reich*. St. Martin's Press, New York.
2. Lowen A (1980) *Fear of Life*. Macmillan Publishing Co, New York.
3. Bass E, Davis L (1988) *The Courage to Heal*. Harper and Row, New York.
4. Resneck Sannes H (1995) A Feeling in Search of A Memory. *Women and Therapy* 16(4): 97-105.
5. Hedges L, Hilton R, Hilton V, Caudill O (1996) *Therapists at Risk: Perils of the Intimacy of the therapeutic relationship*. Jason Aronson, Maryland.
6. Schore AN (1997) Interdisciplinary developmental research as a source of clinical models. In Moskowitz.
7. Schore AN (2003) *Affect Regulation and The Repair of the Self*. WW Norton & Co, New York, pp: 303.
8. Mann D (1997) In: Harding C (2001) *Sexuality: Psychoanalytic Perspectives*, Brunner-Routledge, Philadelphia.
9. Levine P (1997) *Waking The Tiger: Healing Trauma*: North Atlantic Books, Berkeley, California.
10. Bercei D (2008) *The Revolutionary Trauma Release Process: Transcend your toughest times*.
11. Klopstech A (2000) The Bioenergetic Use of a Psychoanalytic Concept of Cure. *Bioenergetic Analysis* (11): 55-66.
12. Lowen A (1975) *Love And Orgasm*, Macmillan Publishing Co, New York.

13. Target M (2015) "A developmental model of sexual excitement, desire and alienation" In: Lemma A, Lynch P Sexualities: Contemporary Psychoanalytic Perspectives, pp: 43-62.
14. Tucillo E (2006) "A Somato-psychic Relational Model for Growing an Emotionally Healthy, Sexually Open Body from the Ground Up. Bioenergetic Analysis 16: 63-85.
15. Baum S (2017) Containment, Holding, and Receptivity: Somatopsychic Challenges. Bioenergetic Analysis.
16. Resneck Sannes H (2012) Neuroscience, Attachment and Love. Bioenergetic Analysis (22): 9-28.
17. Resneck Sannes H (1991) Shame, Sexuality, and Vulnerability. Women and Therapy 11(2): 111
18. Reich W (1971) The invasion of compulsory sex morality. In: Kaslow F, Massey R Comprehensive Handbook of Psychotherapy. Farrar, Straus, and Giroux, New York.
19. Murray E (1986) Treatment history of a man with impotence. In: Heinrich Clauer V (Ed.), Handbook Bioenergetic Analysis. English edition of the German original version. Pyschosozial-Verlag, pp: 247-257.
20. Hilton V (1987) Working with sexual transference. In: Heinrich-Clauer V (Ed.). Handbook Bioenergetic Analysis. English edition of the German original version. Pyschosozial Verlag, pp: 213-223.
21. Harding C (2001) Sexuality: Psychoanalytic Perspectives. Philadelphia: Taylor and Francis.
22. Lemma A, Lynch P (2015) Sexualities: Contemporary Psychoanalytic Perspectives. London, New York.
23. Reich W (1970) The Function Of The Orgasm. Trans. Theodore Wolfe, Meridian, New York.
24. Reich W (1973) The Function of the Orgasm Farrar, Straus, New York.
25. Monk C, Kaye C, Ellman S (1997) The Neurobiological and Developmental Basis for Psychotherapeutic Intervention, Aronson, Northvale.

