

STATUS OF SEXUALITY IN CONTEMPORARY PSYCHOANALYTIC PSYCHOTHERAPY AS REPORTED BY THERAPISTS

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Contemporary psychoanalytic literature places less emphasis than its classical counterpart on sexuality in explaining human motivation. However, up until now no methodical research has been done on the status of sexuality in clinical work. We report on a qualitative interview study that examined the status of sexuality in psychoanalytically oriented psychotherapy ($n = 10$). We studied the extent to which therapists used sexual factors to explain patient behavior: To what extent were sexual themes dominant in the treatment, what importance did therapists attach to them, and what factors affected their place in therapy? The data gathered from the investigation were related to theoretical thinking on the marginalization of sexuality in psychoanalytic theory and practice. On the basis of the investigation, we describe four factors that affect the status of sexual themes in therapy: the extent of the belief in the centrality of sexuality in human motivation, the level of expressiveness of therapy, the narrowing of the concept of sexuality and the separation between sexuality and intimacy, and the tendency to avoid sexual issues because of the discomfort their discussion causes to patient or therapist.

Keywords: sexuality, psychoanalysis, treatment, human motivation, marginalization

The centrality of sexuality was considered one of the cornerstones of psychoanalysis from the movement's beginning until Freud's last days (see, e.g., Freud, 1905/1953b, 1914/1957a, 1929/1961). Freud argued that difficulties in the realm of sexuality were the cause of mental disturbances: Clashes between the demands of sexual drives and the internal resistances they raise encourage repression, which in turn creates neurotic symptoms (see, e.g., Freud, 1896/1962a, 1894/1962b, 1933/1964b, 1895/1955). Today, more than a century after Freud and Josef Breuer published "Studies on Hysteria," is sexuality still regarded as central to the etiology of mental disturbances and to human motivation in general (Freud, 1955)? In recent decades, several dominant schools within the psychoanalytic movement have argued that

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difficulties in the realm of sexuality can no longer explain modern-day psychic suffering. The advocates of such claims have offered alternative explanations, such as the need for intimate relationships or the need for self-fulfillment.

In this article, we describe the outcome of a qualitative study examining the status of sexuality as a factor explaining human behavior in contemporary psychoanalytic psychotherapy. A growing number of theoretical articles have concerned themselves with the marginalization of sexuality in psychoanalytic theory and literature, but to date no methodical research has been conducted on the status of sexuality in clinical work. We begin the article with a description of the main theoretical claims regarding the drawing away from sexuality in psychoanalysis. We then use these claims to interpret the data gathered from the investigation.

Decline of Sexuality in Psychoanalysis

In an article with the provocative title “Has Sexuality Anything to Do With Psychoanalysis?” André Green (1996) lamented the marginalization of sexuality in psychoanalysis. Green pointed out that sexuality, to which Freud attributed a central role in psychoanalytic theory and practice, is nowadays rarely mentioned in case studies or articles published in psychoanalytic journals.¹ We emphasize two major factors here that, according to Green, have contributed to the decline in references to sexuality. The first relates to the differences in attitudes toward sexuality between Freud’s era and the present day. Many believe that the change in attitude helped mitigate the conflict between sexuality and society, thus preventing sexuality from becoming a source of psychic suffering. The second factor is related to the popularity of contemporary psychoanalytic theories that claim that pre-oedipal object relations have more influence than sexual factors on the psychic structure of the subject. According to Green, these two factors create the false impression that sexuality has lost its central role in human motivation. Green claimed that sexuality has never ceased to be a source of psychic pain: Patients still complain of frigidity, impotence, problems related to the merging of sexuality and aggressiveness, and so forth. However, theoreticians and practitioners alike have chosen to ignore the sexual, or to regard it as a kind of “artifact” or as “a defense which should be interpreted in conjunction with other hidden aspects ‘beyond’ sexuality” (Green, 1996, p. 872). Other factors are related to the decline of sexuality in psychoanalysis. Most notable is the new wave of puritanism that has swept Western culture in general and American culture in particular.² Although the new wave of puritanism may be influenced by different scientific and cultural phenomena such as HIV and developments in the field of sexual harassment lawsuits, we believe that it is an inevitable reaction to the trend of sexual liberation. It is as though the taboo on sexuality tends to restore itself. Moreover, the factors that contribute to the decline of sexuality in psychoanalysis are interrelated:

¹ Shortly after Green’s (1996) article was published, a panel took place on the “Review of the Psychoanalytic Theory of Sexuality.” The presentations made by various contributors, some of them dealing with the decline of sexuality in psychoanalysis, were published in the *International Journal of Psychoanalysis* (see, e.g., Barale & Ferruta, 1997; Green, 1997; Spruiell, 1997). In 2000, Leanne O’Shea wrote a comprehensive article reflecting on the absence of the discussion of sexuality in literature and in training programs in Gestalt therapy.

² Target (2007) noted that “while diverse sexual experiences have become increasingly acceptable in Western conversation and the media, in psychoanalytic discussion there seems less reference now to sexual behaviour and fantasies than there was several decades ago” (p. 518).

For instance, the popularity of psychoanalytic approaches that place little emphasis on sexuality and focus on relationships and self-cohesion is undoubtedly affected by the so-called “new puritanism.”

We now examine some references in the psychoanalytic literature relating to the reasons for the deemphasis on sexuality, beginning with the moderation of the conflict between sexuality and society.

Status of the Conflict Between Sexuality and Society

In his early writings (1892–1895), Freud argued that it is morality that stands in the way of complete satisfaction of the sexual drive (Van Haute & Geyskens, 2004). However, in his later writings, Freud contended that “there is something in sexuality itself that goes against complete satisfaction” (Van Haute & Geyskens, 2004, p. 10). For example, in writings found after his death, Freud wrote that “there is always something lacking for complete discharge and satisfaction—en attendant toujours quelque chose qui ne venait point”³ (Freud, 1938/1964a, p. 300). Even as early in his theorizing as “Three Essays on the Theory of Sexuality,” Freud (1905/1953b) highlighted an enigmatic factor that precedes the influence of education in setting restrictions on sexuality:

One gets an impression from civilized children that the construction of these dams [disgust, shame and morality] is a product of education. . . . But in reality this development is organically determined and fixed by heredity, and it can occasionally occur without any help at all from education. (pp. 177–178)

In a later essay, “On the Universal Tendency to Debasement in the Sphere of Love,” Freud (1912/1957b) explained that total freedom is no less harmful to sexual enjoyment than cultural restrictions. In the absence of obstacles, the libido is reduced. This is why, Freud wrote, “where natural resistances to satisfaction have not been sufficient men have at all times erected conventional ones so as to be able to enjoy love” (p. 187). He concluded that “something in the nature of the sexual instinct itself is unfavourable to the realization of complete satisfaction” (pp. 188–189).

Freud (1912/1957b) described two factors that prevent the possibility of complete satisfaction of the sexual instinct: the taboo on incest, which ensures that the final object of our sexual drive will be merely a substitute, and the existence of partial drives, such as sadistic urges, which we repress because they are not consistent with our cultural norms. It seems that these two factors described by Freud have not lost their strength and are still relevant today. Indeed, contemporary culture does not allow us to do whatever we please: It provides us with models of desired and undesired sexuality, sometimes through laws (such as the laws prohibiting sexual intercourse with children) and sometimes through social norms.

O’Shea (2000, p. 10) argued that the sexual tolerance of contemporary culture is misleading and that behind it lies a “growing moral conservatism.” According to O’Shea, “While there seems to be a willingness to embrace diverse models of family and relationships, there is, at the same time, an insistent restating that traditional family values are the only means of creating a stable society.” An example of this is the public’s moral outrage in regard to the story of Bill Clinton and Monica Lewinsky.

Gregorio Kohon (1984) suggested that the tendency to ascribe to sexual freedom and similar social changes the power to affect psychic conflicts is based on the false assump-

³ “Always waiting for something which never came” (Freud, 1938/1964a, p. 300).

tion that the neurotic conflict is one between different conscious sexual drives. “The liberation of sexual morality has, of course, had innumerable consequences for the individual and society,” wrote Kohon, “but only with difficulty could it affect the oedipal unconscious fantasy, the unconscious psychic *scenario*, the incestuous fantasies” (p. 77). In line with Freud’s thinking, Kohon concluded that “desire, in human sexuality, is always transgression; and being something that is never completely fulfilled, its object cannot ever offer full satisfaction” (p. 77).

Another argument in favor of the inherent shame of sexuality was formulated by Phil Mollon (2005), who claimed that sexuality “is the paradigmatic object of shame and repression” and that because its “biological imperative threatens the symbolic nature of our sociocultural world and personal identity . . . it is repressed or banished from discourse (even in our supposedly liberated society)” (pp. 167–168). The banishment from discourse begins in childhood: “Consider the phantasy of the primal scene, the actual or imagined intercourse of the parents in the eyes of the child. The child is excluded—from a scene that he or she does not understand” (p. 171) and will receive no satisfying explanation if he or she enquires. In light of such arguments, the contention that there has been a moderation of the conflict between society and sexuality seems untenable. It is reasonable to assume that the intrinsic dissatisfaction of sexuality and the transgression it entails should continue to provide plenty of cause for psychic suffering even today.

Some have argued that the liberation of sexual morality has changed the symptoms presented by modern-day patients—it is quite clear, for instance, that the prevalence of hysterical conversions is much lower than that of depressive states—but not the psychic structures described by Freud, such as hysteria, obsessional neurosis, fetishism, paranoia, and so forth. Serge Cottet (2000) contended that although one no longer encounters “opisthotonus, exaggerated hysterical mutism, for there are no more grand attacks according to Charcot,” one must bear in mind that “there are hysterics without hysterical symptoms” (p. 7). Elsewhere, Cottet (1998) described modern hysteria and pointed out that feminine Don Juanism and the ideology of sexual liberation have defeated the sexual aversion believed by Freud at the beginning of the 20th century to be an important characteristic of neurosis.

Green (1996, 1997), too, contended that the psychic structures Freud had described remained unchanged. He objected to the common claim that today’s patients suffer mainly from borderline or narcissistic disorders that are characterized by pre-oedipal fixations. Green argued that the analysis of borderline cases usually reveals that their erotic fantasy life is buried deep in the psyche like a precious treasure and that the pregenital anxieties cover it up and conceal its silent existence (Bokanowski, 1997). Elsewhere, he said that his personal analyses of patients defined as borderline or narcissistic had revealed that

the whole structure of symptoms in which sexuality seemed to play a contingent role or an apparently unimportant one, acted as if the other aspects not overtly genital were meant to protect and to hide the core of the pathology. (Green, 1996, p. 874)

According to the theoreticians described thus far, neuroses are still the prevalent psychic structures, and, therefore, sexuality still plays a central role in psychic life in spite of cultural changes. The question of the diagnoses of modern-day patients leads to the second factor described by Green (1996) in “Has Sexuality Anything to Do With Psychoanalysis”: the drawing away from sexuality in psychoanalytic theory.

Drawing Away From Sexuality in Psychoanalytic Theory

The decline or removal in psychoanalytic theory of the role of sexuality in the etiology of neuroses was a long process, starting with the rebellions of Jung and Adler and gaining

momentum with Klein (1945) and Fairbairn (1952), who shifted the focus from the oedipal complex to pregenital factors and to early object relations. Jean Laplanche (1974) suggested that the Kleinians and their successors regarded sexuality as a defense against nonsexual anxieties. Accordingly, “the evident role of ‘sexuality on the etiology of neurosis’ . . . is disputed in favor of a secondary, artificial, defensive sexualization of conflicts. These conflicts are related to the *survival* of the individual rather than to his *desire*” (p. 467).

Contemporary offshoots of object relations theories—intersubjective and relational theories—have retained the focus on early object relations. However, in contrast to Klein’s (1945) object relation theory, the newer developments have also shifted the focus from fantasy to real-life relationships (Mitchell, 1988). This substitution of unconscious conflicts by conscious experience may also have an effect on the place of sexuality in psychotherapy. According to Green (1996), from the conscious point of view we can observe in the psyche many factors independent of sexuality, but the unconscious is still, as Freud discovered, “rooted in sexuality and destructiveness.”

Other post-Freudian psychoanalysts rejected the primacy of the sexual conflict in psychic life and replaced it with various other conflicts that are more in line with the political correctness that characterizes American culture and popular culture in general. Winnicott (1965), for example, emphasized the conflict between the creative, integrated, and authentic true self and the compliant, lifeless, false self. Kohut (1971) stressed the human striving toward self-cohesion and feelings of self-worth. Mahler (1979) focused on the conflict between symbiosis and separateness.

The relevance to clinical work of these changes in psychoanalytic theory is obvious. Kohon (1984), for example, argued that such shifts in focus explain why “psychoanalysts claim not to find hysterics any more in their consulting rooms: patients may be hysterics but *since the theory looks for something else, it also finds something else*” (p. 78). In a footnote, he added that because of their different theoretical positions, “French analysts seem to have less difficulty in finding hysterical patients than their English colleagues” (p. 78). Yarom (2005) pointed out that although today’s young therapists are extremely eloquent in psychoanalytic terms relating to the mother–child dyad and primitive defense mechanisms when describing the psychodynamics of their patients, they do not exhibit similar familiarity with oedipal terms. In addition, they tend to classify most of their patients as borderline or narcissistic, unless they are evidently psychotic (Yarom, 2005). Mollon (2005) argued that “psychoanalysts today do not talk about sex very much—preferring instead to focus on issues of attachment, dependence, fears of abandonment, aggression and envy” (p. 168). He finds this trend ironic, in light of Freud’s emphasis on sexuality in the etiology of neurosis.

Steven Mitchell (1988) claimed that as a by-product of their abandonment of the drive theory, relational theorists tend to “deemphasize the primary clinical importance of sexuality” (p. 66). He described this tendency as “an unfortunate historical artifact” (p. 66). It must be added, however, that Mitchell did not suggest that relational theorists should replace relationships (real or fantasized) with sexuality as the motivational force in life. Rather, he suggested that sexuality “should be regarded as a central realm in which relational conflicts are shaped and played out” (p. 66).

In the editorial statement in the fifth-anniversary issue of *Psychoanalytic Dialogues*, Mitchell (1996) called on relational theorists “to address more directly those domains of experience with which classical Freudian theory was most centrally concerned: *sexuality, aggression, the body, constitution* [emphasis added]” (p. 2). A collection of essays published 2 years later, *Relational Perspectives on the Body*, was deemed by its editors to

provide “a response to Steven Mitchell’s (1996) call for relational theorists to attend to the place of *the body* [emphasis added] and *somatic experience* [emphasis added] in their models” (Aron & Anderson, 1998, p. xv). As the editors’ rephrasing of Mitchell’s call suggests—the terms *sexuality* and *aggression* disappeared and were replaced by *somatic experience*—the collection of essays did not do a very good job of correcting the “unfortunate historical artifact” (Mitchell, 1988, p. 66). None of the articles in the collection deals with sexuality. Instead, the articles deal with different physical sensations that may be experienced during the analytic session, such as breathing (Dimen, 1998), pain (Anderson, 1998), and disease (Pizer, 1998). In fact, many of the authors criticized the Freudian perspectives on the body—the body as sexual, aggressive, or fantasized—and suggested a return to the physical body and the sensations it generates. Tamsin Looker (1998), for example, wrote that “with the development of the structural theory, the primacy of the Oedipus complex and the call for abstinence, the actual body was eclipsed by the fantasized body and the intrapsychic fate of the sexual and aggressive drives” (p. 239). Harriet Kimble Wrye (1998) argued that the time has come “to bring bodily states to the forefront of the minds of patient and analyst alike. . . . Not just the sexual, Oedipal body as object, but the subjectively experienced, lived-in whole body” (p. 114). Indeed, there appears to be a considerable discrepancy between the body in relational models and in traditional psychoanalytic models. Although attempting to respond to Mitchell’s call to attend to the factors that were emphasized by traditional authors, the relational authors seem to have drifted further away from them.

A better and more recent attempt to address the absence of sexuality from psychoanalytic theory comes from the discipline of attachment. Papers featured in the volume *Attachment and Sexuality* (Diamond, Blatt, & Lichtenberg, 2007) form a response to Green’s (1996) criticism of Bowlby’s attachment model, which has ignored the subjective aspects of sexuality. The authors aim to continue where Bowlby left off and to investigate the relationships between the two historically antagonistic frameworks—sexuality and attachment (Diamond & Blatt, 2007, p. 10). Papers contributed by Eagle and by Mikulincer and Shaver, for example, demonstrated that attachment strategies formed in infancy influence sexual behavior and experience and the selection of partners (Eagle, 2007; Mikulincer & Shaver, 2007). Eagle also argued that the split between love and desire, a common problem among patients, is fundamentally the split between attachment and sexuality and that “individual attachment patterns contribute to either minimizing or amplifying [this] split” (Eagle, 2007, p. 31).

Another notable contribution to the integration of psychosexuality with current object relations theories was made by Mary Target (2007). Together with Peter Fonagy, Target formulated a theoretical stance that “concerns the sexualization of states of nonsexual arousal in the child or adult” and “the denial or distortion of sexuality by an adult unwilling to recognize it,” which is in fact “a failure in mirroring” (Target, 2007, p. 529). Target also emphasized the need to reflect in therapy the power of psychosexuality in adult life.

Current Research Question

In the current research, we examine the status of sexuality as a factor in explaining human motivation in contemporary psychoanalytically oriented psychotherapy. Therapists’ narratives are studied to determine their attitudes regarding the role of sexuality in human motivation. More specifically, we examine the prevalence of sexual themes in psychotherapeutic sessions as reported by the therapists. In addition, we delve into the factors that

affect the prevalence of sexual themes, the importance that therapists attach to them, and the extent to which therapists use them when interpreting patients' responses to the world around them. Themes that emerge from the analysis of the interviews are linked to theoretical thinking on the place of sexuality in psychoanalysis.

Method

Participants

The group of therapists interviewed in the present research consisted of 10 clinical psychologists and psychiatrists, all of whom practice psychoanalytically oriented psychotherapy and treat adult patients. The participants were chosen in line with the principles of Glaser and Strauss (1967). According to Glaser and Strauss, the main criterion for selecting participants is their relevance to the development of conceptual categories. Because we assumed that gender, age, experience, and theoretical beliefs could have an effect on the contents of the interviews, we ensured that the group of participants consisted of both male and female therapists and therapists from different age groups, from different seniority groups, and from different theoretical orientations.

The group of interviewees consisted of four male and six female therapists, therapists from various age groups (range = 36–59, *mdn* = 48.5), and therapists with varying degrees of experience (range = 6–30 years, *mdn* = 21). All but one worked in the private sector, although they all also worked, or had worked, in the public sector. The frequency of sessions was once a week. At the end of each interview, each participant was asked to fill out a form specifying his or her theoretical orientation. Five categories were offered, reflecting the current dominant theoretical orientations. The participants were asked to select up to two categories from the list. Two participants (both Lacanian⁴) selected the drive theory as their theoretical orientation; three selected Kleinian object relations; six selected relational psychoanalysis; three selected self psychology; and one selected ego psychology.⁵

Measures

The interviews were semistructured. The respondents were presented with the general question of the research: They were asked to describe the place of issues relating to sexuality in the therapy they conduct. They were told that the term *sexuality* in this context referred to a wide range of sexual phenomena ranging from sexual encounters to sexual fantasies, wishes, and conflicts. Throughout the interviews, the respondents were encouraged to report incidents from therapies (without revealing the identity of the patients) to provide us with clinical material to analyze. The clinical examples were taken from therapies that had already ended.

Before the beginning of the interview stage, we prepared a list of factors that were assumed to contribute to the development of conceptual categories. The respondents were asked to consider these factors in their replies after having given their first idiosyncratic responses. Thus, the respondents' replies consisted of idiosyncratic material and obser-

⁴ Very few clinicians today define themselves as strictly Freudian. Among modern theories, the Lacanian theory is the closest to the Freudian tradition.

⁵ It should be taken into account that relational psychoanalysis and self psychology are much more prevalent approaches in the clinical field of the present day.

variations regarding specific factors. The list of factors was updated after each interview. The interviews were between 1 and 2 hr long and were recorded.

Analysis

The interviews were first typed out verbatim. Each interview was then analyzed in detail and coded according to the bottom-up principles of Glaser and Strauss's grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998). In line with the principles of grounded theory, we began by conducting a thorough reading of the initial interviews and identifying recurring themes. In contrast to traditional research methods, a fundamental principle of grounded theory is to let key issues emerge from the analysis of the data (Charmaz, 1995). The initial themes identified influenced the selection of the next respondents and were used in the fine-tuning of the questionnaire. While reading and analyzing the subsequent interviews, we reevaluated the initial themes and identified new themes. When the interview stage was over, the themes were evaluated once again to ensure that each of them had enough support within the research material (interviews). We then examined the relations between the themes and, as a result, discarded some themes and merged some. Throughout the process, connections between the research material and the psychoanalytic literature were identified. Finally, we established four central themes.

It is important to note that all the interviewees seemed to some degree unenthusiastic to develop and engage in a discussion on sexual themes with their patients. Some of them felt more comfortable avoiding these themes altogether than others, but none of them believed them to be central to the course and evolution of their therapy. This attitude toward sexuality apparently affected patients' willingness or readiness to bring in their sexual fantasies, except in two cases. In one of the therapies described by an interviewee, a patient indicated that he had certain sexual fantasies but did not verbalize them when no encouraging response came from his therapist.

Results

On the basis of the analysis of the interviews and the psychoanalytic literature, we established four major themes relating to the place of sexual issues in therapy: the belief in the centrality of sexuality in human motivation, the level of expressiveness of therapy, the narrowing of the concept of sexuality and the separation between sexuality and intimacy, and the tendency to avoid sexual issues because of the discomfort they cause.⁶

First Theme: Belief in the Centrality of Sexuality in Human Motivation

The majority of the therapists interviewed did not regard sexuality as an organizer of psychic structure or as a factor that determines behavior but as one of many manifestations of deeper psychic patterns. Some of them contended that dealing with sexuality in therapy serves as a (conscious or unconscious) defense against dealing with deeper and more difficult issues, such as problems with intimacy and the search for self-identity. Henri, for example, said that the patients' "fears lie in much deeper and tougher things, such as loss of control, loss of relationships, and existential issues." According to Henri, when a patient talks about castration, he is probably manifesting "fears of annihilation." Henri was trained at a Freudian psychoanalytic institute but gradually discovered his relational

⁶ The names used in this article are fictitious and serve only to facilitate the reading.

affinities. He explained that in contrast to his beliefs at the beginning of his career, nowadays he regards sexual conflicts as “expressions—not causes—of intersubjective problems.” Another therapist, Dan, argued that difficulties in the realm of sexuality should be addressed only after “earlier developmental problems are solved.” The beliefs expressed by Henri and Dan bring to mind Green’s (1996) contention that therapists tend to ignore sexual issues or regard them as defenses. This contention is also clearly manifested in the clinical examples that are presented in the following paragraphs.

Dahlia, one of the interviewees, described a patient whose sexuality was overt and who devoted large parts of the sessions to issues related to sexuality. According to Dahlia, that patient’s sexuality was “misleading”:

It tells of the child who lost her mother at the age of five and was left on her own. So here, too, sexuality is secondary. . . . [This patient] is an example of someone who came and spilled out her sexuality, and I felt that I did not want to be overwhelmed by it. . . . I’m not saying I blocked her, I hope I didn’t.

In the preceding example, Dahlia, in line with the trend described by Green (1996), interpreted the manifest presence of sexuality in the reports of her patient

in a way which bypasses the sphere of sexuality to address object relationships of a supposedly deeper nature, in a way which intentionally refuses to pay attention to the specific sexual aspects that are very often supposed to be a mere defense (p. 873).

Another therapist, Ella, described a 17-year-old female patient who was “extremely sexual, aware of her sexuality, and definitely occupied with it in her life.” However, the patient rarely discussed sexual issues during the 3 years of therapy. The discrepancy between the patient’s conspicuous sexuality and the fact that sexuality was never addressed in therapy did not strike Ella as odd. According to Ella, the patient focused on sexuality, in and outside of therapy, only as a means to avoid dealing with issues that could cause her greater anxiety. “In more difficult moments she went out looking for sex. . . . It was a means of escape. . . . At other times she was busy with her life in a different way.” Another patient of Ella’s was a homosexual man who focused on his sexuality during sessions. In a similar manner, however, Ella interpreted his occupation with sexuality as a means to an end—in this case, the need to examine the limits of her acceptance of him. When the patient recited poems that he had written that contained detailed descriptions of sexual intercourse, she concluded that he wanted

to see if I would still love him after that. . . . As if he wanted to watch me seeing what he was showing me, whether I would love it, accept it, agree with it, say that “it’s ok, however you present it, it’s ok.”

In neither case did Ella regard her patient’s occupation with sexuality as stemming from a psychosexual conflict. On the contrary, she treated the sexual content as something that should be peeled away to reveal the deeper conflict it masked—a conflict belonging to the realm of early object relations. For instance, in the latter of the two cases described here, Ella regarded the patient’s engagement with sexuality as an attempt to test whether the therapist loved him in a motherly way—unconditionally and without limitations.

As noted in the introduction to this article, it is widely believed that sexuality ceased to be a source of psychic suffering because the conflicts between sexuality and society’s demands have been abolished, or at least attenuated. However, some of the examples provided by the therapists interviewed contradict this view. The effect of societal prohi-

bitions can be seen in patients such as Henri's homosexual patient, who tried unsuccessfully to eliminate his sexual fantasies and to forge a meaningful relationship with a woman. Some of those who still believe in the psychological power of sexuality argue that our age is characterized by new types of difficulties in the realm of sexuality, such as shame related to sexual inhibitions or to the feeling that one is not enjoying oneself enough and not taking advantage of all the possibilities that our culture and society offer. Such difficulties were addressed, for example, by one of Dan's patients, a 30-year-old man who had never had sex and who was afraid of AIDS. The patient, according to Dan, was extremely preoccupied by such issues as the moral status of phone sex, erotic movies, and the possibility of having sex with a whore.

Second Theme: Level of Expressiveness of Therapy

Therapists who were inclined toward supportive therapy tended to regard dealing with sexuality as an advanced stage in therapy—one that in practice is rarely reached. Moreover, addressing sexual issues was at times perceived as an impediment to attaining the goals of supportive therapy, such as helping the patient adjust to his or her surroundings and improve his or her functioning.

Eleanor described a patient who became more impotent as his relationship with his girlfriend became more serious. Eleanor explained that the patient was suffering from a fear of commitment and that his impotence increased because for the first time in his life, the possibility of getting married and having children was real. However, Eleanor chose not to explore the possible explanations underlying the supposed fear of commitment. Instead, she asked the patient to imagine himself as a 40-year-old and then as a 50-year-old. The patient, according to Eleanor, "used to be disconnected from his biological age," and the exercise "helped him to adjust himself a little. He became capable of imagining himself aged 50, a father of two sons. He succeeded in strengthening his image as the father of the family. . . . Eventually, he decided to get married." Another patient Eleanor described was a homosexual man who "frequently got involved in masochistic relationships." Eleanor argued that the patient's complaints were not focused on his sexuality but "mainly on the humiliation and shame accompanying it." It is clear that Eleanor regarded the humiliation and shame as side effects of the masochistic behavior, and not as effects the patient actively pursued. In a manner similar to the one she used in the previous example, Eleanor did not aspire to understand her patient's masochism, even though she did find it problematic. Instead, she chose to help him mitigate it, by shifting his focus away from it. "Eventually he chose a career path, made good progress in it . . . organized other aspects of his life, and the sexual issue became moderated as a result." As both examples show, Eleanor chose to help her patients adjust to the existing norms in society rather than focus on the meanings related to their sexuality.

It has also been observed that supportive therapies tend to focus on the superficial, or external, registers of sexuality and to ignore the psychosexual realm. For example, when asked about the nature of the sexual issues brought up by his patients, Dan replied that they talk about "one-night stands, about someone who chatted them up at a party," "about being physically attractive or unattractive," "their body image," "sexual diseases," and "their menstrual period." Several therapists argued that the psychosexual realm, consisting of fantasies, wishes, and so forth, is usually addressed in therapies that are longer and more expressive. Eleanor, for instance, claimed that her patients "are far more absorbed by their actual life than by their fantasy life" and that they usually want to "solve problems that are related" to the former. Dan argued that sexual issues are raised only by patients

for whom sexuality is a dominant part of daily life. Such patients could be, for example, women “who are at a stage of life in which they are looking for a partner.” Perhaps one can better understand Dan’s contention by taking into account that the sexual issues he referred to do not belong to the realm of the psychosexual and are therefore more susceptible to life stages, life events, and other circumstantial factors.

*Third Theme: Narrowing of the Concept of Sexuality and the Separation
Between Intimacy and Sexuality*

One of the main expressions of the restriction of the concept of sexuality was the tendency on the part of the therapists to include only issues such as sexual intercourse in the term *sexuality*. This tendency was observed in the interviewees’ initial responses to the theme of the interview. After presenting the research question at the beginning of each interview, we supplied the interviewee with a definition of the term *sexuality* that emphasized its breadth. For example, the ninth interviewee was told that we were interested in “references in therapy to sexuality in its broad sense. References to actions, such as sexual intercourse, as well as references on the level of fantasy—fantasies, conflicts, wishes.” Despite the emphasis placed on the broad and varied nature of the term, the majority of interviewees’ spontaneous replies focused on sexual encounters rather than on the psychosexual aspects of the term.

A connection can be seen between the tendency to avoid the psychosexual realm and the feeling, described by several therapists, that sexuality is not a major theme in patients’ lives. At the beginning of each interview, we asked the interviewees to describe the three main themes in therapies and to evaluate the centrality of the theme of sexuality. Many of them said that sexuality was a marginal theme in the therapies they conduct. Ella, for instance, said that in many cases, “Two years can go by without my hearing [from the patient] anything regarding sexuality.” The tendency to focus on the superficial aspects of sexuality may also explain the idea, expressed by both Eleanor and Shirley, that sexual issues should be treated by sexologists and not by psychotherapists. The idea was phrased by Eleanor in the following way:

But maybe [the fact that my patients do not raise sexual issues] is related to my definition, that is, I am not a sexual therapist by definition, so it’s possible that they see that I do not focus on such issues.

Most of the interviewees said that relationships were one of the main themes in the therapies they conduct. Apparently, they did not consider sexuality to be an inseparable part of intimate relationships. For example, Tom said that most of his patients “are very much occupied with their love life, not necessarily with sexuality, [and] with their relationships with their parents.” Dan reported that some patients “rarely talk about sexual issues. They can talk about their romantic relationships, the fact that they are alone, that they want a boyfriend or a girlfriend. But it would never have sexual connotations.” We believe that the separation between intimacy (relationships) and sexuality can harm the understanding of the patient’s love life because it ignores such issues as the role of the sexual psychic structure of the patient in determining his or her love object, or object choice.

Fourth Theme: Avoiding Sexual Issues Because of the Discomfort They Cause

One of the major themes that emerged from the current research was that therapists tend to avoid sexual issues because of the discomfort they cause. Explicit and crude sexual

descriptions by patients were viewed by the therapists as indicative of a psychotic, perverted, or borderline psychic structure. Tom, for example, described hospitalized girls, “one of [whose] symptoms was sexual promiscuity.” His patients could say things such as they “had sex with this guy” or “went down on that guy.” Tom described the way these patients expressed themselves as “mainly shocking and revolting.” Ella described a perverted patient whose descriptions of sexual fantasies she felt she needed to stop. “I don’t let him go into . . . his fantasized sexual world as much as he would like. I can’t bear that.” Eva, too, described her need to stop one of her patients, a homosexual man, because “he went inside all the ‘holes’ until that was it. To have to listen to it over and over again.”

Several therapists said that they sometimes perceived their patients’ explicitness in discussing sexual matters as a form of hostility directed at them. Some said they had felt abused by their patients. Ella, for example, described the attitude of one of her perverted patients in the following manner: “It was as if he was thinking, ‘This is therapy so I can talk about everything. So I will talk about it however I want to. And you won’t say a word.’” Henri suggested that the feeling of being abused was common among therapists:

There’s a group . . . of people who bring up sexual issues—it’s more common among men—as a form of masturbation. . . . You suddenly feel that the therapy is not working, and he talks and talks and talks about sex. . . . Often the therapist, if it’s a woman, feels disgusted and abused, and a male therapist too feels that he is not being used for the right purpose.

It is possible that therapists who feel they are being attacked or abused are discouraged from paying attention to the content of their patients’ sexual descriptions. They focus instead on their effect on themselves.

The tendency to avoid discussing sexuality was also affected by the issue of shame. Most of the therapists said that they felt patients tended to avoid sexual issues because of the discomfort they caused. Yet only a few actively tried to mitigate such feelings of discomfort and shame. As a result, therapies could continue for a long time with both sides—patient and therapist—ignoring a central sexual theme. For example, Dahlia described a religious female patient who had been in therapy for more than a year and a half. From the beginning of the therapy, it was clear to Dahlia that the patient was suffering from a problem related to sexual fantasies. Recently, the patient had begun alluding to them. Dahlia knew that the fantasies were causing the patient a great deal of suffering. The patient felt “devastated” and “dirty,” experienced “shame” and “loss of self-esteem,” and devoted “all of her days . . . to trying to eliminate these fantasies.” However, Dahlia knew nothing about the content of the fantasies and was content with filling the gaps in her knowledge with speculation. “I am guessing [the contents of the fantasies] from what she says and from what I know. My feeling is that they are not so wild. . . . But I don’t know what the content of the fantasies is.”

Tom described a recurring situation in which patients raised sexual issues but stopped short of saying everything they wanted to. The patient “may say something like, ‘I had sex with him,’ but it doesn’t go any further than that.” Tom reported that he had been wondering whether this had anything to do with him. Dan wondered whether he should take a more active stance with patients who avoided sexual issues altogether.

I have several older patients who may talk about their relationship with their husband or wife for weeks on end, and never mention the words ‘sexual intercourse’ . . . I often wonder whether I should ask [them about this], because maybe . . . they are afraid it’s forbidden [to talk about this subject].

Obviously, many therapists follow theoretic guidelines that do not encourage active or explicit interference with the patients' therapeutic course, such as posing direct questions or trying to focus on a specific issue. However, it is crucial that therapists create an atmosphere in which patients feel they can bring up anything that comes to mind without worrying about being judged. We believe the therapists whose stories were described here may have failed in creating such an atmosphere for their patients because they, too, preferred keeping the sexual at bay.

Discussion

The drawing away from sexuality as a prime factor explaining human behavior in contemporary psychotherapy, which some have referred to as *repression* (Villela, 1999), is paradoxical in light of the increasing fascination of modern culture with sexuality, the ubiquity of sexuality in the media, and the development of the field of sexology. The paradox lies in the fact that in an age considered to be extremely liberal and permissive, signs of puritanism are found precisely in the discipline that owes its existence to sexuality or, more accurately, to difficulties in the realm of sexuality.

As we have shown in the first theme, analysis of the therapists' responses supports Green's (1996) claim that sexuality is present in case materials but regarded by therapists as insignificant or secondary or merely as a defense. One of the possible explanations for such a finding is the dominance of contemporary psychoanalytic theories that place less emphasis on sexuality as a motivational force and more emphasis on object relations as the primary motivational force in life.⁷ However, the popularity of psychoanalytic theories that do not emphasize sexual factors is in itself affected by the current attitude of society toward sexuality.

It must also be taken into account that the therapist's ability to accept the primacy of sexuality plays a significant role in determining his or her choice of psychoanalytic theory. Lucia Villela (1999), in her article "Why the Plague," quotes Tolpin, who wrote about the effect of theory on the clinician, to emphasize the element of personal, unconscious choice. "Clearly," wrote Tolpin (as cited in Villela, 1999, p. 11), "the way clinicians understand and explain the manifest content of their patient's behavior, symptoms, character traits, wishes, fantasies and dreams differs greatly, defending [sic] on their theoretical orientation." According to Villela, the typographical error (*defending* instead of *depending*) "reminds us that our unconsciously held theories are also operative in our conscious theoretical preferences" (Villela, 1999, p. 11). Target (2007) suggested that there may be a resistance or reluctance among psychotherapists to accept the centrality of sexuality, as anticipated by Freud, because it is rooted in the idea of infantile sexuality. One of the therapists interviewed, Dan, explained to us that his own aversion to dealing with sexual issues was one of the factors that led him to adopt contemporary theories that place less emphasis on sexuality.

We tend to think that the sexual liberation that characterizes our era has not only contributed to the decline of sexuality in psychotherapy but also changed our attitude toward it. To understand this change in attitude, we should consider the possibility that our culture's sexual liberation is not genuine and deep, but rather superficial. The ubiquity of sexuality in the media creates the false impression that everything is allowed and that sexuality is no longer a source of psychic suffering. Green (2005, p.) claimed that such

⁷ Many theorists have stressed the role of the psychoanalytic theory held by the clinician in determining the course of therapy and in shaping the mode of listening to the patient (see, e.g., Mitchell, 1988; Pine, 1988; Schafer, 1983; Spence, 1982).

“public excitement at the relief from ancient prejudice” is a “way of prohibiting a real questioning of the topic [of sexuality]” (p. 22). With regard to adult love, for example, “the choice of reference model is rarely predicated on passion but more on stability, constancy and psychic equilibrium” (pp. 22–23). Such examples show us, he added, that “once again tradition and Puritanism have won the battle against Freud’s conception” (Green, 2005, pp. 22–23). Kernberg (1989) argued that modern sexual liberation is illusory and that the sexuality presented to us in mass culture and entertainment is “structured to appeal to the level of latency” (p. 199). He pointed out that romantic relationships in popular movies and TV shows are almost entirely devoid of sexuality. Perverse sexuality is even more excluded (Kernberg, 1989). This dissociation of eroticism from tenderness, as Kernberg put it, leads to a demonization of eroticism. This can be seen in Henri’s interview. Henri reported that he prefers to think of human beings not as animals who seek to fulfill their sexual needs but as “creatures who need relationships” and who have a “need for recognition, love and mutual understanding.” In fact, Henri admitted that he avoids regarding sexuality as a primary motivational force in life because it creates a disturbing similarity between human beings and animals.

The separation between sexuality and intimacy described by Green (2005) and Kernberg (1989) may partially explain why most of the therapists interviewed said that patients were concerned with love relationships but not with sexual issues—an observation discussed in the third theme. Perhaps the therapists were influenced by the tendency to regard sexuality as a negligible, sometimes rejected aspect of love relations. Green (1996), for whom the goal of therapy is to enable the patient to “enjoy life a little more than he used to do before beginning treatment,” asks whether “our psychoanalytic Puritanism” might be “responsible for the fact that we would consider sexuality as negligible in such an enjoyment” (p. 880).

A broader problem of contemporary times, as we have shown in the second theme, is the tendency toward superficiality. It is reflected in the therapists’ stated preference to avoid dealing with unconscious elements and fantasies and to focus on improving their patients’ ability to cope with their surroundings. Such a preference may affect the way sexuality is dealt with in therapy. It has been claimed (Green, 1996) that because sexuality is prominent in the unconscious life and not necessarily in the conscious life, the drawing away from the unconscious realm in psychotherapy involves retreating from sexuality. Some of the vignettes provided by the therapists demonstrate the way in which the preference for dealing with the conscious registers of experience necessarily requires abandoning sexual elements and focusing instead on social norms. For example, Eleanor chose to comply with the conscious expectations of her masochistic patient: “He actually came to me to help him with the choice of career.” In the course of this patient’s therapy, she helped him abandon his masochistic fantasies. In other words, the goal of the therapy was not to help the patient better adjust to his inner wishes but to become better adapted to society’s norms. The wish to help the masochistic patient give up his fantasies of humiliation is based on the social norm that genital sexuality is the preferred form of sexuality and that psychotherapy should aspire to achieve it.⁸ Similarly, in her treatment

⁸ According to Lacanian theory, “There is no superiority of genitality, because genital sex is no less problematic than non-genital sex” (Nobus, 1999, p. 121). Therapists should not, therefore, aspire to change a patient’s perverse sexuality into their preferred form of sexuality, which is genital, harmonic, and usually heterosexual (Nobus, 1999).

of the impotent patient, Eleanor helped him become accustomed to the idea of being a family man.

Another finding that can be attributed to the tendency to focus on the more superficial registers of the psyche was the low prevalence of sexual fantasies in therapy. Most of the therapists interviewed reported that sexual fantasies are very rarely dealt with in therapy. Supportive therapies that aim to rapidly improve the patient's functioning may be inclined to avoid dealing with sexual fantasies because they can temporarily impair functioning. According to Jacques Alain Miller (1983), this temporary impairment stands in contrast to the therapists' drive of curing the patient. The symptom, by contrast, stands in the way of the patient's normal functioning and thus demands immediate response from therapists who focus on cure (Miller, 1983). The neglect of sexual fantasies and other forms of psychosexuality is related to an observation from the field of sexology, according to which many psychotherapists refer their patients to sexologists as soon as they mention anything to do with sexuality (Wernick, 2003). When the psychosexual element is neglected, sexuality is deemed better treated by sexologists.

Another of our findings, presented in the fourth theme, was that despite the social change in attitudes toward sexuality, therapists reported that patients are still reluctant to discuss sexual issues. Carmella, for instance, said that patients are afraid to be thought of as "perverted" and to "create a negative impression." Such observations remind us that despite the significant change in society's attitude toward sexuality, the inhibitions surrounding it have not lost all of their force. In addition to the long-standing and familiar inhibitions related to sexuality, a new category of inhibitions has emerged. Ironically, sexual liberalism itself can be a source of shame for many; contemporary culture has created a new set of standards regarding sexuality, and comparing oneself to them may cause anxiety. For example, if losing one's virginity before marriage would have aroused anxiety in the Victorian era, nowadays getting rid of one's virginity in high school may be necessary to avoid mockery and shame.

Patients are not alone in preferring to avoid sexuality in therapy. The therapists interviewed described several instances in which an opportunity to deal with sexuality presented itself but was not taken up by them. Stories about patients who did raise sexual issues were often accompanied by negative emotions. Patients whose sexuality was overt were usually thought of as having a psychotic, perverted, or borderline psychic structure. This finding is in line with an observation made by Yarom (2006), according to which therapists tend to define as perverted patients who create an erotic atmosphere in the clinic. Moreover, many therapists felt that their patients' graphic sexual descriptions were intended to be abusive and aggressive.

Last, we found that therapists do not tend to encourage patients to discuss important sexual issues when they seem to be avoiding them. For example, Dahlia described a patient who reported having disturbing sexual fantasies, but the content of those fantasies remained concealed throughout the therapeutic process. It is important to note that by encouraging patients not to avoid discussing sexuality, we do not necessarily mean that patients should be expressly confronted with the issue, but rather that an atmosphere should be created in which the patients feel they can say whatever crosses their minds, something akin to Freud's (1913/1958) fundamental rule of psychoanalytic technique. By not doing so, a vicious cycle is created: The patients' tendency to avoid sexual issues in therapy is explicitly or implicitly strengthened by the therapists. We assume that because a sense of awkwardness has always accompanied sexuality, the fact that therapists let themselves surrender to it is related to the general decline in the importance of sexuality in psychoanalysis and to the belief that sexuality has ceased to be a source of conflict in

the modern era. Such a belief was, for example, expressed by Dan, who noted that “sexuality is not what it used to be; sexuality is no longer the forbidden thing. Today, the forbidden issues are far more complex than sex. Issues of separation and autonomy, these are the dangerous and complicated issues today.”

Another important factor that could contribute to the therapists’ preference to avoid dealing with sexuality in therapy is related to ethical concerns and, more specifically, to the fear of litigation on the grounds of sexual harassment. A lot has changed since the days of Freud, who advised his colleagues to be “dry and direct” when talking about “such delicate and unpleasant subjects,” so that they would not be accused of corrupting inexperienced girls (Freud, 1901/1953a, p. 48). The growing social awareness of the possibility of sexual abuse and exploitation has probably made therapists more careful and conservative in their dealings with sexuality.

The legal definition of sexual harassment is somewhat obscure and involves a large variety of behaviors, some of which are verbal. Although the broadness of the legal term serves the purpose of protecting the weak, it also places therapists in a situation in which their every utterance can be misinterpreted and used as grounds for prosecution. As Yalom (2002, p. 192) wrote in *The Gift of Psychotherapy*, therapists “are advised to adopt a ‘snapshot’ mentality—that is, avoid any moment that, taken even out of context, might appear suspicious.” Such a high level of precaution is not surprising in light of the existence of some U.S. studies suggesting that up to one in 10 therapists have sexually abused their patients (Twomey, 1993).

It can be assumed that fear of litigation would be more predominant for male therapists. In the current research, we interviewed four male therapists, two of whom addressed the issue of ethical concerns. Teddy contended that the way therapists listen to their patients was influenced by cultural concerns, among which is the

ethical culture, which prompted you to make me sign this form [referring to the form of consent to participation in the research]. It says that the sexual issue should be dealt with in therapy in a certain way. There should be nothing in therapy which implies sexual abuse.

Tom said that “dealing with sexuality, especially with female patients, can easily be regarded [as] intrusive.” He admitted being more careful with female patients, especially when they were close to his age. This specification, which takes into account elements from the reality of the therapeutic encounter (the age of the patient and that of the therapist), brings to mind the blurring of the therapist’s authority and the change in the nature of the patient–therapist relationship that characterize contemporary psychoanalytic approaches. It could be assumed that the intersubjective approach, which emphasizes the person of the therapist and promotes a more intimate relationship between the patient and the therapist, makes discussion of sexuality more problematic. Indeed, Target (2007) noted that “psychosexuality retreated from analytic focus at about the same time and rate that transference issues started to occupy the center ground” (p. 527). She suggested that this trend can be explained by the assumption that “psychosexuality was easier to focus on when the relationship with the therapist was not also the central focus of analytic work” (Target, 2007, p. 527). She went on to propose that the intersubjective experience in therapy has the potential to become “unethical in relation to sexual experience” and that “discussion of sexuality in sessions may for that reason be unconsciously avoided [by therapists] or relabelled, as not ‘really’ about sex” (Target, 2007, p. 527). Further research is needed to shed more light on the effects of the rise in awareness of sexual harassment.

Conclusion

Paradoxically, despite a growing tolerance for sexual issues in Western culture and the media, there seems to have been a decline in the emphasis on psychosexuality in psychoanalytically oriented psychotherapy. In this article, we sought to draw attention to the paradox and to suggest several explanations for the relative absence of sexuality from therapy, despite its centrality in determining our psychic organization, behavior, symptoms, and so forth.

On the basis of the data gathered from interviews with psychotherapists working within different psychoanalytic frameworks, we described four themes that are related to the place of sexuality in psychoanalytically oriented psychotherapy. The first theme is the extent to which therapists consider sexuality to be a prime mover of human behavior. In line with Green's (1996, 1997) contention, we found a tendency to treat sexual issues raised by patients as mere expressions of deep psychic patterns or as defenses against deeper difficulties. The second theme we described was the level of expressiveness (or exploratory elements) of therapy. We found that a tendency to focus on concrete—actual life events in treatments led therapists to avoid psychic aspects of sexuality such as sexual fantasies and conflicts. The third theme we described was the tendency to separate conceptually between sexuality and intimacy. The last theme was the discomfort accompanying the discussion of sexual themes, which we found to be strong despite the seemingly tolerant attitude toward sexuality that characterizes our age.

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