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Sexuality The Taboo of Being Human

- **Masculinity and Gay Men in the Therapy Room**
- **Homosexual Men: A journey from Shame to Authenticity**
- **Erectile Dysfunction**
- **Mutual Desire in the Therapeutic Relationship**

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Our Title
The word Éisteach means 'attentive in listening' (Irish-English Dictionary, Irish Texts Society, 1927). Therefore, 'duine éisteach' would be 'a person who listens attentively.'

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Each issue of Éisteach is planned well in advance of the publication date and some issues are themed. If you are interested in submitting an article for consideration, responding to the Therapist's Dilemma or wish to contribute a book or workshop review or Letter to the Editor, please see 'Author's Guidelines' on the IACP website, www.iacp.ie.

From the Editor:

Donna Bacon

Dear Colleagues,

I am delighted to be editing this autumn's edition of Eisteach. What a beautifully hot summer we have had but nothing is permanent and the drop in temperature, shorter days and return to school are testament to that. Apparently, climate cooling sends a signal for humans to pair up. "Pairing up" or lack thereof can bring many individuals to counselling and it is one aspect of the theme of this edition - Sexuality. The World Health Organisation informs us that sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Despite this however, sexuality in the therapeutic relationship appears analogous to autumn's hibernation; it often lies dormant and hidden away for either or both the client and therapist. This is supported by research which shows that across many health care professions, sexual issues are unlikely to be discussed with clients. Furthermore, research has found that while many clients want to and are comfortable discussing issues regarding their sexuality, they take the lead from the therapist. So, when a therapist demonstrates initiative and comfort with starting the conversation, there is no doubt that much can be achieved. If sexuality is a part of who we are as human beings then it is equally as important to explore as it is a client's mental, physical, and emotional well-being. My hope with this edition therefore, is that we as therapists will see the need for us to be brave in introducing the topic of sexuality with our clients and to create a safe and comfortable space for its exploration.

I'm excited to bring you four fantastic articles which give us a flavour of the issues pertinent to this area. Our first article is by John McMahon which examines the topic of gender roles and explores how beliefs about masculinity and male gender roles may impact gay men. Our second article by Ivan Kennedy brings forth the concept of the journey involved in "coming out" for gay men and how we as counsellors can play a pivotal role in facilitating and supporting this process. Our third article by Luke Devlin provides an intriguing insight into erectile dysfunction, a sexual dysfunction that is more common than currently perceived. Finally, our fourth article by Antonia Colum Tobin shares some essential literature and current research on sexual desire in the therapeutic relationship, and effective ways of dealing with such.

While these are four informative articles, I must add that this edition merely touches on the depth and breadth of sexuality issues and I would encourage us as a profession to continue educating ourselves and expanding our awareness of the vastness and significance of the area.

Donna Bacon, MIACP

Masculinity and Gay Men in the Therapy Room. A look at Male Gender Role Conflict

by John McMahon

Introduction

Working with masculinity ideals and gay men within a therapy room can be a challenge. One's gender identity affects how we think, behave and communicate. The rules of 'being a man' are deep rooted, well established and socially constructed. Levant's 'Code of Masculinity' infers societal beliefs that males must (1) be autonomous and self-sufficient; (2) curb their emotions; (3) be seen as tough and aggressive; (4) seek high social status; (5) always be ready for (heterosexual) sex; (6) avoid all things 'feminine', and (7) rebuff homosexuality (2001, p.357). For gay men, identifying with this 'code' can cause more difficulty, as one tries to retain their masculine identity, whilst living with a sexual orientation that can be perceived as less male. For others, the acceptance of their same-sex sexual orientation can reduce the need to follow gendered rules. But, as therapists, how do we explore this issue? And what are the subtleties to attend to if we ask how gay men (and indeed straight/bisexual men also) relate to their masculinity.

A pivotal area of masculinity research that can help therapists work with masculinity in the therapy room was the development of Gender Role Conflict (GRC) and the Gender Role conflict Scale (GRCS) (O'Neil, Helms, Gable, David & Wrightsman, 1986). This construct looks at how certain areas of masculinity can cause conflict within the individual and highlights crucial areas that rigid male gender roles can affect. By looking at the areas affected by GRC, therapists can link these issues with perceptions of male self identity and examine how male clients relate to their perceived gendered roles. Presently 350 research studies have been completed on GRC culminating in the publication of *"Gender Role Conflict Research 30 Years Later: An Evidence-Based Diagnostic Schema to Assess Boys and Men in Counseling"* (O'Neil, 2013).

Male Gender Role Conflict

The theoretical underpinnings of O'Neil's concept are based on an interaction of environmental and biological factors promoting certain masculine values; *the masculine mystique* - a developmental process under which boys acquire gender role characteristics that can lead to psychological distress if used in situations that require less gender typed behaviours, and *the fear of femininity* - a fear of possessing or expressing ideals, stances or actions that are stereotypically associated with appearing feminine. These values are learned in early childhood when gender role identity is moulded by parents, peers and societal values. Any violation of, or inability to, endorse these gender role stereotypes creates the possibility of 'Male Gender Role Conflict'. There are four patterns which GRC relates to;

- Personal attitudes about achievement practised through competitiveness and power in *Success/Power/Competition* (SPC)
- Reservations and restrictions in expressing one's feelings and vocabulary used to communicate basic emotions in *Restrictive Emotionality* (RE)
- Limitations of expressing

one's feelings and thoughts and difficulties with physical contact with other men in *Restrictive Affective Behaviour Between Men* (RABBM)

- Restrictions experienced in balancing school, work, and familial relations, resulting in problems with health, working too hard, stress, and an absence of leisure time and respite in *Conflict Between Work and Family Relations* (CBWFR).

Understanding these areas can be of great use to therapists when faced with clients who are having issues that relate to these subscales and can give useful insight into how rigid their gender roles are. GRC can affect men; *cognitively* - thoughts about gender roles, stereotypes, homophobia, anti-gay positions and attitudes towards women; *affectively* - with increased reports of depression, anxiety, homonegativity, anger, low self-esteem and negative identity; *unconsciously*; and *behaviourally*; acting, responding and interacting with others.

Pivotal life stages such as getting married, having children, the death of a parent can challenge gender role assumptions. The experience of both being 'in the closet'[1] and 'coming-out'[2] can also cause difficulties for gay men in how they relate to their masculinity. This is something therapists may work on when dealing with clients going through similar situations.

Gender Role Conflict and the Gay Man

Examining GRC and masculinity with gay men can be perceived as a paradox. Gender and sexuality are two very separate entities but they are inextricably linked. On one side Wester et al. (2005) noted that gay men can be less affected by gender role because of their lack of

[1] Not telling people about ones homosexuality.
[2] Recognising and accepting one's homosexuality publicly.

Real men can cry, can express emotions, can embrace their feminine sides and still be real men.

conformity. The realisation of their same-sex preference may give them a greater awareness of self, helping them to be less affected by the expectations and restrictions that hetero-normative society places on them. There is the perception that gay men lack masculinity (Connell, 2001, p. 143). O'Neil (1981a) hypothesised that homosexuality violates the gender role norms of traditional masculinity because male homosexuality is often equated with femininity. The notion that gay people can hold characteristics of the opposite sex has been discussed in the Implicit Inversion Theory (Kite & Deaux, 1987, p. 84). This related to Kimmel who noted that homoerotic desire is seen as feminine desire, which homophobia seeks to suppress (2001, p. 34).

On the other side, however, gay men continue to endorse the strong gender role paradigm and embrace their masculinity (Halkitis, Moeller & DeRaleau, 2008, p. 107). Heterosexual men equated masculinity with their sexuality and rebuked gay men for their non-confirmatory sex roles (Keiller, 2010, p. 39). Effeminacy in men has been viewed as undesirable, unattractive and to be stigmatised (Haywood, 2003, p. 131). Sánchez et al. (2010, p. 105) viewed this as coming from internalised homophobia. They reported that masculinity is an important construct for gay men who wished for themselves and perspective partners to have masculine characteristics (p. 109). Gay men felt they needed to reject previous discourses of themselves as weak, non-men and to own an identity which corresponded to their homosexuality (Duncan, 2007, p. 334). This resulted in a rejection of femininity from within the gay community itself. Hyper-masculinity or 'straight-acting' became revered and with this the retention of rigid gender roles, and possibly greater levels of GRC, seen through body shape, dress code and emotional restriction (Edwards, 2004, p. 56; Mosher, Levitt & Manly, 2006, p.97/115).

GRC in Therapy. An Irish Study on Gay Men.

GRC considerably affects men's psychological wellbeing and distress and causes difficulties in the expression of feelings. The perception that the therapeutic process means the abdication of control and power can lead to a failure in attending counselling services. Further, the stigma of seeking help can threaten male identity. Many men need factual information about restrictive gender roles to understand how GRC affects their lives. They need to be psycho-educated that GRC stems from sexist attitudes (flawed perceptions that anything perceived as feminine reduces a man's sense of self), and distorted schemas about men and emotion which will give them insight into their own emotionality. Linking the client's lack of emotional potential to their masculinity can allow therapists investigate the cause of their emotional restrictions. Highlighting this as a consequence of the social construction of masculinity, rather than as a personal deficit can promote change (Good & Mintz, 2001). When these schemas are distorted they create exaggerated thoughts and feelings about masculinity ideology in a man's life. This can be caused by the fear or pressure about conforming or not, to stereotypic ideas of masculinity. They can affect the areas of emotionality, affection, sexuality, power, success, and self reliance and through the therapeutic alliance can be assessed,

The perception that the therapeutic process means the abdication of control and power can lead to a failure in attending counselling services.

their illogical nature explored and modified through rationality and education.

Therapists with higher levels of GRC themselves have been reported to have disliked more and empathised less with gay clients, were less likely to be available and felt less comfortable with clients who were homosexual (O'Neil, 2008). These studies imply further therapist training may be necessary to explore their gender role beliefs and preconceptions about men who do not fit their masculinity ideology. The Gay Men's Health Service in Dublin offers training to therapists working with gay/ lesbian/ bisexual/transgendered people (please see www.gmhs.ie for details).

A small exploratory study on GRC was conducted to highlight how this construct would relate to an Irish and therapeutic setting. It aimed to help therapists' link sexuality to gender and understand how societies view on gender affects gay men. It also looked to promote a healthy gender role for gay men. Men being intimate, either emotionally or physically, with another man shake the foundations of the masculine mystique and can be contrary to the fear of femininity. This can increase or decrease susceptibility to GRC. This, along with the difficulties that gay men encounter in publicly expressing affection among themselves, must be considering factors when dealing therapeutically with gay men and GRC. Looking at this study's findings and how they may relate to us as therapists may give a better example of how we can interweave the concept of GRC into our therapeutic material.
The preliminary investigation was to examine a comparable study between heterosexual and gay men to see if sexual orientation would be an influencing factor in levels of GRC. The findings within this suggest that gay men did not have statistically significantly higher rates of GRC than heterosexual men. This could be explained by the point made previously by Wester et al., (2005) that gay men can be less affected by gender role *because* of their lack of conformity through having to realise their same-sex preference. However, the answer may not be as simple as this. It is very possible that the strength of the unconscious masculine code over-rides sexual orientation. Simply put, homosexuality in men is not enough of a factor to reduce or increase levels of GRC. This could mean that the masculinity issues within the four subscales could affect men of all sexual orientations. This implies that as therapists, we must examine gendered roles and its complexities in men of all sexual orientations.

When looking if age was an influencing factor in GRC scores, an interesting finding showed that younger gay men had higher scores in Success/ Power/Competition (SPC) than their heterosexual counterparts. This gave a clearer understanding that younger gay men placed a greater importance on success, power and competition. Evidence of this in the therapy room, where the individual feels a greater pressure to succeed or compete in areas within his life, could be seen as a way of asserting his masculinity and tied to older masculinity scripts. The findings of Restrictive Emotion (RE) suggest that younger men have more difficulty with emotional expression and that older men are more comfortable with emotion, something that may come with age. For therapists, this can be important as therapy itself is emotion-led. Talking with younger clients about how they relate to their emotions can reveal how they relate to their masculinity. Interestingly, older gay men scored higher in RE than their heterosexual counterparts, the opposite to the findings in the younger groups. This would go against a possible stereotype that gay men would be more emotional than heterosexual men. As therapists, the importance of looking at our own bias around stereotypes is paramount to our own therapeutic involvement in the counselling relationship. Our own unconscious ideas around how gay men may relate to emotional expression may hinder our involvement with our clients and as a result of this bias, therapeutic processes could be missed.

Race and GRC was also examined. Men's multicultural origins can play a part in how GRC is perceived, with some cultures placing a greater importance onto gender roles. Wester (2009) noted that gay men of colour may face additional difficulties when they do not meet the male gender role as defined by their culture of origin. Their issues of religious faith can also play a factor in their GRC issues. Therapists need to consider the issue of masculinity from the perspective of other cultures as important when working therapeutically with gay men. Gaining knowledge in how homosexuality has been accepted or rejected in non-Irish clients' country of origin can strengthen empathy as well as expand our cultural competence as therapists. Previous research on African-American gay men (Crawford et al., 2002) has reported significant feelings of loneliness, isolation, depression, suicide and substance abuse.

Conclusion

The construct of Gender Role Conflict is an important theoretical concept when working with male clients, their masculinity and their sexual orientation. The embedded foundations of the 'masculine mystique', how males acquire rigid

masculinity scripts, and the 'fear of the feminine', give valuable insights into how negative aspects of masculinity can be developed and instilled. By understanding the four subscales within GRC, therapists can link client issues to their maleness ideals, and can offer a therapeutic space to give masculinity a voice. This will give important support to gay men who struggle with their sexuality and their emotional expression.

The size of the study was admittedly small (n = 40) and further studies should aim to increase the participant size to confirm this study's results and gain a more satisfactory and representational reading of GRC in gay men living in Ireland. However, these findings may go against what we would have thought about gay men. This offers us the experience of reflecting on our own possible biases, as therapists, which may rely on vague stereotypes about gay men and emotional expression, and how they communicate with their masculinity.

O'Neil (2008) suggests working with men to form a *'healthy masculinity'* to learn alternatives to sexist gender role attitudes. Highlighting strengths moves the shift away from what is wrong with men to identifying the qualities that empower men to improve human life and society and this could work in conjunction when working with gay men. This is important as it shifts from pathologising to exploring a positive masculinity. Real men can cry, can express emotions, can embrace their feminine sides and still be real men. Riggle et al., (2008) noted that a positive aspect about being gay was "a sense of freedom from gender role stereotypes and expectations and the social constructions of gender roles." By taking these positive aspects of gay life and looking at how they relate to GRC we can, as therapists, have the means and abilities to work with gay men and their masculinity in ways that can foster movement and progress in a safe and therapeutic way.

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Homosexual Men: A journey from Shame to Authenticity

by Ivan Kennedy

Abstract

"Homosexuality is wrong": This message is ubiquitous throughout society (e.g., family, peer-groups, media, institutions), and internalised in many gay men (Downs, 2005). Reported evidence highlights LGBT people's vulnerability in society with particular emphasis on homosexual men whose internalised shame underlies much of their distress and despair. Whilst illuminating this issue, this article explores Downs' (2005) 3-stage-model of male homosexual development: Overwhelmed by shame; compensating for shame; and discovering authenticity. Because it is important to explore clients' experiences, beliefs, and/or attitudes of homosexuality and our own as therapists, this article combines Downs' model with aspects of Gay Affirmative Therapy (see Davies & Neal, 1996) which necessitates counsellors exploring their own feelings, motivations, and behaviours of homosexuality from personal and professional capacities—and how these capacities are linked. This piece considers this issue from national, international, and psychological contexts.

Irish and International Contexts (Background of Perspectives on Homosexuality across Cultures)

Perspectives on homosexuality have changed over time and across cultures. In recent years many societies adopted more affirmative views of homosexuality than they had in preceding years. A cursory glance at popular culture can highlight changing attitudes towards homosexuality; seemingly, it has become more acceptable, common, and/or discussed. Similar movement occurred with legislation changes in many countries which, to varying degrees, legally protect homosexual people. However, despite progressive changes, undercurrents of societal homophobia remain.

By 1974 the American Psychiatric Association declassified homosexuality as a mental illness due, partly, to protests against labelling homosexuality as an illness and various "radical" research of homosexual development (Cain, 1991). Research swung from viewing homosexuality as a sign of psychological maladjustment to focussing on how society's rejection of homosexuality leads to many societal and individual problems, e.g., abuse, isolation, low self-worth, and self-harm. Subsequently, many health-care professionals' treatment methods and awareness changed accordingly; essentially, psychological problems were seen to be caused more by society's imposed covert existence than sexual preferences (Cain, 1991).

By the 1980s homosexuality was legal in many current European Union countries which promoted equality for Lesbian, Gay, Bisexual, and Transgender (LGBT) people (Waaldijk, 2009). However, despite

advancement, no European country ensures full legal equality for LGBT people (ILGA Europe, 2013). The ILGA Europe (2013) study includes 6 categorical issues (46 sub-categories)—e.g., equality, family, verbal/physical bias—affecting LGBT people across Europe. When compared with other European countries, the UK performed best, ensuring 77% compliance; Ireland performed below average, ensuring 36% compliance, suggesting that across Irish culture there may be many pervasive homophobic attitudes and beliefs that view homosexuality as an abnormal variation of sexuality.

Regardless of whether such attitudes and beliefs are transparent or opaque to oneself or to others, they affect clients and therapists because virtually everyone receives society's anti-gay messages; it is presumptuous, states Iasenza (1989), to think that therapists are immune to such influences. Consequently, therapeutic neutrality is impossible (Isay, 1989) especially if therapists are unaware of their own sexual biases (Iasenza, 1989).

Davies (1996a) highlights the importance of therapists being trained to work ethically with LGB[T] people and states that training/retraining is essential to be aware of (i) the varying theories of homosexual identity and components thereof, (ii) the varying cultures and subcultures and how to develop identities within them, and (iii) their own homophobia and heterosexism.

Until 1992 the World Health Organisation using the International Classification of Diseases (commonly used in Ireland) still classified homosexuality as a mental disorder (Davies & Neal, 1996). According to Davies (1996a), this "heterosexist bias" contributed much therapeutic prejudice towards clients in numerous counselling disciplines and is intrinsic to several traditional counselling and personality development theories.

The underlying societal message is that heterosexuality is the norm: Therefore, forming an "atypical" sexual identity is extra challenging

Regarding Ireland, homosexuality was decriminalised in 1993 (Waaldijk, 2009) after much legal battling ending in the European Courts of Human Rights in 1988—the High Courts of Ireland refused to decriminalise on grounds of public health, religion, and institute of marriage (Norris v. Ireland Judgement, 1988). However, many similar arguments influence Irish society still. Despite the Equal Status Act, 2000 and the Employment Equality Act, 1998, discrimination of homosexuals legally occurs in areas of (i) health (e.g., blood donations), (ii) employment (e.g., religious, medical, and educational institutes), and (iii) marriage (e.g., adoption and social support) (see Marriage Equality, 2013).

Although the majority of the public support same-sex marriage (Marriage Equality, 2013), Catholic organisations, in contrast, do not. For example, the Iona Institute (2013) says care provided to children is superior in heterosexual marriages than same-sex marriages. However most evidence contradicts this view (Allen & Burrell, 1997); evidence provided by the National Association of Social Workers, the American Psychological Association, the American Psychiatric Association, and the American Psychoanalytic Association state that no research comparing heterosexual with homosexual parenting styles found detrimental effects upon children (Cahill & Tobias, 2007).

Although, the Iona Institute often cites Regnerus (2012) as evidence showing hazards of homosexual parenting, several researchers have claimed that this research is methodologically flawed (e.g., Perrin, Cohen, & Caren, 2013). Therefore, as evidence predominantly reports no detrimental effects of homosexual parenting styles, perhaps fundamental Catholic ideology influences beliefs that homosexual parenting is harmful, e.g., homosexuality is a "strong tendency ordered toward an intrinsic moral evil...the inclination itself must be seen as an objective disorder" (Ratzinger & Bovone, 1986). Most mainstream religions express similar sentiments except the Society of Friends (Quakers), who accept homosexuality as normal self-expression; not doing so condemns the search and/or formation of homosexual identity (Lynch, 1996, p. 200).

Seemingly, society provides disparate messages: Homosexuality is not a mental illness and is an objective disorder; homosexuality is legal but less legal than heterosexuality. In general, the underlying societal message is that heterosexuality is the norm: Therefore, forming an "atypical" sexual identity is extra challenging (Cass, 1984).

Importantly, therapists must explore their own values, beliefs, and attitudes, and their origins from personal and professional positions. We must question if our principles and viewpoints prevent us from respecting clients, compassionately exploring their identity, lifestyle, and culture, and/or fully accepting or supporting clients who are gay, i.e., working ethically.

The Psychological Context (Understanding the Individual's Experience)

To understand how these perspectives impact on one's life and therefore our work, it is important to first outline some theoretical processes of homosexual identity formation.

Theories. Several theoretical models outline processes of homosexual disclosure and identity formation. For example, "coming out"

is not a single event but a process of tentatively and continually assessing the environment and its people's reactions (Cain, 1991). Coleman (1982) states that it incorporates five developmental stages: Pre-coming out; coming out; exploration; first relationship; and identity integration. Similarly, Cass (1984) proposes six stages of homosexual identity formation—confusion, comparison, tolerance, acceptance, pride, and synthesis. Both theories suggest that homosexuals, typically experience various behaviours relating to sexuality: Uncertainty and turmoil; denial, avoidance, and comparison with other homosexuals; tolerance; acceptance; anger with society's prejudice; and self-integration/identity formation.

Akin to Erikson's (1963) stages of identity, each stage of developmental crisis must be resolved before subsequent stages are resolved (Cass, 1984). Conversely to Erikson's model, many homosexual identity formation models (e.g., Cass, 1984; Coleman, 1982; Downs, 2005; Elizur & Ziv, 2001) de-emphasise the importance of family support (potential environmental stressors) and emphasise the importance of social support to achieve identity formation. Particularly, minority culture association can provide a sense of belonging, validation, well-being, and self-acceptance and ease familial and societal alienation (Elizur & Ziv, 2001). Specifically, within a supportive group of gay people, nurturing and respectful friendships can be formed which promote the belief that one's homosexuality is normal, can be fulfilling, honourable, and self-affirming, and can counteract society's homophobia.

Naturally, just as some heterosexuals fail to form their true identity, some homosexuals fail in overcoming the crises of the coming out and homosexual identity formation processes (Downs, 2005). Indeed, because of (perceived) threats of rejection and/or physical harm from family, peers, and society, some homosexuals reject disclosing or accepting their true sexual identity (Cain, 1991). Such environmental stressors can manifest in various forms of self-destructive behaviour stemming from internalised shame and homophobia (Isay, 1998; Higgins, 2002).

Evidence of self-destructive behaviours. Much research, investigating homosexuals' risk/self-destructive behaviour, concludes that homosexuals are more psychologically vulnerable than heterosexuals because of society's negativity towards homosexuality, not for being gay specifically (see Elizur & Ziv, 2001). When compared with heterosexual peers, homosexuals are more likely to:

(i) abuse substances more frequently/intensely to numb the ridicule and suppress the anxiety and depression for being gay, and to partake in excessive substance abuse common in gay pub/nightclub scenes (see Bontempo & D'Augelli 2002; Hughes & Eliason 2002);

(ii) engage in risky sexualised behaviours, e.g., multiple and/or anonymous partners, unprotected sex (McNamee, 2006);

(iii) be linked to homelessness, self-harm, prostitution (Jordan, 2000), and

(iv) attempt suicide in their teens (Savin-Williams & Ream, 2003).

Regarding adults, many heterosexual married men engage in homosexuality covertly (Brownfain, 1985). Such secrecy, and entering/remaining in heterosexual marriages is often due to self-esteem injury; essentially, one has internalised society's homophobia (Higgins, 2002; Isay, 1998). All gay men, states Isay (1989), internalises frequently experienced social hostility and these injuries make "social compliance important and acceptance of sexual orientation impossible" which manifests in various self-harming behaviours (Isay, 1998, p. 424). Indicatively, clients presenting with self-harm, risk-behaviours or marital/relationship issues might have sexuality issues. This suggests therapists need to view exploration of sexuality and emotional and physical wellbeing as similarly important, to be comfortable with exploring sexuality, and to have addressed their own values regarding sexuality.

Therapists must become aware of their own feelings, motivations, and behaviours of homosexuality from personal and professional positions

Downs' Three Stages: Shame; Compensation; Authenticity

Overwhelmed by Shame. Society's constant heterosexism and homophobia creates an immense sense of internalised shame in the typical homosexual man (Downs, 2005). This stage mostly includes the "in the closet" period whereby one hides, denies, avoids, or rejects his sexuality.

Numerous homosexual men concurrently recognise their difference (same-sex attraction) in youth (majority pre-puberty) and experience society's homophobia (e.g., Savin-Williams & Ream, 2003). Research of gay high-school students show that (i) 97% report regularly hearing homophobic remarks from peers which are generally ignored by teachers (MSSGLY, 1993) and (ii) 69% experience harassment: Verbal, 61%; sexual, 46.5%; physical, 27.6% (GLSEN, 1999). Although similar research in an Irish context is scarce, similar patterns emerge: Homophobic bullying was experienced by 15.6% of Irish secondary-school students

(students' reports; Minton, Dahl, O'Moore, & Tuck, 2008), excluded from most schools' anti-bullying policies, often ignored, and less manageable than non-homophobic bullying (O'Higgins-Norman, 2009).

Regarding the family, the bilateral socialisation process between child and parent enables the child to form his/her identity through perceiving and rejecting or accepting parental values (Knafo & Schwartz, 2004). For many who "come out", mismatches in parent/child values leads to various negative reactions—e.g., (i) estrangement and rejection, (ii) physical/verbal abuse (Savin-Williams & Ream, 2003), and (iii) increased suicide ideation (D'Augelli, Hershberger, & Pilkington, 1998)—to which one may foreclose on identity formation and remain stuck in that stage of the process or revert to heterosexuality (Coleman, 1982).

The aforementioned research suggests a salient anti-gay bias and threat that is rarely corrected and is caused by peers and authority figures. Consequently, many people (i) hide their sexuality to avoid similar negative reactions whilst completing the identity formation process (Cass, 1984), and (ii) internalise societal and familial values and deny their own needs due to internalised shame and/or homophobia (Downs, 2005; Higgins, 2002). Indeed, throughout life, gay men need to hide their sexuality, adopt heterosexual mannerisms and behaviours, and disregard the importance of their sexual fantasies: This damages their true identity as the external heterosexism is internalised (Davies & Neal, 1996). Therapists must resist colluding with anything that may reinforce the clients' internalised homophobia or shame and instead, offer unconditional positive regard and a safe, respectful space to explore and accept their sexual identity.

This stage of development, states Downs (2005), concludes with a crisis of identity—foreclose or, ideally, acknowledge and disclose one's homosexuality.

Society's constant heterosexism and homophobia creates an immense sense of internalised shame in the typical homosexual man

Compensating for Shame. Years of frequent, prevalent societal invalidation produces an obstinate sense of shame on gay men's psyche (Downs, 2005). According to this model, despite coming out and (partly) accepting his gayness, he fails to silence the shame and futilely compensates in many forms—from excelling in vocation, material wealth, sexual prowess, aesthetics, etc., to being the most "out and proud", most flamboyant, exuberant, zealous gay man possible. Such shame-compensation is extremely evident in the gay community with body image and contributes to increased incidences of body dissatisfaction, disordered eating behaviours, and gruelling exercise and diet regimes (for more see Duncan (2007); Siever's (1994) sexual objectification theory; Williamson & Hartley's (1998) internalised homophobia theory). Essentially, perceived invalidation begets attempts to attain tangible, aesthetic, or persona "perfection" to overcome psychological "imperfection" and hinders true personal growth as authentic validation is denied.

This stage of development concludes with crisis of meaning—foreclose (behaviour is repeated/enhanced) or, ideally, achieve authenticity. Therapists must challenge the shame of homosexual thoughts, behaviours, and feelings and explore the reasons for any compensating behaviour and its impact. Effectively, therapists must try to help eliminate the internalised message from society (he is gay ergo he is bad) and encourage him to talk openly and warmly of same-sex attractions in the hope of eradicating his internalised homophobia (Davies, 1996a).

Discovering Authenticity. True identity and sexual expression grows through resolving feelings of uncertainty, turmoil, hesitancy, fear of rejection [or punishment] (Elizur & Ziv, 2001) and shame (Downs, 2005). In this stage, behavioural repertoires built on avoiding and compensating for shame are redundant. Instead, ambiguity grows as shame-fuelled behaviours are slowly replaced with new behavioural repertoires whereby more trusting, authentic relationships are formed (Downs, 2005). The client/therapist relationship could model trusting and authentic relationships. As the therapist explores, respects, and accepts the client for who he is, the therapist provides a template for wholesome relationships whilst he begins to see himself with less shame and guilt and more compassion and acceptance.

Of the various factors of achieving authenticity, i.e., healing past relationships traumas (abandonment, abuse, ambivalence, betrayal, etc.), passions, and loves, the main factor Downs (2005) highlights is integrity. Specifically, honestly synthesising one's components; resolving past hurt and blending private and public selves (cf Cass's (1984) and Coleman's (1982) models).

However, families (and social networks) can hurt and heal; therefore, controlling information (and potential repercussions of coming out) and synthesising public and private selves is essential for identity formation (Elizur & Ziv, 2001). Whether coming out or controlling the information one reveals, integration of one's sexuality is crucial to identity formation (Davies, 1996b). As this developmental stage can be tumultuous, fragile, and incredibly painful (Elizur & Ziv, 2001), therapists must support clients in their journey

by exploring various aspects of their lives, e.g., locality, family, and ethnicity. In particular, to protect the client whilst promoting his identity formation explore whether or not his (i) locality is safe, has support groups, clubs, and/or others who are visibly "out", and has safe and nurturing places/ groups to explore his sexuality, (ii) family is supportive of his decisions and prepare for possible reactions, and (iii) minority/majority group might object to homosexuality and how this might manifest. Clients from minority groups might experience prejudice on two fronts: Sexuality and race. (Other considerations include gender, age, individual variations; see Davies (1996b) for more).

The Counsellor Context

In recent years, high risk-levels (destructive behaviours outlined above) have stimulated concern of those caring for LGBT community members suffering society's heterosexism/homophobia (McNamee, 2006). Indeed many gay men realise their "difference" before they realise their sexuality (average age 12-14 Years Old; see Carolan & Redman 2003; Warner et al 2004) which enhances their confusion over the harassment and their self-identity and attitudes towards it (Morrison & L'Hereaux 2001).

To support clients most effectively, therapists must explore and/or challenge their own attitudes towards homosexuality or indeed their own homophobia and to acquire more relevant information of a (sub) culture like we might do any other. Davies (1996a) states that to work effectively with LGB[T] clients, therapists need to re-evaluate their attitudes, values, beliefs, and awareness of LGB[T] issues, identities, and cultures, and to integrate this awareness into therapy.

Furthermore, therapists must become aware of their own feelings, motivations, and behaviours of homosexuality from personal and professional positions (Davies, 1996). So, let's consider these questions:

(i) Would you promote your clients' homosexual feelings?

(ii) Would you bring your clients' experienced heterosexism into consciousness to work with?

(iii) Would you challenge negative homosexual stereotypes that may have become part of your clients' identity?

(iv) Would you try to desensitise your clients' feelings of shame and guilt around homosexuality?

(v) Would you encourage your client to establish support networks in gay communities?

(vi) Are you comfortable/aware of any homosexual feelings you may have?

(For more see Davies (1996a) and Clark (1987).)

Exploring these points helps to honour our feelings about homosexuality and our clients' homosexual identity, the oppression that they experienced, their growing self-awareness, and how best to support them in their crisis (Davies, 1996a).

Conclusion

Evidence shows that gay men are disproportionately vulnerable when compared to their heterosexual peers. Through society's palpable and continual negative messages that homosexuality is wrong, gay men internalise and compensate for shame of their sexuality. Such is evident in how they try to off-set shame through destructive behaviours, e.g., substance misuse, suicide, and body dissatisfaction. The evidence highlights the need for counsellors to be aware of schemas of homosexuality and of specific issues affecting LGBT people who may be experiencing distress or despair because of society's prejudices and discrimination and their own internalised shame. Only through integration and self-acceptance can identity achievement occur—when one's public and private selves become more congruent, trusting, and nurturing, longer lasting relationships are formed, and shame dissipates.

As therapists we must explore our values, beliefs, and attitudes towards sexuality, and be willing to explore, respect, and accept our clients' sexuality thereby modelling a truly warm, safe, authentic relationship. Such will enhance our clients' acceptance of their sexuality and rejection of their sense of shame because of their sexuality. Furthermore, it will honour them for who they are. We must be aware of the typical and unique perils facing our homosexual clients; how sexuality based prejudice and abuse from family, friends, community or society in general can manifest in various self-destructive behaviours.

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Any thoughts or reflections on the subject of this article are welcomed and can be sent to kennedy.ivan@gmail.com

Erectile Dysfunction: Entering the conversation

by Luke Devlin.

A Problem!

No, she's seductive: squandered so many kisses on me:
urged me on with every one of her powers!
She could have moved heavy oak-trees,
stirred hard adamant, or the deafest stones.
She'd have moved all men, all living things for sure:
but I was neither man nor living, as once before.
What joy can deaf ears have when Phemis sings?
What joy can blind Thamyras have in painted things?
But what silent delights my mind invented!
What did I not imagine, all the various ways!
But still my sex lay there prematurely dead,
shamefully, limper than a rose picked yesterday –
Look, now, he's lively at the wrong time, able,
now he's demanding work and service.
Why can't you lie down modestly, worst part of me?
You've caught me like this with your promises before.
You failed your master: I was left weaponless, through you,
enduring sad hurt and great embarrassment.

(Ovid, The Amores. 16BC.)

Introduction

Erectile Dysfunction (ED) is not a condition that is specific to the modern world we live in. The extract above from the poem, "A Problem" was written by the Roman lyric poet Ovid in 16 BC, and although it is wonderfully artistic in its articulation of the experience of ED, its importance and inclusion in this article serves to demonstrate the timeless nature of the condition. Today it is estimated that ED affects up to 25% of males globally and yet it seems to be a condition that is largely suffered in silence. At the time of writing, no statistics are available on the prevalence of ED in Ireland but there is nothing to suggest that we might differ from the rest of the world. With a reported ratio of 1:4 men experiencing ED at some stage in their lives the chances are that we, as counsellors, will have to be prepared, professionally and personally, to deal with it. Sex and sexually related issues has long been a taboo subject in Ireland. Thankfully, that is changing although it is a slow process of change. As agents of change (such as the counselling process is) we have a duty to challenge ourselves and our thinking on all issues including sex and sexuality. We can only bring our clients as far as we are willing to go ourselves so we must continue to push our boundaries in a safe but courageous way. This article will seek to provide a brief overview of the aetiological understanding of ED and also discuss the implications this may have on the therapeutic interventions that are adopted in a counselling and psychotherapy context. It is hoped that if we can become more comfortable in our own conversation around ED, this might help us to initiate (if necessary) and become part of the conversation with our clients.

Sexual dysfunction

Erectile dysfunction is classed as a sexual dysfunction. Reber et al (1985) define sexual dysfunction as being "marked by

inhibition of arousal or of the psychophysiological aspects of the sexual response cycle" (p.734). The DSM V describes sexual dysfunctions as "a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (p.423). To understand this better though perhaps we need to understand the concept of normal, healthy sexual functioning. In 1966, Masters and Johnston proposed that the human sexual response cycle proceeded through four clearly defined stages of (1) Excitement (2) Plateau (3) Orgasm (4) Resolution but something was missing from this neatly constructed cycle. What if a person was unable to get to stage one of "excitement"? Clearly the element of desire was missing and Wincze and Carey (2001) have documented that "most sexologists agree that healthy sexual functioning comprises three primary stages: desire, arousal, and orgasm" (p.4). At the risk of being crude but to address the stages from a non-professional and, for the purpose of this article, male viewpoint, desire can be described as being "horny" or "turned on", arousal is often reflected or understood in the ability to get an erection or "hard on" and orgasm describes the sensation or ability to ejaculate or "come". If this is the accepted view of healthy sexual functioning then it should naturally follow that sexual dysfunction should also fall into these three categories. Erectile dysfunction (ED), previously known as "the ambiguous and pejorative term impotence" (Burnett, 2006. p101), is described by Schumacher et al as "constant or frequent difficulty in obtaining or maintaining an erection" (1981, p.40) and as such is classed as an arousal disorder.

Today it is estimated that ED affects up to 25% of males globally and yet it seems to be a condition that is largely suffered in silence.

The erection

An erection occurs when blood flows into the penis. There is "increased arterial inflow to the penis, penile blood engorgement, and decreased venous outflow" Saenz de Tejada et al., 2004). Glands in the penis swell and harden with this increased blood flow and the penis becomes erect. Erectile difficulties arise when there is decreased or insufficient blood flow to the penis.

Erectile dysfunction (ED) and DSM V

The current Diagnostic and Statistical Manual of Mental Disorders (DSM V) uses the term "Erectile Disorder" and classifies the diagnostic criteria as follows:

A. At least one of the three following symptoms must be experienced on almost all or all (approximately 75%-100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
   1. Marked difficulty in obtaining an erection during sexual activity.
   2. Marked difficulty in maintaining an erection until the completion of sexual activity.
   3. Marked decrease in erectile rigidity.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition. (DSM V. p.426)

In order to bolster these diagnostic criteria, the practitioner is asked to specify whether the condition is: Lifelong: The disturbance has been present since the individual became sexually active or, Acquired: The disturbance began after a period of relatively normal sexual function. And also to clarify if the condition is either Generalized: Not limited to certain types of stimulation, situations, or partners or, Situational: Only occurs with certain types of stimulation, situations, or partners. This author feels that although it is useful to have an understanding of the current diagnostic criteria for ED, it is not the job of the counsellor to diagnose any client but what should be taken from this is the necessity to ask two clear questions each time we are presented with a sexual dysfunction in therapy. (1) Is the condition lifelong or acquired? (2) Is it generalized or situational? and to explore these comprehensively. These alone might uncover any precipitating or causal factors in the client's experience of ED.

The causes of ED

Early understandings and attitudes towards impotence and ED seemed to suggest that 90% of cases were psychogenic, the cause being psychological as opposed to physiological in nature (Schumacher et al. 1981), but we have come a long way in our understanding of the aetiological understanding of ED since then. Jern et al (2012) contend that "ED

Maybe we need to challenge this particular script and start inquiring about sexual and erectile functioning as a matter of course.

is proposed to have a multifactorial etiology, with organic and/or psychogenic causal factors" and The National Health Service (NHS) in Britain provide a comprehensive guide to these causes and describe three main areas:

- **Physical causes**

  Vasculogenic: Affecting blood flow to the penis.

  Neurogenic: Affecting the nervous system.

  Hormonal: Affecting hormone levels.

  Anatomical: Affecting the physicality of the penis.

- **Medicinal causes**
  There are certain medications that can cause ED and many of these are taken/ prescribed routinely. They include medications to treat: High blood pressure, Cholesterol, Depression, Stomach ulcers, Epilepsy, Hayfever as well as medications that are used for chemotherapy, mental health and steroid replacement.

  (http://www.nhs.uk/Conditions/Erectiledysfunction/Pages/Causes.aspx)

- **Psychological causes**
  The psychological well-being of an individual can have a huge impact on the incidence and severity of ED. Any of the following factors can have a contributing factor to ED: Depression, Anxiety, Stress, Relationship difficulties and pressures to conform/ achieve perceived sexual norms

- **Other causes**
  Alcohol misuse or abuse can seriously affect the ability to achieve an erection as can drug or other substance misuse. Tiredness and fatigue can also play a significant part in the experience of ED. It should be noted that any of these causes may not happen in isolation and quite often will overlap. For example, a person experiencing ED who may be depressed might be prescribed an anti-depressant, which might in turn make the ED even worse.

ED and the pathways into therapy

Regardless of any moral or ethical viewpoints on the medicalisation of male sexual dysfunction and particularly ED, the advent of PDE5i drugs such as Viagra, (sildenafil), Cialis (tadalafil) and Levitra (vardenafil) have, at the very least, "normalised" the experience of ED. Clever marketing ensured that worldwide sporting icon Pele made it alright to have ED and that this could be cured with this new, wonderful magic bullet. The term "erectile dysfunction" is now a part of our vocabulary and conversation and although most middle-aged men with ED are routinely prescribed a PDE5i without any psychological evaluation (Leiblum, 2007) there is a growing awareness in the medical profession of the need for "an integrated medical-psychological approach to treatment...because of the importance of the psychological/ interpersonal factors that may have caused, contributed to, or arisen as a result of ED" (Aubin et al. 2009, p.123). Rosen et al (2006) describe how "partner concerns are a potentially motivating factor in encouraging men with ED to seek treatment and may be a critical factor in the decision whether to initiate or to maintain therapy" (p.217). Perhaps we need to be both perceptive and brave enough in our practices to acknowledge that ED might well be an unspoken element in clients presenting issues such as depression, anxiety, stress and relationship difficulties. Berry (2013) contends that men's reluctance to engage in psychotherapy for sexual issues is rooted in particular scripts of masculinity (p.32) so maybe we need to challenge this particular script and start inquiring about sexual and erectile functioning as a matter of course. Interestingly, a study has shown that 80% of men with ED who had not consulted a medical professional stated that they would have been open to discussing ED if a physician had initiated it. (Wylie, 2003). This surely has implications for the need for counsellors to, at least, ask the question or open a discussion.

Diagnosis / measurement

One of the most commonly used diagnostic tools for ED is the International Index of Erectile Function or IIEF. This is a 15-point, self-reporting instrument, which is based on five specific questions that have a choice of five standard answers for each. Normally though, "diagnosis of ED has historically been based on the self-reported ability of the man to achieve and maintain erection sufficient for sexual performance" (Leiblum, 2007, p.283) and this highlights the necessity to ask the key questions around Lifelong Vs. Acquired / Generalised Vs. Situational as this will give a clear insight into the context of the problem but also, and just as importantly, the clients subjective understanding of normal sexual functioning.

The implications for therapy

"Before the advent of modern therapies, erectile dysfunction was often treated through psychoanalysis, when treated at

all." Melman, (1999). Now that our understanding of ED has improved significantly it is possible to have the root or cause of the ED issue treated by a specialist in that field. If the cause of ED is a physical one such as cardiovascular disease, this can be treated by a cardiovascular specialist, if the problem is being caused by a prescribed medication, this can be altered or at least understood by the health care professional prescribing the medication but what are the therapy implications for counsellors and psychotherapists?

Clients presenting with or who disclose ED

It is the opinion of this author that one of the first responsibilities the counsellor has with a client presenting with ED is to encourage them to liaise with their GP. Given the knowledge that is available regarding the causes of ED (such as cardiovascular disease etc.) this would seem to be the safest and most pragmatic thing to do. ED is a very complex issue and there is a danger that more harm than good could be done in the counselling space by a professional who does not understand not only the causes of the condition but also the distress it can create in a client's life. A lot of men see getting an erection as a statement of how masculine they are and the counsellor needs to have a real empathy and understanding of the possible embarrassment, upset, anxiety and destabilising effect this perceived change in masculinity can have. Neukrug et al (2012) explain that these feelings alone can "prevent clients from discussing their concerns and can result in poor or even lack of treatment," and so a successful treatment outcome will rely heavily on the skill and knowledge of the counsellor.

In researching this work, the author has noted that the preferred or at least, most written about form of therapy for ED is with a specialist sex therapist. One of the most successful treatment models is the Sensate Focus model which was developed by Masters and Johnston in the 1970's and focuses on sensation rather than performance and encourages partners to approach intimate physical and emotional involvement in a gradual, non-threatening manner (Leiblum, 2007. p.124). This can be an expensive and unrealistic option for most though and so it is quite probable that a counsellor in general practice will come across a client, or quite possibly a couple, affected by ED at some stage. Stevenson (2010) talks about "developing a curious, positive, affirmative, comfortable, non-judgemental and integrated approach" (p.35) as a basis for working with clients who present with any sexual difficulties or issues and this approach can be very beneficial in working with ED. This somewhat "Rogerian" stance may allow the client to feel accepted and give space to discuss feelings of loss, embarrassment or anxiety but it also needs to be carried out from a place of understanding and with a comprehensive knowledge of ED from the counsellor's perspective. Popovic (2007) describes how the initial therapeutic work should centre on information giving and psychosexual education about erectile dysfunction, disclosure, spectatoring (attention is focussed on the act of sex and not erotic stimulation) and performance anxieties and these are all aimed at normalising the condition. To do this authentically and effectively though requires the counsellor to be confident and clear about his or her own understanding of ED and to know their own place in the conversation. Perhaps even knowing what books, articles and websites to recommend can be as effective as the therapeutic approach that is adopted. There should also be an investigative and information-gathering element to these initial sessions and this will require the counsellor to be comfortable discussing issues around masturbation and masturbation fantasies, sexual practices and orientations and perhaps being honest enough to ask for clarification around sexual terminology that they may not be familiar with.

Sex therapy in counselling and vice versa

Sex therapy, although a specialised area of practice, has many similarities to the counselling work that is undertaken every day in this country. In reality, perhaps we as counsellors will be the first person with whom someone who lives with ED will be able to talk to about their experience. We should be confident in our core skills to work effectively with ED and indeed any sexual dysfunction and it is not coincidental that the traditional sex therapy approaches as listed by Leiblum (2007) of Anxiety Reduction, Cognitive Behaviour Interventions, Increased Sexual Stimulation (exploring sexual scripts and boundaries), Interpersonal Assertiveness and Couples Communication Training, Relapse Prevention /Planning bear more than a passing resemblance

Sex therapy, although a specialised area of practice, has many similarities to the counselling work that is undertaken every day in this country."

to the work we carry out, and approaches we utilise for any other client presenting issue. At first glance it might seem that this type of work might be best suited to a CBT approach as it will "directly target symptoms, reduce distress, re-evaluate thinking and promote helpful behavioural responses (Leichsenring et al, 2006. p234) and the time limited structure of CBT may be preferred as many men who seek help for sexual dysfunction are looking for a quick fix (Hawton, 1998). However, this author argues for an integrated approach possibly combining elements of Person Centred Therapy (PCT) and CBT. PCT can be just as effective as CBT in reducing stress, re-evaluating thinking and promoting behavioural responses and Tursi and Cochran (2006) explain that by allowing a client to struggle with beliefs and attitudes and by expressing empathy and acceptance with their struggle, we allow them to take responsibility for the decisions and actions they take, and beliefs that they may hold, and this will empower them to take ownership of any changes they wish to make.

Conclusion

Starting a conversation can sometimes be a daunting challenge, especially if we are not sure of our knowledge, status or credibility. There is always the risk that we might be proved wrong or that somebody disagrees with our world view. This was the experience of the author throughout the process of researching and writing this article on ED but there was always a strong motivation to at least start the conversation. This article has given a very brief overview on the aetiological understanding of ED and explained some implications for therapy. For a more detailed understanding the author recommends the texts of Masters and Johnston, Wincze and Carey and Sandra Leiblum.

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http://www.nhs.uk/Conditions/Erectiledysfunction/Pages/Causes.aspx

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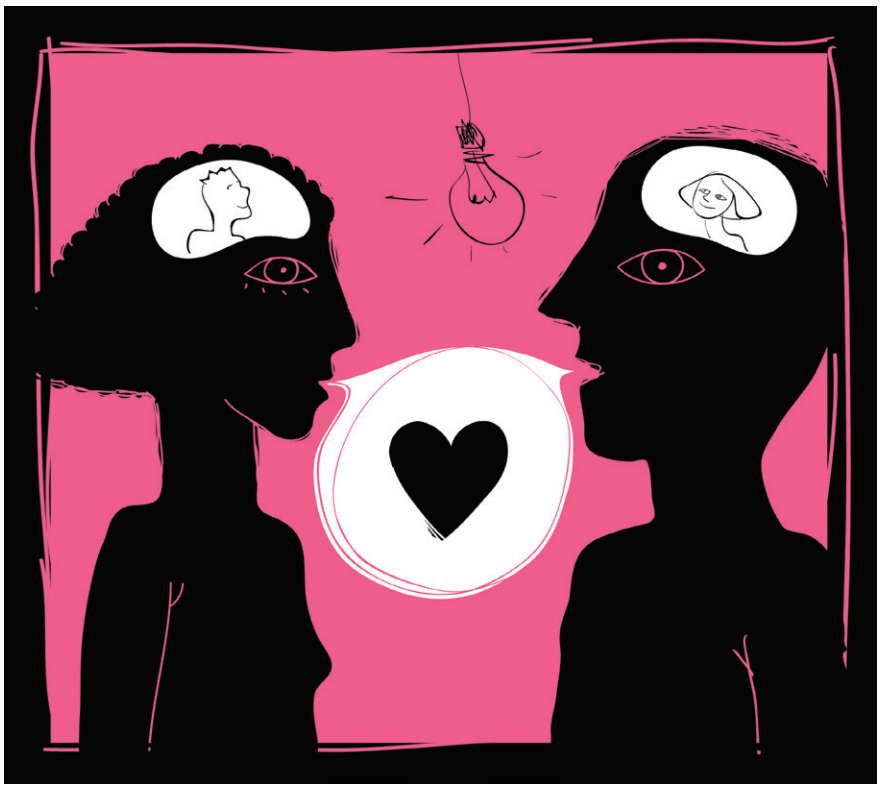
Mutual Desire in the Therapeutic Relationship

by Antonia Colom-Timlin

Introduction

Erotic transference (ET) and countertransference (ECT) have received media attention through the series 'In Treatment' and movies such as 'Mr Jones', 'Basic Instinct' and 'A Dangerous Method'. They dramatically portray therapists breaking boundaries and entangled in sexual relationships with their clients, over-simplifying the often misunderstood concepts of ET and ECT. Even amongst therapists there is an apparent tendency to view ET/ECT as sexual attraction *only*, when in fact they are so much more. Understanding the word 'erotic', derived from the Greek term 'Eros' (love), is key to fully grasping the true meaning of ET/ECT, which also include feelings of unconditional love and affection (paramount to building the therapeutic relationship). In fact, Mann (1997) views love and ET/ECT as one and the same. Yet in the literature, ET/ECT have been described as "erotic horror" (Kumin, 1985), "concepts that have long been difficult and mysterious" (Rachman *et al*., 2009) or "the taboo which silences" (Stirzaker, 2000). Research consistently shows that ET/ECT are commonplace; yet cause uneasiness and avoidance amongst therapists, even from core trainings. There is an apparent and surprising lack of guidelines on how to deal with ET/ECT effectively. In this article, the concepts of 'Eros' and the 'erotic' are explored in order to clarify any over-simplifications of ET and ECT, together with a review of the literature. Some recommended guidelines in dealing with these effectively (which proved hard to find) are laid out, as well as some current perceptions and research. Finally, a small research study is presented (with a total of 63 participants), which explored the attitudes of accredited therapists in Ireland towards the concepts of ET and ECT.



Eros and the erotic

In popular culture today, the word 'erotic' is arguably and primarily linked to sensuality and sexual pleasure, which could limit our understanding of ET/ECT to feelings of sexual attraction. While they do *include* sexual feelings, constraining erotic phenomena to these would be doing them a great disservice. Therefore, an exploration of the concept of Eros seems important and necessary to clarify the vast array of dynamics (not only sexual) that occur in the ET/ECT. Eros (Greek god of love) is a complex term, which can be hard to define. Mann (1997) clarifies the meaning of 'erotic' and sees no distinction

In the meaning of 'erotic' [there is] no distinction between erotic transference and normal love, viewing them as one and the same.

between erotic transference and normal love, viewing them as one and the same. All expressions of love generally come under the umbrella of Eros and "*Eros* leads us into development, complexity and unity. It binds, bonds, creates and is also the 'mischief maker' (Freud, 1923)" (Mann, 2012, p. 11). It is the longing and desire that drives us to transcend ourselves towards completion, seeking union (Harvey, 1997) and is intimately related to the term 'agape', on which Rogers (1962) based his concept of unconditional positive regard. Ahlgren (2005) defines Eros beautifully:

> The deeply human urge to form connections, ... to work together, to reach beyond oneself and dissolve boundaries of selfhood, to bind up wounds and restore life, to move ... toward wholeness, ... *Eros* is at the heart of all curiosity and desire, all creative activity, all commitments to sustain and enhance life, all attempts to share who we are with others, all community building (p. 37).

Is this not, precisely, what we are trying to achieve with our clients? If the 'erotic' is ever present in the intimacy of the therapeutic relationship, then we need to understand it and address it openly as a force that is a very natural part of our work; not something that should be avoided. This broader view of the 'erotic' (which goes way beyond just sexual attraction) normalises and expands the much-avoided and often misunderstood concepts of ET and ECT, defined next.

Erotic Transference and Countertransference

The concepts of ET and ECT originate from Freud's (1915) paper on transference-love. He describes

Eros is at the heart of all curiosity and desire, all creative activity, all commitments to sustain and enhance life, all attempts to share who we are with others, all community building.

ET as a client's open declaration of love to the therapist. It is 'unreal', entirely induced by the analytical situation, and a manifestation of the client's resistance. He views it as powerful analytical material that has to be worked through to get to its unconscious roots. He defines ECT as the therapist's erotic/amorous reaction to the client, considering it a direct threat to analysis, advising therapists to repress it. He is clear on the dangers of reciprocating the client's 'unreal' love, and warns that there is not a therapist who experiences this who would "find it easy to retain his grasp on the analytic situation" (p.161). Some believe that Freud's demonization of ECT has prevailed for almost a century, which put a lid on future examination of therapeutic Eros, keeping it hidden under a veil (Mann, 1999, Stirzaker, 2000, Bodenheimer, 2010). Eickhoff (1993) argues that this was as a direct result of Freud's worries over the many 'transgressions' of his male contemporaries with their female patients, referred by Springer (1995) as 'incest on the couch'. He believes that Freud's paper on transference-love might have been a direct reaction to Jung's affair with his patient Sabina and to Ferenczi's with his patient Elma (and later with Elma's mother Gizella!). Freud's stance on ET/ECT remains unclear though; he does state, in a letter to Jung in 1906, that psychoanalysis is a cure effected through love, but he never elaborates on this thereafter. This, again, reinforces that erotic phenomena goes way beyond just sexual attraction.

In the more recent literature, the role of ET/ECT has been demystified. Blum (1973) classifies ET on a scale ranging from the milder type (positive fondness/affection) to the most severe, which he called *eroticised transference* (intense sexual obsession with the therapist). This suggests that ET/ECT can be a positive and necessary condition for therapy to succeed. Mann (1997) agrees, suggesting that, apart from eroticised transference, ET is an essential part of therapy and life; an ever-present dynamic in every relationship regardless of gender or age, and one of life's most transformative experiences. He believes that working through ECT can enable the client to experience a different and transformative reaction, facilitating change and development. Bridges (1998) description of eroticized transference is useful:

> Clinical work often evokes strong feelings including attraction and sexual arousal, in our patients and ourselves. It is to be expected. Often, these feelings signal important information about our patients' development and relational difficulties, and about ourselves, and the therapeutic work to be done (p. 218).

It could be argued, in relation to eroticised transference, that often clients' experiences of love (in childhood and beyond) might not have been healthy. Love may have been confused with sex, manipulation, idealisation, power, pleasing, etc. Therefore, working through whatever erotic feelings (whether loving or sexual) might be present in the room could be a huge facilitator for growth, hopefully helping clients to love (themselves and others) in healthier ways.

Managing Erotic Transference and Countertransference

What do we do when we experience strong feelings of love or attraction for a client? And when a client has these feelings towards us? Whereas there is a vast amount of literature dedicated to managing general transference, it was surprisingly difficult to find a set of clear guidelines in relation to managing erotic phenomena safely and efficiently, and even less on how to deal with *erotisised transference* (ie: when a client falls madly in love with their therapist). Freud's (1915) advice was therapist abstinence, believing therapists should interpret the patient's ET (without satisfying it or rejecting it) by behaving like a detached expert, and suppress their ECT completely. But research shows that this only increases the chances of breaking boundaries or ending therapy prematurely (Schamess, 1999). Jacobs (2004) seems to view ET in terms of sexual attraction only, stating that "a responsible counsellor will not drop the client when the going gets tough ... (and) needs to be sure he can handle a client's strong feelings ... such as sexual desires for the counsellor" (p.137). Yet he seems to give no clear guidance on how to actually manage it, except for his reference to the "triangle of insight", whereby an insight into the transference links the current dynamic in therapy to dynamics in the client's past, and/or to dynamics in the client's other present relationships (p. 139). However, this seems to refer to managing 'general' transference, not ET/ECT.

Bridges (1998), an instructor in Psychiatry, places the responsibility on supervisors to educate supervisees, suggesting a strategy where supervisees are: encouraged to combat taboo and silence; taught that mastering ET/ECT takes time and can be initially startling and disorientating for trainees; educated to listen to their physical sensations in the room (emotional stirring, heat, arousal in the body); offered models of therapeutic action; facilitated in increasing their ability to tolerate and work through intense sexual states; and assisted in considering how to deal with the ECT (whether to discuss openly with clients or not). Bridges suggests a list of helpful questions, such as: 'What do these feelings tell you about your client's developmental issues, needs and wishes?' 'Do these feelings defend against more difficult feelings such as rage, terror, denial of vulnerability? 'Do these feelings represent an unconscious desire to love and be loved?' 'Do they signal a reenactment of earlier trauma or abuse by a trusted other?' and encourages supervisors to share their own ET/ECT experiences with supervisees. She advises that discussing this material directly with clients requires skill and sensitivity, as it is likely to frighten the client. She also warns that there is not enough evidence to support direct disclosure and that clients could be burdened or traumatised by it. However, Bond (2000) suggests that exploring openly (with clients) what their needs might be from a sexual relationship with their counsellor is a facilitator for growth. Not breaking boundaries is paramount and "the work (should) remain exclusively within the domain of fantasy and words" (Koo, 2001, p.31).

Spilly (2008) provides an exceptionally useful review of the literature on ET/ECT management. She concludes that knowledge of contemporary psychoanalytic theory coupled with building the connection, trust and safety of the therapeutic alliance, is what is necessary. Rodgers (2011) agrees, warning that working ethically with ET and ECT "requires understanding of transference phenomena" (p.267). Spilly (2008), in her own literature review, learns that the therapist should find a proper balance between empathy and objectivity (Gabbard, 1994) and accept the transference without seducing the client or avoiding the subject all together (Kumin, 1985). She recommends therapists achieve a level of comfort with erotic dynamics, as well as seeking support through supervision, peer groups or personal therapy. Hudson-Allez (2006) link ET/ECT with attachment and suggest knowledge of attachment theory is needed.

Current Perceptions and Research

In a UK study on therapists' loving/erotic feelings for clients, Stirzaker (2000) sent 107 questionnaires and only 4 were returned, with some of the comments stating that his study was 'abusive' and 'unethical'. Yalom (1980) also acknowledges that Eros can make therapists "squirm" (p. 407).

Schamess (1999) found, from surveying a class of Social Work students, that many felt attraction/love towards their clients but were uncomfortable addressing it. Rodgers (2011) refers to findings of 78% of counselling psychologists acknowledging loving/erotic feelings (Giovazolias & Davis, 2001) and 70% to 90% of health professionals claiming sexual attraction (Fisher, 2004). Moreover, Pope et al. (2006) find that 95% of men and 76% of women in their study had been sexually attracted to at least one client and felt uncomfortable about it. Half of the respondents did not receive any training around this and only 9% described their training/supervision as adequate. Martin et al. (2011) find in a UK study that therapists agreed about boundaries at the extremes, but when it came to fantasising,

flirting, or touch, opinions varied. They found this might increase the chances of breaking boundaries, highlighting the importance of training and supervision. Rodgers' (2011) UK study observes the need for better access to training and that participants had a strong motivation to learn more on the subject.

In relation to gender, the findings of Abramowitz et al. (1976) suggest that female therapists actively avoid treating attractive male clients. Gibson and Pope (1993) found that male participants were more likely to view feelings of sexual attraction towards clients, disclosing sexual attraction to clients and becoming sexually involved with former clients as ethical. They quote findings that male therapists were significantly more likely to approve of and engage in sexual activities with or about a client (Pope et al., 1986; Pope et al., 1987; Gabbard, 1989; Pope and Vetter, 1991). It is in light of these findings and of the literature review that the following study was undertaken.

Findings and Discussion

For this Irish study, questionnaires were distributed to 150 randomly-chosen accredited counsellors/psychotherapists in the IACP website (75 male and 75 female). Permission was sought and obtained from IACP and the participants identities remained annonymous. In all, 63 questionnaires and consent forms were returned. Of these, 25 were male and 38 female. The majority (68%) were over the age of 50, with 31% between 30-49. This could possibly be explained because therapists tend to train later in life. 70% of participants were married, which could be potentially related to the age profile of the cohort. The average years of accreditation achieved was 8.40 years, with the majority being accredited for less than 10 years, and with the range going from 1 to 25 years. Almost half (46%) had trained to Diploma level in the field, and only one person had achieved a PhD. Finally, in terms of participants' preferred working styles, under half (43%) described themselves as Client-Centred, followed by 21% indicating an Integrative approach.

The response rate of 43% was positive and unexpected, seen as it did not match Stirzaker's (2000) experience of receiving only 4 responses, or that love/erotic feelings in therapy are taboo (Stirzaker, 2000; Pope, 2006; Boddenheimer, 2011). This could possibly suggest that, either the level of comfort around these topics has risen in general in the last decade, or that therapists in Ireland are generally more comfortable around love and attraction in therapy.

It was found that 52% of respondents stated to have felt sexual attraction for a client. It was asserted by 40% that they felt *both* love and attraction, while 84% felt either one or the other. These numbers are high and match existing research. Surprisingly, participants' reported comfort levels in disclosing sexual attraction to their supervisors (Figure 1) was higher than what other studies suggest, with 56% stating they would have no problem. This could mean that therapists are more open about these issues in recent times or it could be related to more openness in Irish culture in general. Their reported levels of comfort telling their peers (Figure 2) is lower though and concurs with other studies, with 63% stating various levels of discomfort. In all, only 32% stated they felt comfortable disclosing their sexual attraction towards clients to both supervisors and peers, which concurs with findings that ET/ECT create discomfort in therapists.

Gender appeared irrelevant regarding participants feeling both love and sexual attraction (with 40% of men and 39% of women). Although for the 84% of participants who had felt either love or attraction or both, 70% of these were male and 30% female. Similarly, a higher proportion of the male sample (76%) felt sexual attraction to a client, relative to the female sample (36%). This concurs with Pope et al.'s (2006) findings that 95% of the men and 76% of the women in their study had been sexually attracted to a client. However, more women in this study stated they had no problem discussing feelings of attraction with peers and supervisors than men (36% of women compared to 28% of men). It is worth mentioning here the findings of Abramowitz et al. (1976) that female therapists actively avoided treating attractive male clients, but these findings are of 36 years ago and attitudes might have changed since then.

Clinical work often evokes strong feelings including attraction and sexual arousal, in our patients and ourselves. It is to be expected. Often, these feelings signal important information about our patients' development and relational difficulties, and about ourselves, and the therapeutic work to be done.

Figure 1: Participants' Comfort Level in Disclosing (to their Supervisor) Sexual Attraction Towards their Client.

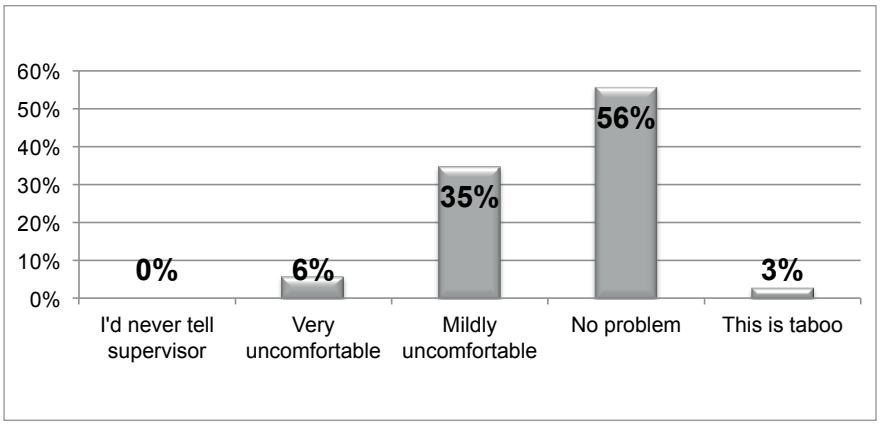
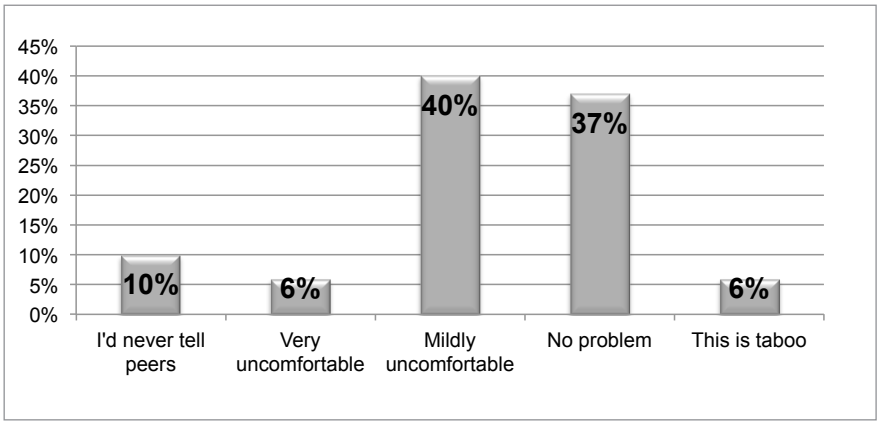


Figure 1: Participants' Comfort Level in Disclosing (to their Peers) Sexual Attraction Towards their Client.



In relation to how skilled participants felt in dealing with a client who shared sexual attraction towards them, 89% claimed they would feel skilled enough to discuss this openly with clients and to work through these feeling. The majority (68%) of participants said they learnt how to deal with sexual feelings in the therapeutic relationship during their core training in counselling and psychotherapy. Of these, only 38% claimed they would like further training. Interestingly though, of the 89% that asserted feeling skilled enough, 33% claimed they would like further training too. These findings do not appear to coincide with the findings of Pope et al. (2006) and Rodgers (2011) that show therapists did not feel skilled in this area and did not receive adequate training. These results are also surprising given the difficulty that was encountered in finding any specific guidelines on managing ET/ECT in the literature.

Conclusion

It is evident that erotic feelings are common in the therapy room and still the levels of comfort are not that high. It is also evident from the literature that ET/ECT is a natural and ever-present dynamic that is a facilitator for growth when dealt with appropriately. Participants' reports of high levels of competence in dealing with these feelings effectively is striking, given the lack of guidelines in the literature and the common finding that ET/ECT is avoided in core training. It is evident that achieving a level of competence around this could be an unusually difficult task, especially with erotisised transference. The fact that participants self-reported could be a limitation to this study. A pilot study would be recommended in future, as well as a larger sample with participants from several accrediting bodies and posterior face-to-face interviews.

Given that ET/ECT encompasses not only sexual feelings but also feelings such as love, affection, desire, connection, creativity and transformation, it seems that understanding and normalising it, together with building the skills to deal with it appropriately, is of paramount importance.

Given that ET/ECT encompasses not only sexual feelings but also feelings such as love, affection, desire, connection, creativity and transformation, it seems that understanding and normalising it, together with building the skills to deal with it appropriately, is of paramount importance to our clients. Using supervision, personal therapy and achieving a clear understanding of key concepts in psychodynamic theory and attachment theory, combined with the use of a Rogerian approach, seem to be the way to go in order to address ET/ECT safely and to help our clients to love and be loved in the way they deserve.

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Workshop Reviews

SUPPORTING CLIENTS WHO PRESENT WITH PTSD

Presenter:	Dr. Fergus Heffernan	Reviewed by:	Clair Bel Maguire
Date:	12th April 2014	Venue:	Newpark Hotel, Castlecomer Road, Kilkenny

The South East Regional Committee has been very active this spring in the matter of producing workshops, so for the second time this week I have been to Kilkenny, notching up more CPD points. But it's not just point scoring, yesterday's seminar presented by Dr. Fergus Heffernan was full of interesting and useful information, experiential in a way that really impacted on the delegates, and fun.

Dr. Heffernan knows that the more relaxed we are the better we learn. So, although he said that he didn't want to burden us with technique and theory, I was having such a good time that the information just slipped into my head.

The workshop was billed as "Supporting clients who present with PTSD" but Dr. Heffernan made it clear that it is not only the trauma of the client, but also our own traumatic memories inhabit the counselling room. He spoke of the necessity for us as therapists to be aware of our own 'stuff' and be honest with ourselves about it in order to avoid the kind of transference which will inhibit the therapeutic process. He recommends sharing this with our clients as it will help them, to understand their own reactions and behaviour. He places great emphasis on the therapeutic alliance and referred to Rogers' maxim that it is the relationship which heals.

Dr Heffernan has wide experience of PTSD / PTSS and spoke about how the stress response works in body and mind. We need to activate the Fight or Flight response about 300 times per day but nowadays we experience this about 1,200 times daily, building up excess negative energy. As a teacher of stress reduction techniques I was very interested to hear him speak about how we can regulate this response and silently applauded his emphasis on the primary importance of breathing. We need to attend to every part of us, physical, neurological, biological, psychological, emotional and spiritual. He said these are like a mobile with the spiritual element in the middle and the others moving around it. He spoke of the importance of diet, exercise and journaling to trigger the parasympathetic response and build resilience.

Our first experience in life is our loss of the security of the womb. This loss means that our needs for belonging and attachment are unmet and perhaps unnamed. This leads to anxiety which if unmanaged, Dr. Heffernan says, is at the root of all mental illness. All therapy clients present with loss of something important in their lives and the goal of therapy is to learn to remember our losses without pain.

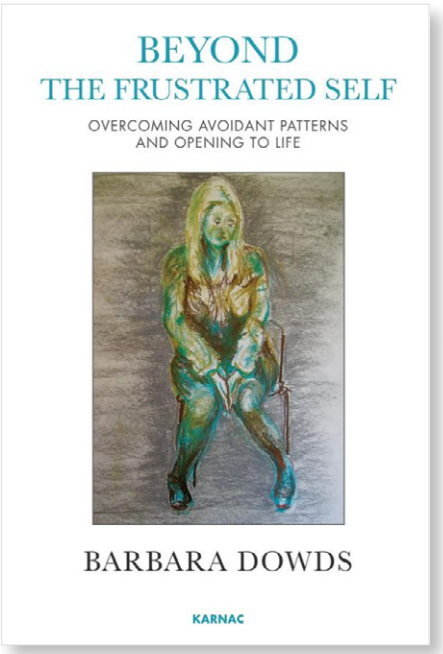
We saw a simple tripartite picture of the brain; the Conscious brain for cognitive reasoning, problem solving and creativity; the Limbic brain for feeling anxiety and pleasure and the Rear brain for holding onto memories and survival strategies. He made the point that when we go into mid brain the front, logical, problem solving brain stops working and we connect to the rear brain. Here is the repository for long term memory and information on how to survive. It remembers feelings such as injustice, terror, humiliation, guilt, and self-blame. It holds innate knowledge, habitual behaviour and thought patterns as well as early input (cellular) information which is often false, and in conflict with evident truth. Also in the Rear brain are what Dr. Heffernan calls "unsaids", that is the suppressed emotions and perceptions which are never expressed out loud, but influence everything we feel and do.

Throughout the day he illustrated with gentle exercises how we can control our responses and we ended the workshop with a relaxation tape by Joan Borysenko. As I walked back to the car I felt light and my knee which had been really painful that morning was supple and painless – must be just a coincidence!

Book Review

Title:	*Beyond the Frustrated Self Overcoming Avoidant Patterns and Opening to Life*
Author:	By Barbara Dowds
Published:	2014
ISBN:	1782200525
Reviewed by:	Maureen Raymond-McKay MIACP

When I was asked if I would review this book for Eisteach, not by the author I hasten to add, I had a quick look at the cover and was drawn to the word "avoidant" in the title which immediately struck a chord. I am a self-confessed introvert. I was a bit intimidated by its weight. I flicked through the pages as one does and spotted words/phrases such as-existential; internal conflict; neuroscience; cognitive restructuring; amygdala- and couldn't wait to get started on it.



The book is about Brenda and her search for existential meaning in a world that has no inherent meaning. It is hypothesised that Brenda's neurosis is a function in the first instance of an insufficiently available mothering and this would place her in the category of insecurely attached-avoidant according to Attachment Theory. She moves away from people when in fact she is seeking the opposite. There are times when she even wants to be enmeshed with them. But she had learned that it is not safe for her to be herself. Appropriate affect expression or energy regulation was not provided by her mother in the first instance so it could not therefore be internalised by Brenda. She did not know how to arouse herself when withdrawn or depressed or to soothe herself when anxious or angry.

Brenda learned to over adapt to her mother for fear she might lose her and so in turn she over adapts to her friends for fear she will lose them. Because human behaviour is so complex it is difficult to assign any one cause to specific behaviour. Brenda's over armoured avoidant behaviour is also deemed to be a function of and /or reinforced by a "globalised, technologised, accelerated and ceaselessly changing world....that favours and helps generate avoidant relationships p xvii."

Brenda's self-cure was to subordinate her need for authenticity to her need for recognition from others for her achievements. She lived in a state of high anxiety which would not be apparent in her demeanour due in part to heavy physical armouring. She managed to get away with this self-cure until her thirties when she had a break-down in the form of clinical depression. Frustration is one of the givens of life and is the key to political action. However it is when it remains in the unconscious that the problems arise.

With the appropriate help including psychotherapy, Brenda made the unconscious conscious. She was able to shed some of the armour. Meaning for her is in being a friend and not trying to hold on to friends at all costs for fear of being lonely. She knows that no amount of armouring will protect her from her existential isolation. She is learning to live more authentically but realises that this is not an end state to be sought after but is a life-long process of becoming. She also realises she has a secure base in the form of a loving partner who is available to play with her when she wants to.

This book does not take the form of a case study in the sense that it includes verbatim accounts of dialogue, or accounts of insights made in or between counselling sessions. Nor does it overtly make any attempt to protect Brenda's need for privacy which would be usual in an account of this nature. Whether she is real or imagined or even if she doesn't exist apart from the author, she affected me. Having finished the book I feel a lot lighter in more ways than one.

My one mistake was attempting to read this book at bedtime. It is not bedtime reading, so be warned and don't frustrate yourself. It is very well researched and requires concentration. I discovered late in the day that many of the chapters can stand alone. They are also summarised so you can work backwards if your attention is grabbed. Whether you are just starting your training as a psychotherapist or are well seasoned and think you have nothing more to learn about attachment theory this book should be on your reading list.

Therapist Dilemma

Dear Reader, we are eager for your involvement, ideas, thoughts, and replies to the Therapist Dilemmas.

Below is new scenario for you to consider...

Send your Dilemma and / or replies to this issue's Dilemma to:

Dialogue, Éisteach, 21 Dublin Road, Bray, Co Wicklow or eisteach@iacp.ie

Dilemma from Summer 2014 Issue:

Dear Editor,

It was with interest that I read the new Children's Bill 2014 regarding the Mandatory Reporting of child abuse. In my work I have responsibility as Child Protection Officer, and as a therapist and supervisor I have responsibility to my clients and supervisees.

I needed to re-read the document a couple of times as I was concerned about the implications for my work and practice. In particular as I understand it, the new legislation emphasises the need to report any facts and concerns a Mandated Reporter (specified professional) may have for the actual or possible risk to a child. In addition, if a child tells me that he fears he may be at risk, this too needs to be reported.

With new clients I can explain the new legislation and my obligation to report. In the case of an established client relationship where I gave assurance of confidentiality with the exception of risk to self or others, where do I now stand? Over the course of our therapeutic relationship a client may have disclosed facts of previous or current abuse. How do I now address the situation of mandatory reporting? I do appreciate the need to protect children, but how do I balance this with my responsibility to my clients and supervisees?

Thank you, *Anne Duffy*

Response:

You have written that in your work your responsibilities are as a Child Protection Officer, a Therapist and Supervisor, your concern relating to the Children First Bill 2014 and the effects of this Bill on your work and practice.

As a therapist/supervisor there have always been limitations to confidentiality, and 'giving assurance' to a client, albeit an adult or child is not feasible. As you advised, you have spoken with your clients at the beginning of your work with them and in doing so you have followed a code of ethics.

The IACP code of ethics states the following in relation to privacy, confidentiality and reporting, see below;

1.2.4. Break confidentiality only where required by law, or where there are grounds for believing that clients will cause physical harm to themselves or others. Where feasible, practitioners shall endeavour to obtain the client's consent, and consult their supervisor or an experienced colleague, in advance of any such disclosure. However, in emergencies, practitioners shall make their own judgment as to what action is best.

1.2.5. Minimize any breach of confidentiality by conveying only that information which is necessary, and only to relevant persons.

The reporting now extends to retrospective allegations. It is important to remember that although it is seen as 'historical abuse' the abuser may still be alive and could have access to other children no matter what their age. That is what the Children First Bill is trying to do, to keep children safe.

Reporting is the responsibility of the therapist/child protection officer/supervisor not the client. It is however, important to work with the client in obtaining the appropriate and relevant information to report to the appropriate agency. Where situations arise over the course of a therapeutic relationship, it is necessary to remind your client what was discussed at the contracting stage and advise them of the changes in Irish Law and the implications involved for both you (the therapist) and the client, if the client is not already aware of them. Where dealing with a minor you will more than likely have a parent, guardian, social worker or other organisation involved and the above can be discussed with them as well as the client.

The IACP are holding Child Protection & Psychotherapist training presented by the organisation 'One in Four' where the aim is to provide clear information regarding your legal obligations to report retrospective allegations.

Alison Larkin, MIACP.

Dilemma for Autumn 2014:

Dear Editor,

I am concerned about a client I am currently working with who presented with issues regarding erectile dysfunction. When he first engaged he outlined that his aim was to resolve any issues he had with obtaining an erection when intimate with his wife. His wife refused to engage in the therapeutic process so it was agreed that we would continue on an individual basis. He did however, invite his wife to one of our sessions and she attended. Over the previous few months we worked on this issue and he has recently he stated that he is confident enough and has agreed with his wife to resume sexual intercourse. My concern however is that he has now just disclosed to me that in the last few months he had unprotected sexual intercourse with a work colleague to "see if it worked" and has been diagnosed with an STD by his G.P. He explained that he could never tell his wife as she would end the marriage, that he has put so much work into resolving their sexual issues, and that he feels there is no need to since he "got the all clear" from the G.P. I am unsure as to where I stand with confidentiality because although he has stated that he is not at risk for infecting his wife my sense is that this may not be the case due to his very recent diagnosis of the STD and therefore poses the potential risk of harming his wife. I'm wondering how I might proceed with this matter?

Thank you.