CRISIS INTERVENTION AS A FORM OF THERAPY FOR PERSONS WITH HOMOSEXUAL CONCERNS: AN EXPERIMENTAL STUDY

by

Gordon Michael Isaacs
B.A.(S.W.)(Wits.)

School of Social Work University of Cape Town

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...we should be seeking to make it possible
for human beings to realise their erotic
potential in full and responsible conscience.
The energy now required to maintain the wasteful
blockage by fear and guilt of the erotic
could then be freed for creative purposes
in the life of humankind.

MARY S. CALDERONE

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CONTENTS

Page

LIST OF TABLES

CRISIS INTERVENTION AS A FORM OF THERAPY FOR PERSONS WITH HOMOSEXUAL CONCERNS: AN EXPERIMENTAL STUDY

ABSTRACT

Thirty male patients who, because they were experiencing homosexual crises, had made contact with a walk-in crisis clinic in Johannesburg, South Africa, were admitted to a series of therapy sessions based on the model of crisis intervention as expounded by Naomi Golan. The Paper reports upon a study which examined the degree of anxiety associated with the crisis, and measured the efficacy of crisis intervention techniques in reducing anxiety and distress.

Two basis tests were administered: one before therapy and the other upon completion. The first test was the Kinsey Homosexual-Heterosexual rating scale to gauge the level of the patients' understanding of their homosexual-heterosexual spectrum and to facilitate therapy. The second test consisted of ten items selected from the Manifest Anxiety Scale (M.A.S.). Using Magoon's validation of the study (which differentiated items in terms of levels of significance) and using Busses' study (which produces a follow-up item analysis of the M.A.S.), the writer selected those items that were significant at the 5% level or better, and also those that could be broken down into the following categories:

a) items which were indicated by physical anxiety or discomfort

b) items which were indicated in verbal terms.

In this way items were identified as correlates of anxiety experienced by persons with homosexual problems (in a crisis state). A rating scale was constructed using a five-point semantic differential for each item.

Outcome measures in respect of the Kinsey Scale revealed no significant differences in homosexual-heterosexual ratings before and after treatment. The Anxiety Test, however, revealed a highly significant difference in the readings before and after therapy.

INTRODUCTION

More than two decades ago, Kinsey, Pomeroy, and Martin[1] estimated that approximately 13 per cent of the white male population of the United States of America was predominantly homosexual for at least three years of adult life. A recent interpretation by Berger of the Kinsey data suggests that 8 per cent of the total adult population at any one time would fit the category of "homosexual".[2]

Evidence from other recent studies in Western countries supports the impression that homosexuality is much more common than had previously been believed. Nevertheless, and despite the difficulties engendered by homosexual behaviour in what has been normatively described as a heterosexual society, social work practitioners, and indeed clinicians in the health care field, have devoted little attention to it.

It has been the writer's experience that the majority of social workers are both uneasy and reluctant when confronted with the sexual concerns of their clients. This impression has been endorsed by the literature. Numerous authors, including Reiner, Turner, and Wasserman have pointed out how social workers tend to feel both hesitant and uncomfortable when having to deal with sexual matters.[3],[4],[5]

Strydom points out that social workers' negative feelings towards so-called sexual deviations are often coupled with their own sexual fears and insecurities, and that this makes for a reluctance to treat the person with a sexual concern -- furthermore, that this accounts for heavy referral rates to other "specialist disciplines"[6]. This view has also been expounded by Bell, who states that clinicians maintain their own special or biased impressions of homosexuals, which can unfavourably affect their relationships with their clients[7].

He points out that a common view encountered among helping professionals (including social work practitioners) is that homosexuals are a priori "sick", and hence a "cure" or change away from the homosexual spectrum is the primary goal of intervention.

Beaton and Guild point out that the majority of treatment approaches involving homosexual persons use aversion therapy or psychoanalysis.(8) While these therapeutic methods may claim some success, they continue to stress the pathology or deviance of homosexuality.

Therapeutic intervention is for homosexuals mostly sought when some form of "crisis" is manifested. In treatment of homosexual crises, two major variables are crucial:

a) the person experiencing the problem (i.e. his own interpretation of his semantic/cognitive and emotional needs and wants)

b) the therapist's attitudes, understanding, and clinical expertise.

The therapist, often being a member of the "establishment", or at least identified by the client as such, would tend to bolster society's general bias against homosexuality, and to know little or nothing of the sociological and cultural dynamics of the world of the homosexual. Such knowledge, in the writer's opinion, should however be an integral aspect of the helping process.(9)

Attitudes are a learned set of feelings, expectations, and ideals, which are basically acquired via parental and societal instruction.(10) They are internalised to form part of our cognitive personalities. Attitudes towards sex, and towards the broader concept of human sexuality (both in respect of client and therapist populations), are riddled with fear, anxiety, and guilt. What happens to persons who are confused;

who cannot or will not accept or understand their homosexuality? They often transfer their feelings into overt anxiety manifestations, and become unhappy, often not functioning to their maximum potential. Or they "act out" their internalisation of society's expectations. Thus, according to Lionel Ovesey[11], homosexual crisis or panic is often a reflection of the individual's own ingestion of the attitudes in his society. He epitomises this situation in a sequence of equations as follows:

I am a failure (i.e. unable to cope as a man in terms of society's and significant others' expectations)

↓

I am not a man (i.e. the internalization of the often confused concept of the <u>ideal man</u>)

↓

I am castrated (i.e. feelings of inadequacy)

↓

I am a woman (fantasies and feelings about lack of masculinity begin to take over)

=

I am a homosexual (i.e. the attitudes of the broader social social system now begin to take effect)

↓

I am confused (a rise in anxiety, and a crisis phenomenon may emerge)

The above sequence (with the writer's comments in parentheses) which reflects psychodynamics and indeed Freudian terminology is frequently observed in persons experiencing a crisis with their sexual identity.

In the writer's clinical experience[12] such sexual identity crises are frequently brought to social welfare agencies, psychiatric units, and to private clinicians. If a primary sexual problem is not presented, it is often found that sexual concerns manifest during the treatment process. Treatment however need not always require the uncovering of the unconscious origins of such problems, nor need the resolution of such problems necessarily be the aim of intervention. Turner describes how significant gains can be made in improved control, changed attitude, and enhanced growth by means of short-term intervention; not to mention the beneficial effects on functioning that can be obtained by reducing guilt, anxiety, and fear that usually (if not always) accompany any sexual problem.[13]

This Paper goes on to describe a study undertaken by the writer at the Johannesburg Crisis Clinic in 1976 and 1977. The subjects of the study were white male persons between the ages of 18 and 30 who were experiencing greatly highlighted anxiety connected with homosexuality.[14] Details of the study and its findings now follow. Three fundamental theses underly the work as here reported upon, viz.:

(i) the "crisis moment" is accompanied by an acute anxiety state which is clinically recognizable

(ii) Golan's framework for identifying stages in crisis can be used in facilitating short-term therapeutic intervention

(iii) Specific techniques can be developed from the principles of crisis intervention and used in working with persons experiencing homosexual crises.

II

DEFINITIONS

A comprehensive definition pertaining to homosexuality has been given in the Paper entitled Working with the Male Homosexual Client: Some Major Theroretical and Clinical Assumptions[15]. The three terms crisis, homosexuality, and anxiety, are here, however, for the sake of clarity and convenience, reviewed.

Crisis

A crisis is a relatively short period, usually lasting from one to six weeks, when an individual faces a hazardous or threatening event, while at the same time he is fatigued and unable to mobilise his usual or safe coping techniques. A crisis is usually further characterized by:

- disequilibrium of a psycho-social and physical nature, and accompanied by increased or heightened anxiety;
- a threat, or apparent threat, perceived by the individual as involving challenge or loss;[16]
- a lowering of the individual's defences, thus rendering him more susceptible to therapeutic intervention.

Homosexuality

Homosexuality is seen as a broad spectrum of psychological, emotional, and sexual variables in a state of interplay between two persons of the same sex. Homosexuality is NOT only sex attraction between two persons of the same sex, but must also include:

- an emotional as well as physical bond
- a fantasy system[17]
- an element of symbolism, eroticism, and sexuality.

It should be noted that homosexuality can be experienced in different degrees, as Kinsey has made so clear.[18]

Anxiety

It is widely accepted that most persons respond to stressful situations with increased anxiety, and that anxiety reactions are characterised by feelings of apprehension, tension, and the activation of the autonomic nervous system.[19][20][21]

To define anxiety is difficult. According to Lader, one in anxiety basically encounters both a cluster of overt behavioural characteristics that can be studied scientifically and a set of introspective feelings that are scientifically often inaccessible.
Anxiety can be a mood, a feeling, an emotional response, a syndrome, or an illness with a course or prognosis.[22]

Anxiety within the Framework of Crisis Intervention Therapy

Caplan states that man is constantly faced with a need to solve problems in order to maintain equilibrium.[23] When a person is confronted with an imbalance between the difficulty as he perceives it and his available repertoire of coping skills, a crisis may be precipitated. If alternatives cannot be found or if solving the problem requires more time and energy than usual, disequilibrium could occur. Tension rises and discomfort is felt, with associated feelings of anxiety, fear, guilt, shame, and helplessness.[24]

Depending on past experience related to the immediate problem, some people will be more proficient at finding solutions to their problems than others. Aguilera points out that internal and external factors affect the process at any given time -- the greater the stress and hazardous factors affecting the individual's ability to cope, the greater the anxiety.[25]

When anxiety is kept within tolerable limits, it can be an effective stimulant to action. Rosenbaum and Beebe[26] feel that therapists (intervenors) should remain aware that moderate levels of anxiety have adaptive functions in alerting the individual, in mobilizing and directing energies, and in providing the persistent motivation that is required to cope successfully with the problem. Anxiety could be a NORMAL response to a dangerous or hazardous situation confronting the individual. Of course, one must take cognizance of the fact that increased anxiety can be a debilitating factor; which may immobilize the person's usual array of coping devices.

Crisis intervention is based primarily on the paradigm of loss and impending loss.[27] With the onset of the crisis state, there is the fear within the client of loss of self control, loss of previous abilities to cope, loss of approval from significant others, loss of self image, loss of a relationship, etc. From this emerges a general profile of an anxiety state:

- Sense of bewilderment
- Sense of danger or threat to one's very existence, be it psychological or social
- Sense of confusion
- Sense of impasse
- Sense of desperation
- Sense of apathy
- Sense of helplessness
- Sense of urgency
- Sense of discomfort (both physical and emotional).

This anxiety can be described as the subjective accompaniment of the awareness of loss or impending loss. Searching for a solution in respect of the lost "object", be it part of the self, a person in a relationship, or a significant other,

will elicit some of the above-mentioned anxiety feelings. Searching, by its very nature, implies the loss or absence of an object, and is an essential component of anxiety.[28]

Anxiety within the crisis intervention parlance must be understood as covering a wide range of meanings, which include an indefinable threat, fear of present danger to the self (or others), and worry over possible future dangers (future anticipation).

Client Description

The statistical information presented below, which was reported in a Paper presented to the 27th Annual Congress of the South African Psychological Association by Barling and Zimbler, is not accurate and definitive, since it was not gathered from complete records. This was because many clients wished to remain anonymous, hence comprehensive files were not completed. Furthermore, the presenting problem was often not the cause for the initial contact at the clinic. Weber, in his criticism of the gathering of statistics at the clinic, makes the pertinent point that classifying the presenting problem in terms of one feature only means that many "classifications" are blurred in terms of the true dynamics of the case.(30)

To give an idea of the scope of the clinic's work, and of the type of client it drew, the following information pertaining to the year 1975 is cited. In that year, 72% of its clients were male, and 28% female. Almost half (46%) were drawn from the Hillbrown and City areas, and 84% came from the lower and middle classes. Details of age and the presenting problems follow in Tables 1 and 2 respectively.

TABLE 1

The 1975 Intake of Clients
at the Johannesburg Crisis Clinic
Classified according to Age

Age Group	Percentage
0-19	23
20-29	33
30-39	20
40-49	14
50+	10
All ages	100

TABLE 2

The 1975 Intake of Clients at the Johannesburg Crisis Clinic Classified According to Presenting Problems

Presenting Problems	Percentage
Substance dependence	39
Personality problems	19
Miscellaneous problems, e.g. accommodation, relief	12
Marital and sexual problems	30
All problems	100

The Nature and Extent of Sexual Problems

It is almost impossible to assess the number of clients under treatment for sexual confusion, conflict, or anxiety at any one time. Weber, in his analysis of the nature and extent of sexual concerns at the clinic from a descriptive and statistical viewpoint, revealed a growth in the caseload from 3,4% for the period September 1973 to March 1974, to 7,5% for the period March 1975 to May 1975. This figure increased to approximately 12% of all cases seen as discussed in a Paper on homosexuality presented by the writer in 1976.(31)

The writer found whilst working at the clinic that cases of sexual disturbance or confusion are not always classified as such, but might equally be classed as "emotional problems". Weber has pointed out most significantly that in terms of the existing figures (and this coincides with the writer's own findings) the largest number of sexual problems dealt with by the clinic are concerned with homosexual crises -- either homosexual proper (in which case the client is usually having difficulty in adjusting to his sexual orientation and/or relationship problems) or homosexual panic (where the client is afraid that he is homosexual because of some recent traumatic experience or fantasy or because he has a feeling of inadequacy in meeting the masculine stereotypes).(32)

Conceptualisation

Whilst working at the Johannesburg Crisis Clinic (a specialised social work agency dealing specifically in the method of crisis intervention) the writer in his capacity as Senior Professional Officer (Welfare) and Head of Therapeutic Services became growingly aware over a four-year period of the number of persons who contacted the clinic with homosexual problems, most of which were manifest in an acute crisis state[33]. Otherwise, the crises were revealed in presenting problems which were not directly related to the actual problem of importance (i.e. the homosexual concern) because of:

(a) the delicacy of problem
(b) attitudes inherent in the person and the social system
(c) lack of skill on the part of therapists either in eliciting the problem or confronting the individual with it.

As the mode of therapy at the clinic was geared towards short-term or brief intervention according to a model of crisis intervention, the writer saw the need to apply the concepts of this approach to homosexual crises.

In those instances in which the therapist/social worker has confronted a client with his homosexual behaviour, a traditional model of treatment has most frequently been applied. Berger contends that this model can be characterised by five assumptions.

1. Adult individuals are either exclusively heterosexual or homosexual.
2. The homosexual is rarely encountered in typical social work agencies/clinics.
3. The homosexual individual is readily identifiable, he is generally male, and is recognized by a cluster of distinctive characteristics, including dress and mannerisms.

4. Homosexual behaviour nearly always causes problems.

5. Homosexuality is an individual phenomenon and is the result of severe psychological disturbance.[34]

These statements appear to the writer as basically exaggerated, particularly as the application of a crisis model separates the person from his problem. Crisis intervention is primarily based on the contention that the crisis state is a normal response to a stressful or anxiety-provoking event. In dealing with the crisis state, two fundamental guides to the therapist are:-

(i) the person is to be acknowledged first and foremost, no matter how he presents or how he looks

(ii) His verbalisation of his dilemma is to be seen in an emotional or feeling context, without a value judgement placed upon it.

With these comparatively simple yet important assumptions, the writer began to use a model of crisis therapy with persons in "homosexual crises". This model (a) sought an understanding of the client's concept of his problem, and (b) utilized the writer's familiarity with homosexual dynamics, sexuality concerns, and the wide spectrum of homosexual variations, including the homosexual subculture. Margo,[35] in describing aspects pertaining to the homosexual subculture, and its implication for therapy, points out how a client picks up clear messages from a therapist's non-verbal behaviour. Body tension is an obvious sign of anxiety. Raising an eyebrow when a client discloses a homosexual orientation could be a message of rejection. Verbal messages, of course, are even more straightforward. Clinical language can raise the client's level of anxiety. For instance, many clients are put off by the term "homosexual". The therapist is therefore well advised to use and understand the vocabulary of the client in so far as he is comfortable in using it. Awkward use of expressions,

particularly in the wrong context, can be viewed as condescension or the therapist being extremely uncomfortable -- itself a subtle but effective form of rejection. (See Appendix A)

IV

THE STUDY METHOD

SELECTION OF SUBJECTS

Thirty male clients between the ages of 18 and 30 years were selected as subjects for the study. Certain criteria were required to be met before a client was selected.

(1) The client had to be between the ages of 18 and 30 years.

(2) The client had to be of the male sex.

(3) The client had to be in a state of crisis as defined.

(4) A presenting problem of homosexual concerns had to be present.

It is clear from the above rather rigorous criteria for selection, as well as the delicate nature of homosexuality, that few clients at the clinic qualified as subjects. Hence the study was conducted over a two-year period.

THE PROCESS

Briefing

(a) The Clinic Staff

The clinic team, including full-time staff as well as the volunteers, were assembled and briefed on the aims of the writer's research hypothesis. Furthermore, a series of in-service training groups were held on the concept of homosexuality and its related concerns. The following matters received special emphasis.

(i) The definition of a crisis state was discussed with the intervenors.

(ii) Clients who 'fitted' the selection criteria were to be informed that the writer would see them in a therapeutic capacity, and were to be told that "a person specialising in this particular

field would see them."

(iii) The intervenors would be required to make the client as comfortable as possible, until the writer could see them. In all the cases, the clients were seen within 24 hours of their initial contact with the clinic.

(b) Other Major Resource Persons

By means of personal contact, the writer informed the following persons or agencies about his research: the intake officers at the Department of Social Welfare and Pensions, the local Mental Health Society, the Casualty Officers at the General Hospital, the Medical Officer in charge of the V.D. Clinic, the clinical staff of welfare organisations dealing with male clients in the abovementioned age range, the team of personnel at Lifeline (Witwatersrand), and Suicides Anonymous. He suggested that if they were confronted by a client (as described above) in crisis, they could refer the person to the writer. Contact was also made with the owners of three clubs (discotheques) catering for homosexual clientele, as well as two well-known medical doctors in Johannesburg who dealt almost exclusively with homosexual patients.

(c) The Interview Procedure

All the clients were seen by the writer in his consulting room at the clinic. The room was warmly furnished with a couch and easy chairs, soft lighting, and piped music (at a subliminal level). The interviews were conducted in the evenings and during the weekends. The first interview (which is theoretically and clinically the most important[36]) lasted for approximately three hours. A total number of 136 therapeutic sessions were held with the 30 subjects.

(d) Interview Process

The process of the interview unfolded within the framework of an intake model based on the crisis intervention paradigm (see Appendix B). Its basic stages were as follows.

(1) The client was met by the writer, made as comfortable as possible, and the introduction took place, its primary aim being to create rapport, reduce anxiety, and to explain the nature of the therapy.

(2) The first leading statement or question was aimed at eliciting the presenting problem and at facilitating the diagnostic implications, having regard to the client's subjective interpretation of his problem.

(3) A clear definition of the problem was sought, aiming at identifying what the real problem was, and whether the presenting problem was the real one.

(4) The "here and now" was emphasized, with the objective of bringing out pertinent and relevant feelings. At this point the subject was required to fill out the Kinsey Scale, and to explore aspects pertaining to the levels of homo-heterosexuality. It was explained that this would facilitate the process of therapy. There were reasons for asking the client to do this.

(a) It facilitated knowledge of the client's self-understanding

(b) The client committed his thoughts to paper

(c) A lead-in for discussion was provided.

(5) The problem was partialised and focus placed on a specific area. This helped to:

- reduce anxiety
- find the precipitating area or moment of the onset of the crisis
- control catharsis
- gauge the feeling level of the client
- formulate a contract plan[37].

(6) Alternatives were then presented to the client (basically dependent on interpretation and clarification of the facts and feelings presented by him). The aim was to provide a broad base for the client's growth, to aid the participation of the therapist in sharing facts, and to acknowledge the relevant and appropriate feelings of the client.

(7) After the foregoing clarification, the problem was discussed with the client. The aim here was to reflect the "here and now"[38], to determine the client's insight and level of defences, and to determine his level of observed and expressed anxiety.

(8) The final stage dealt with termination and future planning. This stage aimed at jointly assessing goals of treatment and the concrete formulation of the contract for future sessions (if these were necessary, which depended upon the extent of the problem).

At the end of the session, the anxiety scale was filled in by the writer on the basis of the interview, and filed away, together with the Kinsey document as completed by the client.

A diagnostic intake sheet (See Appendix C) was also completed by the writer to facilitate the process of therapy and to

obtain the necessary demographic data. It must be remembered that all the subjects were assured of the confidentiality of the therapy. In terms of the clinic's policy, they would be entitled to remain anonymous if they so wished.

A PROFILE OF THE SUBJECTS

The clients, who were all white male persons, and whose ages ranged from 18 to 30 years (mean 26,26 years) made contact with the writer over a two year period. It is noteworthy that one of the clients was currently married, and two were divorced with children. Details of the origin of referral, educational qualifications, occupation, religion,and a description of the presenting problem in respect of the client's crises follow consecutively in tabular form.

TABLE 3

Origin of the Contact of the Clients with the Clinic

Origin of Contact	Number
Self-referral and walk-in	9
Clinicians in the field	7
Friends/family	1
Welfare agencies	1
Hospital	1
Medical practitioners	11
All	30

TABLE 4

Description of the Educational Background of the Client Group

Educational Background	Number
Std. 6 - 8	5
Matric	10
Higher or professional qualifications	15
All	30

TABLE 5

Occupational Status of the Client Group

Occupation	Number
Professional	10
Business and managerial positions	9
Civil/Public servants	3
Arts/Theatre	5
University students	1
Unemployed (at time of study)	2
All	30

TABLE 6

Religious Affiliations of the Client Group

Religion	Number
Roman Catholic	7
Methodist/Church of England	8
Jewish	5
Protestant	3
Dutch Reformed Church	4
Non-specified	3
All	30

TABLE 7

The Presenting Problem as Manifest in the Initial Contact

Presenting Problem	Number
Homosexual relationship-breakdown or separation	14
Bi-sexual confusion leading to acute panic	2
Poor self-acceptance (pseudo homosexual anxiety)	2
Guilt feelings, identity confusion, and difficulty in terms of functioning within a homosexual spectrum	12
All	30

V

SCALES OF MEASUREMENT

Testing Materials

Information pertaining to homosexuality has mostly been gathered in the course of long-term psychotherapeutic intervention[39]. Weber describes additional forms of information gathering, such as structured interviews, psychometric tests, anonymous questionnaires, and field studies[40]. In the present study, the writer used two scales of measurement on a test re-test basis.

The two tests used were administered during the first interview and again at the termination of the therapeutic contract. They were:

- The Kinsey Homosexual-Heterosexual Rating Scale (see Appendix D)
- Ten items selected from the Manifest Anxiety Scale (MAS) (See Appendix E).

1. The Kinsey Homosexual-Heterosexual Rating Scale

Homosexuals differ with respect to the degree in which they are exclusively homosexual in their sexual arousal and behaviour. These differences are often reflected in terms of their past and present sexual and emotional fantasies; the degree to which they have responded to a person (both physically and emotionally) of the opposite sex; and the emotional, psychological, and societal contexts in which arousal is most likely to occur.

The Kinsey seven-point rating scale has been the most widely used and accepted scale of measurement in respect of the polar extremes of heterosexuality and homosexuality.[41] Marmor and Green feel that this scale is useful and accurate in that it takes into account both the individual's overt behaviour and his fantasy system.[42] The sexuality of individuals

may hence be rated more precisely than by the mere designation of 'homosexual' or 'heterosexual'. The scale also makes allowance for bi-sexual experience. However, Bell states that while self-ratings of this kind have been exhaustively used, few factors have been analysed in respect of understanding the stimuli which prompt responses. When a person is rating himself on a scale, he is often comparing himself to others.(43) What needs to be clarified is the person's understanding of the word homosexual or, for that matter, heterosexual. His semantic interpretation is often not due to his experience, or the owning of his feelings, but rather to his misinterpretation of the situation because of:

(a) the anxiety state and crisis moment

(b) his rationalisation or other defences in respect of a system which imposes negative value judgements on his behaviour.

Bell stresses the following points with which the writer concurs, and which in fact convey the essence of any research pertaining to homosexuality.

(i) Homosexuals differ individually in terms of their sexual and emotional response, according to their needs and life experiences. Stereotypes must be avoided.

(ii) The physical characteristics and emotional bonding they seek in their partners differ.

(iii) The degree of intimacy in relationships varies.

(iv) The emotional meaning of the relationship differs in respect of each person.

(v) Locales of meeting prospective partners, in which sexual or psychic (or both) contact takes place, differ.

(vi) The extensiveness of sexual preference, repertoire, and techniques differ.(44)

Each of the above parameters affect the measurement on a test such as the Kinsey Scale, and of which research workers must be aware. Furthermore, the above parameters need and deserve extensive investigation.

The main aim in using the Kinsey Scale in the present research was to elicit the following guidelines for the intervention programme.

- It was a way of determining, at the intake level or moment of crisis, the individual's own interpretation of his problem.
- Is he coming in to solve his 'homosexuality' or does he seek relief from the anxiety engendered by his homosexual dilemma?
- The Kinsey Scale is able to help the individual confront his sexuality and emotional involvement with same-sex persons almost immediately.
- The fact that he is committing his thoughts to paper helps facilitate the therapeutic process. The area or focus of anxiety is contracted and is brought within reach.

2. Ten Selected Items from the Taylor Manifest Anxiety Scale

The Manifest Anxiety Scale (MAS) was devised as a method of selecting subjects differing in emotional responsiveness. The rationale underlying the development of the scale was based, firstly, on the experimental evidence concerning acquired fear or anxiety which provides firm support for the hypothesis that anxiety-provoking stimuli invoke internal emotional responses which in turn could increase drive level. (This corroborates the view that when a client has reached a crisis point, the level of anxiety would induce the client to seek a means of reducing the anxiety or stress -- in the case of the present research, actively to seek help.)

Secondly, the MAS was based on the observation that many of the symptoms elicited from or reported by individuals diagnosed as suffering from anxiety symptoms were similar to overt behaviour patterns in studies of acquired fear. Thus it seemed probable that anxiety or fear in threatening situations as described by the experimentalist has properties in common with fear described by clinicians.

Hence, so as to obtain a convenient and objective device for rating subjects, a series of items judged by clinical psychologists and psychiatrists to describe the physiological reactions and the accompanying reports of worry, self doubt, anxiety, etc. were chosen from the Minnesota Multiphasic Inventory (MMPI) to form the Manifest Anxiety Scale[45].

Validity of the MAS

In deciding to use the MAS in this research study, the writer satisfied himself on the following three points.

1) The content validity was consistent with the working definition of the research, i.e. a crisis state as defined in this Paper would produce anxiety manifestations.[46]

2) The concurrent validity of the MAS as a measure of anxiety was well established in terms of the correlations of the scale with clinicians' ratings of anxiety in clients.[47]

3) The construct validity of the MAS as an index of the drive component had been empirically demonstrated.[48]

Using Magoon's validation of the study which differentiated items in terms of level of significance, and by using Busses' study which produced a follow-up item analysis of the MAS[49], the writer selected those items that:

a) were significant at the 5% level or better

b) could be broken down into the following categories:

(i) those that indicated physical anxiety or discomfort

(ii) those that indicated anxiety in terms of verbal content which could be easily rated.

In this way, 10 items produced. These were then used to construct a rating scale using a five-point semantic differential scale for each item. Items were listed in the third person to allow ratings to be made of the subjects. (See Appendix E).

THE DESIGN PROCEDURE AND STATISTICAL RESULTS

A one - group test - retest design was employed. Since the data are ordinal and the same size relatively small, a t-test for related samples was used to test for the significant differences between the one group test-re-test design.(50)

Test (Initial contact)	Treatment (Intervention)	Retest (Termination)
t1	X	t2

First ratings in respect of the MAS (10 Selected items)were made immediately after the first session and then filed away for future reference.

The final rating was made after the completion of the last therapeutic or contract session. It was thus totally independent of the first rating. (In order to gauge the emotional and/or physical responses pertaining to the scale in respect of the client's anxiety, the writer asked specific questions of the client during the course of therapy.)

A mean of 4,533 sessions took place between the first and last interview for all clients. While the writer was in contact with his clients throughout this period, his final ratings were

influenced by his appreciation and understanding of the clients at the terminal stage of therapy, and were not influenced by earlier ratings.

The results of the two tests for related samples appear hereunder.

1. The t-test for related samples (Kinsey)

   t = 1,875 (for degree of freedom (N-1)) = 29

   p = .05

   This means that there was no significant difference in the homosexuality - heterosexuality ratings as identified during the first session and upon termination.

2. The t-test for related samples: (The 10 item selection from the Manifest Anxiety Scale)

   t = 15,46 (for degrees of freedom (N-1)) = 29

   p = ,0005

   This means that the difference between the readings taken at the first session and those taken at termination is highly significant, and not due to chance alone. It may therefore be deduced that the exposure to crisis intervention therapy is successful in reducing the anxiety related to the crisis situation. This result is in accordance with the conclusions of Rusk and of Atkins et al.[51][52] and is expounded upon in the research findings which now follow.

VI

FINDINGS

The findings of this study will be discussed in two parts, first the methodological or statistical inferences concluded from the results of the two tests, and next the clinical implications and therapeutic findings.

A. Methodological or Statistical Inferences

1. The research findings demonstrate that the premise that homosexuality is a treatable concern, the goal of this treatment being to change the orientation of the person to that of heterosexuality, is false.

2. Homosexuality was not seen as a disease condition; therefore cure was not apparent or necessary. This is in concordance with the findings of Atkins et al[53] who found, in a similar study in respect of applying short-term intervention with homosexuals, that because one is working within the framework of a crisis intervention model, there is no attempt to work towards a personality change.
   It is consistent within the philosophy of crisis intervention that the focus of the intervention will not be homosexuality itself, nor a long-term decision about sexual orientation, but only the particular crisis that brought the client to therapy.[54]

3. In the first contact, the majority of clients identified themselves as homosexual on the Kinsey Scale (26 out of 30). They gave their homosexuality as an initial explanation of why they were in crisis: for instance, "My parents have just found out I am gay." In all cases, the clients wanted to talk about their homosexuality, but it usually was presented within the context of the problems (the crisis) they faced, the anxiety accompanying their problems, and the difficulty in placing the crisis moment in perspective.

Thus it seems apparent that the crisis experience was a primary concern, and the homosexual "qualification" was secondary. In other words, the issue of homosexuality in itself was found not to be the area of therapeutic concern. Clients needed therapeutic intervention because of a state of crisis related to homosexuality, and the homosexual condition per se was important only because of its consequences within the total crisis situation.

B. The Clinical Implications

The clinical implications and therapeutic findings will be discussed under three heads, viz. anxiety, Golan's model as an aid in identifying the stages of homosexual crises, and specific techniques evolved from the study, (with specific emphasis on homosexuality).

Anxiety

Three basic forms of anxiety have been isolated as a result of the present study.

(a) The first form of anxiety is specifically related to the crisis event. This is dealt with by Rusk[55] who interprets the crisis state as related to the inadequacy of the ego's adaptive and creative capacities to handle the stimulus (change of input to the system). The mild anxiety signals (the normal anxiety range in an individual) are replaced by increasing anxiety, which constitutes a threat to ego equilibrium and integrity.

(b) The second form of anxiety may be termed therapeutic anxiety. It in turn may be analysed into different components.

(i) There is an anxiety factor which acts as a drive to seek help.

(ii) The fantasies accompanying the help-seeking process, i.e. the person's fears of becoming a patient, evoke a form of "meta-crisis". The person experiences a feeling of powerlessness and loss of control of his situation, which in turn precipitates specific feelings of apprehension, fear, and guilt.

(iii) Feelings of anxiety are directed towards the therapist, who the client may initially distrust, particularly about homosexuality. Thus a period of "testing-out" behaviour is apparent, often with the client asking the therapist about his views and feelings pertaining to homosexuality. Atkins and associates make the important point of not exclusifying the homosexual crisis from other crises. They stress that the anxieties presented by persons in homosexual crises were in general similar to heterosexual crises. Nevertheless, they were able to identify specific instances where the crisis was unique to the homosexual person.[56] Examples of anxiety uniquely associated with homosexuality included the process of "coming out" or being discovered, anxiety to family or community reaction to homosexuality, and the fear of being labelled or not accepted by the therapist. This last point in the writer's opinion has important implications for the reduction of anxiety, for it is within the therapeutic process that the therapist becomes the client's <u>significant other person</u>, and a process of ego-borrowing or identification is apparent. This point has been endorsed by Rosenbaum and Beebe who state that all initial interviews are

> predisposed towards anxiety, as well as the loaded questions of the therapist, and the client's need to transfer his pain onto the therapist. Hence one of the immediate tasks of the therapist is to remove these initial symptoms to reduce the state of therapy-induced anxiety.[57]

(c) The third form of anxiety may be termed "true anxiety". This is the phase of re-integration, where the crisis becomes manageable, and where the client acknowledges his problem and begins to work on the solution. As crisis intervention is short-term, and aims at restoring the person to his level of comfort prior to the onset of the crisis, not all the anxiety will be removed. True anxiety is seemingly in accordance with Aguilera's concept of the use of anxiety factors to motivate the client towards growth[58]. This is best described in the form of an example, where a client expresses no anxiety in respect of his homosexuality, but expresses concern in respect of meeting a person in the future, who will help to fulfil his needs -- especially if he has just experienced a loss in terms of a relationship. Thus true anxiety is the process whereby the client and the therapist explore future anticipations in respect of the crisis situation.

Having described the various correlates of anxiety that were extrapolated from the clinical findings, the writer wishes to discuss the five basic stages of Golan's model of crisis intervention,[59] special emphasis being placed on the homosexual - anxiety-crisis triad that emerged from the study. The model is cited below with the writer's premise on the one side, and Golan's rationale on the other.

Homosexual-Anxiety-Crisis	Golan's Model
Stage One	**The Hazardous Event**
This represents recognition by the individual of his state of anxiety. He confronts himself with a change in his life space. In respect of the study, the hazardous event which caused the crisis in each of the clients was either an acknowledgement of a "homosexual feeling" or the result of being homosexual. Hence the hazardous event is two-fold. First there is a build-up of internal and external stimuli, which pertain to the individual's self concept, his sexuality, and his presenting confusion. (This occurs within the boundaries of his homosexual dilemma.)	A specific stressful occurrence, an external blow or internal change occurs to an individual in a state of relative stability. It is the starting point that provides a base line for gauging changes in the person, and can usually be found by probing the person's relative recent past. Such events can be classified as anticipated and predictable, or un-anticipated and accidental.
Secondly, there is the actual result of homosexual behaviour, e.g. two men in a relationship with the threat of it disintegrating. Thus the hazard is not necessarily homosexuality *per se*, but the implications of the relationship turmoil within the context of two men living together.	
Stage Two	**The Vulnerable State**
In the present study the vulnerable state was evident in two ways. First there is a recognition by the client of his vulnerable feelings, specifically directed towards the	This is the subjective reaction of the individ-ual to the initial blow both at the time it occurs and later. He

therapist. Secondly, there is the actual fantasy the client reveals in respect of his present feelings of discomfort and confusion. This includes his interpretation of the consequences of his crisis, for instance, his acknowledgement of self-acceptance but fearing to impart his "homosexual behaviour" to significant others (parents, friends or employers.) A further manifestation of this stage found in the study includes feelings of psychological danger and a projection of negative attitudes onto the homosexual world -- a "twilight" system of psychological defences emerge which reflects the client's need for self-protection.

Stage Three

The precipitant was revealed by all the clients in the first session by virtue of their acknowledgement of a homosexual state, or panic situation, and by the writer's exploring the most recent critical moment that led them to seek therapeutic intervention. It must be noted that the anxiety, per se, was not necessarily the precipitant, rather it was the manifestation of the strain or may see it as a threat, loss or challenge. Each of the reactions is accompanied by high levels of anxiety.

Precipitating Factor

The precipitating factor or precipitant is the most important facet of the crisis sequence, for it is the most recent event or link in the chain of stress-provoking events that converts the vulnerable state into one of disequilibrium. The precipitating factor is frequently stated in terms of a presenting problem.

signal, warning the individual of his inability to cope. In the study, the precipitant refers to the actual breaking up of a relationship, an act of physical violence, the fear of being alone, the guilt at being found in a gay club, the reaction of the person to female rejection, etc.

Stage Four

This features the critical stage in therapy where contracting and the focusing or partialising on the individual's responses becomes a major task. This period indicates a strong tendency on behalf of the therapist to do a lot of work. He sustains and interprets the anxiety in a meaningful way to the client. (The process of true anxiety is dealt with). At this stage the emotional components of the reality phases ensue. The acknowledgement of the loss and the right for the individual to express the appropriate emotion, e.g. anger, sadness, in the safety of the therapeutic bond is dealt with. It is the stage where alternatives and suggestions are given to the client, helping him to get in touch with aspects of his genetic past (vulnerable stage) into the genetic present.

The State of Active Crisis

This describes in a more longitudinal way, the individual's subjective condition. There is a period of painful preoccupation with the events leading up to the crisis state, often a preoccupation with loss. His normal defences are still at ebb, and emotional discomfort and psychic pain are intense. This is the key aspect in crisis theory and should be the determining factor in the decision whether or not to use the crisis approach as the treatment of choice.

In the study this stage reflects the understanding of the facets of the crisis, with the aim of offering the person alternatives, or a realistic appraisal of his dilemma. Clarifications pertaining to homosexual life styles are offered, as well as allowing the client to search for his appropriate feelings related to the crisis event. In the instance (say) of a homosexual relationship discontinuing, this stage facilitates the exploration of the client's feelings of self worth; cynical or sceptical attitudes related to his loss and helps him restore maximum perspective in respect of his total person.

Stage Five

Re-integration Phase

This stage reflects growth and movement in therapy, and the ability of the client to risk himself and find new alternatives. It is also the process whereby termination begins to take place. If necessary, this phase makes provision for referral, and the providing of tasks (e.g. for the client to visit a gay club, contact his ex-lover, re-explore his fantasies or reconcile ambivalent or confused feelings related to the "homosexual happenings" which initially caused concern.

This is an extension of the state of active crisis, as the tension and anxiety gradually subside. The anxiety is now recognised as a meaningful process and is not negated. New areas of adjustment, either adaptive or maladaptive, are to be found.

These tasks aim at eliminating twilight areas in the client's current dilemma and offer him future projections and/or alternatives in terms of his specific problem area.

Although the stages as expounded by Golan are clearly identifiable within a continuing process, they are in practice not so logically demarcated. All five stages can occur in one interview, and indeed occurred in the above study, particularly with the client who had only one or two sessions. The purpose in using Golan's structure is that it gives a valuable guideline to the therapist in respect of:

(a) focusing on the immediacy of the problem or crisis

(b) understanding the precipitant (which aids the diagnostic effort)

(c) placing the anxiety and fantasy expressions into a meaningful context for the person.

Specific Crisis Intervention Considerations for the Treatment of the Person in Crisis in respect of his Homosexuality

Before one can isolate the therapeutic indices within the framework of a treatment model, it is essential to understand the homosexual spectrum. The following summarised profile is offered here.

The Homosexual Spectrum

Homosexuality (as the term is employed in the present study) is a relationship between two men. It includes both an emotional and physical bonding. The concept of maleness is vital -- it is a man who becomes the basis for the fulfilment of the desired need. The emphasis is on the physical and sexual characteristics as well as the emotional and social qualities purported to lie within the realm of masculinity.

Homosexuality is primarily manifested within a fantasy system that incorporates a symbolic or erotic as well as emotional component. A desire to encompass or be encompassed by a man is very evident, and will vary according to each individual's personality, life style, emotional wants and needs, and his own projection of his sexuality.

The Homosexual Happening

A kaleidoscope of feelings pertaining to homosexual anxiety emerged from the study. The follow extracts from the research, give a clear indication as to the diverse, and often painful emotional and moral conflicts which confront a person in homosexual crisis.

Fear: "It can't be happening to me. I must block it out. I must repress it or act out as society deems correct. It's wrong."

Loss: "I can't really form meaningful relationships. I cannot have children. I can't walk arm in arm with my lover. My family have rejected me."

Guilt: "I have religious and moral conflicts. I am not a man. I am letting myself and my family down. I will be punished."

Law: "It is illegal. I am in fear. I will have to go underground. I am frustrated because I am dishonest."

Confusion: "Some say it is normal, others not. I can't really relate to people. My fantasies torment me. I live by double standards."

Searching: "I expend energy. I read books and become frightened. I seek other gays and go to clubs and bars. Where can I meet the 'right person'?"

Bearing the above in mind, the writer will now highlight a 'blue-print' of treatment tecniques which, although generic to the model of crisis intervention, have specific ramifications for homosexual crises. These techniques have been isolated from the study, and can be used when working with a client in homosexual crisis.

Existing Treatment Strategies

Rapoport[60] points out that as yet there are no well-defined or developed treatment criteria in crisis-oriented brief treatment, any more than there are in any other casework approaches. Rusk, however, in a later critique of therapeutic strategies, elaborates on the crisis therapeutic approach, and draws considerably from two major sources:

a) The researchers at the Benjamin Rush Clinic[61]

b) Major theorists contributing towards the new concept of short-term therapy, with the emphasis on ego process and development in crisis.[62]

The classic model, as used by the Benjamin Rush Clinic, clearly demonstrates the active structuring and prescription of typical therapeutic responses:

(i) The assessment of the severity of the crisis

(ii) The planning of intervention

(iii) The intervention itself, incorporating the following objectives of therapy[63], the list however not being by any means exhaustive:-

- To describe to the person the problem as the therapist sees it, integrating the present crisis into the perspective of his life pattern, without losing the here-and-now orientation of the treatment

- To help him to gain a cognitive grasp of the issues at hand, at the same time bringing into the open his present feelings to which he may not have had access

- To bring into play previously learned behaviour patterns not being employed at present

- To explore with him the alternative mechanisms of coping with the problem, and different ways in which the problem may be seen and defined

- To consider re-peopling his social world and re-distributing the role relationships within it

- To clarify and re-emphasize an individual's responsibility for his own behaviour, decisions, and way of life.

(iv) Anticipatory Planning.

The fourth step above, anticipatory planning, calls for further comment. As time passes, and the hoped-for reduction in anxiety and increased ability to cope occur, a summary is made of the changes which have resulted, thereby reinforcing the adaptive behaviours which are developing. Help is given to the person in making realistic plans for the future. Although the necessity for long-term treatment occurs only in the minority of cases, plans for referral for such treatment may be made (if need and motivation for it are present). Also explored are specific ways of warding off future crises, using the new coping tools which the person has gained during the consultation(s).

Golan in her latest work Treatment in Crisis Situations, 1978,[64] has formulated a model with four stages which include many of the points as discussed above. She has synthesised aspects or tenets of the major therapeutic approaches as follows. (It is within this paradigm that the writer wishes to isolate the specific techniques used in the research.)

Stage 1: There is immediate focus on the crisis situation, which involves ascertaining the precipitating factors, and gauging their severity.

Stage 2: Cognitive awareness of the crisis situation, and the consequent feelings of guilt, anxiety loss, fear, etc., are stimulated.

Stage 3: This stage attempts to partialize, and focus on, the crisis situation. This involves formulating and defining the problem, breaking it up into manageable parts, and setting goals.

Stage 4: Acceptable and available alternatives are found, possibly involving significant others and community resources.

Specific Techniques Gleaned from the Present Research

A. The Immediate Focus on the Crisis Situation

Technique No. 1

Create rapport, indicating that it is not taboo to speak about the crisis. Acknowledge the relevant and appropriate feelings, giving recognition to the aspects of loss and the symptoms related to the loss. Explore the area pertaining to the anxiety, and ask for the client's own interpretation of his problem. Technique No. 1 is entitled semantic interpretation and reflection.

"Tell me what you understand by homosexuality or being gay?"

"What feeling does this evoke in you?"

Technique No. 2

Deal with the obvious anxiety, and the resultant 'scaredness' of revealing intimate details.

"Can you share your anxiety with me?"

"What do you feel has contributed to the crisis?"

"Why have you come to see me now, and how did you cope previously?"

Technique No. 2 involves isolating the precipitant, gauging the client's previous areas of coping and his latent ego strengths, and allowing for affectual release.

Technique No. 3

Ascertain the severity of the problem. This will include the relevant exploration of sexual behaviour, as well as understanding the person's concept of the self.

"How do you feel about yourself as a person?"

"How do you feel about talking with me?"

"Is there anything that disgusts you, or frightens you about the subject of sex?"

"Can you share your fantasies with me?"

Technique No. 3 involves the presentation of genetic past material as related to the genetic present. It focuses the person's attention on the present and the here and now.

Technique No. 4

Deal with the role barriers that exist between the therapist and client. This will include the creation of an atmosphere of acceptance within the rather delicate profile of homosexuality. Bring the client's feelings to the surface and motivate the client to "own his feelings". Focus on the "here and now", and engage the client in realistically appraising his crisis state. Technique No. 4 is entitled confrontation and mirror feedback or reflection.

"If you do not understand what is making you feel confused, then it is extremely difficult for me to help you."

"Your confusion is overwhelming, and makes me feel anxious. Let us explore this confusion of yours as it relates to your problem."

B. Stimulation of the Cognitive Awareness of the Client

Technique No. 5

Formulate the levels of the severity of the problem. Use the didactic method of interpretation and clarification based on the client's presentation of his script. Technique No. 5 consists of the selective use of history; the conceptualising of the complaint and the feedback to the client relating to the levels of crisis, anxiety, loss, guilt, and feelings.

"What factors if any, make you feel comfortable, or in fact do you enjoy about your feelings of homosexuality?"

C. Partialising and Focusing on the Crisis Situation:

Technique No. 6

Make use of the contract[65]. In doing so, emphasize the following points:

a) break down the role barriers between the therapist and client, and promote an element of risk from both parties, as there is no longer a therapist-client model with which to contend -- rather, a person to person configuration is worked upon

b) lead in to discuss feelings of transference more systematically -- a primary treatment objective is to allow the person to "borrow the ego" of

the therapist, but not to become dependent on the therapist, or to regress maximally (as in analysis)

c) allow for symptom management, so that the client does not focus on repeated areas of conflict, but rather gains perspective into his emotions underlying the crisis state

d) help with the termination process, which is indicated to the client during the course of the first session -- each interview must be regarded as being the last one, and have a beginning, a middle, and end.

Technique No. 7:

Formulate the problem into manageable parts so as to facilitate the following dynamics:

- minimise anxiety
- help bring on controlled catharsis, which eliminates the possibility of dropout -- client should not feel totally empty when he leaves, but, because of certain tasks he has to fulfil (either in writing or in action) he often would need the therapist to help him carry them out.

Technique No. 7 also helps to prevent indiscriminate history-taking, and to focus upon the crisis, the hazard, the precipitating factors, and the pre-morbid period prior to the crisis.

D. Finding Acceptable and Available Alternatives

Technique No. 8

Focus upon the process of future anticipation. This projects the person into his immediate future, and aids the realistic anxiety syndrome. It also facilitates the

process of positive ego restructuring and endorses the client's strengths rather than concentrate on areas of weakness or patterns of non-adaptive functioning.

"What do you think you will enjoy or find constructive when you go to a gay club?"

"How do you think you will feel when you leave the clinic?"

"If you are going to tell your parents that you are gay, let's talk about your possible fantasies and fears, as well as your anticipated response from them."

Technique No. 9

Concentrate upon the double bind phenomenon, whereby the person is not only being prepared for the future (a basic tenet of crisis intervention) but the possibility of a repetition of the same crisis as well as the client not returning for therapy is reduced.

From the above, a format, or blue-print for treatment strategies can now be offered. It is by no means complete, but synoptically brings together all of the foregoing, in a set of guidelines such as a manual of operation might contain.

1. Create immediate rapport indicating that as far as the therapist is concerned, it is not taboo to talk about homosexuality, nor will the client be judged on the basis of his homosexuality or of his concern with it.

2. Deal with the obvious anxiety, and bear in mind that speaking about a fragile topic will induce embarrassment and possible withholding of information.

3. Explore recent sexual behavioural patterns which will include both fantasy exploration of homosexual and heterosexual attitudes.

4. Remember that the exploration of fantasy levels is the most accurate form of understanding homosexual behaviour[66]. The following three points (with their subdivisions) will be helpful.

   (a) Fantasy is a conscious determinant of a person's thought process, i.e. it is self-induced and can be controlled by the person.

   (b) The fantasy should be understood in terms the person's present needs, and the following questions should be asked:-

      (i) Is the fantasy erotic and does it produce erotic sexual implications?

      (ii) Is the fantasy in accord with Ovesey's definition (i.e. that homosexual fantasies and wishes often have their roots in unresolved power and/or dependency needs, having little to do with homosexual impulses or urges <u>per se</u>)?[67]

5. Explore carefully the person's emotional needs and wants in respect of the homosexual spectrum, including:-

   (i) the Narcissitic element

   (ii) the need to be possessed by a man or possess a man

   (iii) the need to be different (rebellion)

   (iv) the need for emotional as well as sexual involvement with another man.

6. Briefly ascertain the person's sexual history, i.e. onset of homosexual fantasies, involvement with persons of the same sex, masturbatory processes, and allied fantasies.

7. Briefly explore social history in respect of

   (a) childhood experiences, specifically if there were any sexual traumas

   (b) relationship and attitudes towards parents and family and/or significant others.

8. Explore self-identity and self-worth -- both at a physical and emotional level.

9. Understand the person's cultural background, both in the context of his social milieu and that of the homosexual subculture. Hence be aware of dress, jargon (argot), and attitudes.

10. Actively explore areas of unresolved conflicts, particularly:-

   (a) guilt in respect of homosexuality, religion, society, family, work, etc.

   (b) relationship conflicts

   (c) previous treatment or psychiatric "illness"

   (d) emotional manifestations such as anger, hate, depression, anxiety, etc.

Concluding Note on the Treatment Process

Crisis intervention measures the therapist's ego strengths as well as his capacity for working at a fast and highly emotive pace. Multiple systems and variables must be considered, including the therapist's own personality and his attitudes towards sexuality; the client and his crisis together with his addendum of related problems; agency policy; and wide societal implications.

According to Rusk[68] good therapy is based on the results, and the ability to assist the person to adapt to crises less histrionically. Often the most useful benefit a client derives from crisis intervention is the feeling that he has the genuine interest of a confidant and professional person, and the assurance that the therapist or his colleagues (as was the case at the Johannesburg Crisis Clinic) remain available 24 hours a day, 7 days a week, demonstrating continued interest, concern, and support during the days and weeks of precarious balance that follow the initial crisis visit.

VII

EVALUATION

An important reason for the preponderance of unenlightened views on homosexuality is the lack of sophistication in behavioural science research. The literature, specifically in the area of medical research, is replete with studies on homosexuality, employing small biased samples -- usually of a patient population or a prison group. The results are always almost predictable. Most of the sample populations are found to be riddled with psychosocial pathology.(69)

The researcher, at the outset of the study, must answer the following questions.

- What is the nature of the homosexual population?
- What efforts were made to reach highly inaccessible individuals?
- Will the sample include a diversity of life experience?
- Is a control group utilised?

In an attempt to explore the efficacy of the crisis intervention approach with persons experiencing homosexual crises, the writer draws attention to the following major theses which were deduced from the study.

(1) Crises produce anxiety which is clinically measurable, and which manifests in various forms.

(2) The application of crisis therapy reduces the manifest anxiety of the individual into manageable adaptive patterns of coping.

(3) The anxiety experience, i.e. the current anxiety, is placed into perspective within the therapeutic structure.

> behaviour and reproduction. It would seem that the introduction of information on homosexuality in the context of a valid and non-moralistic framework, rather than as an unacceptable form of sexual expression, would affect attitudes in a positive way.

The writer now proceeds to discuss the limitations of the study, within the methodological framework. Although the limitations include weaknesses in the research design and its application, certain conclusions emerge which highlight important clinical assumptions reflected in the research. Bell[71] warns clinicians who are involved in clinical studies, particularly within the framework of therapy involving homosexual persons, that they should constantly remind themselves as to the number of parameters that are evident in the assessment of a patient's homosexuality. He points out that, as the therapy (or the study) progresses, the various dimensions of the homosexual experience can change. Thus the clinical study is often determined by the subjective interpretations and the skills used by the therapist (researcher) concerned.

1. The Sample

The sample was limited to males between the ages of 18 and 30 years.

(a) Clark found that most homosexuality concerns are acknowledged in the late teens and early adulthood.[72] This point has been endorsed by Erikson[73] who postulated that sexual identity and experience is discovered in the adolescent years and carried through to adulthood.

(b) Saghir and associates claim in their research that the peak periods for establishing homosexual identities and the forming of relationships occur with individuals in the 20-29 year age range.[74]

(c) A further rationale for the "cut off" point in selecting the sample was the fact that the majority of the clients attending the clinic were males, and that their age range fell into the category of 15-30 years.[75]

(d) The study was limited to male homosexuals only. Female homosexuality has similar psychological references to that of male homosexuality; but female sexuality and homosexual experiences have many variant psychosocial and specific cultural determinants requiring discussion beyond the scope of the research.[76]

2. The Rating

The subjects did not do the actual rating in respect of the primary scale of measurement (The Manifest Anxiety Scale). The therapeutic milieu does not necessarily provide for accurate ratings, specifically when the client is in a state of emotional distress. While the scientific importance of rating is acknowledged by the writer, the study was essentially involved in a delicate relationship between the therapist and his clients. Hence for ethical as well as practical reasons (the clinic had no one-way mirror facilities) it was not possible to have independent raters (which would have allowed for maximum control and comparison).

The drawing up of the scale posed the largest methodological problem. Instead of drawing up a questionnaire which rated specific items or measured attitudes, etc., the writer reviewed the literature in order to select an appropriate anxiety scale[71]. A scale that most suited the study was the Manifest Anxiety Scale (MAS). This scale, however, utilises many self-rating (qualitative) items which were invalid for the study. Thus the adaptation of the MAS was rather arbitrary, in that it had not been psychometrically assessed for the purpose of the present research. This means that reliability and validity are absent.

However, the scale does have face validity, as it has effectively differentiated the client responses in terms of the therapeutic assessment (the lowering of anxiety, and placing the crisis into perspective).

In respect of the Kinsey Scale of Measurement, the writer refers the reader to the critical overview as discussed on pages 22-24 in the present study.

3. The Control Design

The study does not allow for maximum control design, and uses a minimal control method of a one group test - re-test situation. It has the advantages of internal validity as it provides for the comparison of the same group of subjects. According to Stephen Isaac, in his Handbook in Research and Evaluation,[78] this kind of study provides a control for selection and mortality variables if the same subjects take t1 and t2. This feature was taken into consideration in the study. At the same time, Bell clearly points out[79] that studies which do not include control groups with matched age, socio-economic status, education, etc. are often not scientifically valid. However, he discusses the contention that control groups do not always have clear significant differences, and that in any one study one is apt to find a great deal of overlap between comparison groups. The reader will need to guard against constructing a stereotype of the homosexual -- on the basis of statistically significant differences reported between the two groups -- which does not fit even the majority of the homosexual sample, much less a given individual.

4. Experimentor Bias

Although all the interviews were carried out by the writer, the following control design was employed.

(a) The criteria for the selection of the sample were rigidly adhered to.

(b) The method of therapy, as well as the techniques applied within the framework of crisis intervention, was administered to the entire group of subjects with as little variance as possible.

(c) All the subjects were exposed to the two tests, and in all cases a clinic diagnostic form was completed by the writer.

5. Clinical Bias

Transference and Countertransference

Within the context of therapy, transference is that phenomenon which occurs when the client displaces feelings, needs, desires, and often unfinished business related to his past onto the therapist. Alternatively, countertransference refers to the therapist recognising those elements in the client's person which include similar experiences and emotional displacement of feelings as being similar to his own. It is important to note that, whilst the literature[80] warns one of the therapeutic consequences of the transference phenomenon, crisis intervention endorses the conscious use of the self (or person) as therapeutically valid. Thus transference and countertransference are essentially highlighted at the beginning of the therapeutic contract; with the primary goal of engaging both the client's and therapist's feelings about each other. This point is significant within the therapeutic process for the following reasons:

(i) it facilitates the contract system

(ii) it helps eliminate fantasies and anxieties the client may have about the therapist

(iii) it helps with the termination process

(iv) it can bring out the conscious use of the therapist's self -- a necessary feature to facilitate the client's projection of feeling

toward him, which may be valid in respect of the client's sexual concerns

(v) it promotes progression rather than regression, which in fact is the aim of long-term therapy.

Thus, whilst transference and countertransference did occur in the study as an "uncontrolled variable", cognizance of these two powerful therapeutic agents were taken into consideration by the writer.

6. Follow-up

Follow-up after the completion of the therapy was not, for the purpose of the study, measured. The efficacy of the intervention programme in terms of a longitudinal study was not evaluated. Caslyn and colleagues[81] criticise this limitation, reporting that relatively few outcome studies have been undertaken to describe the conditions under which crisis intervention is successful. This point has bearing for future research in the field. However, the writer wishes to stress that the crisis intervention approach has the primary task of helping the individual confront his crisis in manageable terms, and restore him to a position of relative comfort, prior to the onset of the crisis. Crisis intervention does not set out to change the personality of the individual, a process which is often long-term and time consuming.

VIII

CONCLUDING OVERVIEW

In terms of people experiencing crises in respect of their sexual problems, and more specifically with homosexual concerns, there seems to be a need to establish a sophisticated approach geared to serving persons who are experiencing:

- crises in respect of homosexuality concerns
- anxiety as a correlate of the crisis situation.

It would seem that the crisis intervention approach as mapped out in this study could offer a blue-print for practitioners in the field.

Crisis intervention is particularly applicable in terms of working in the context of the "immediacy" of the problem. Crises, specifically when precipitated by a sexual or allied concern, will not wait to be solved. They are, by their very nature, time limited, the individual usually restoring his equilibrium either adaptively or maladaptively. The chances of slipping into a further confused state if intervention is not offered at the appropriate moment cannot be ignored. Inherent in the philosophy of crisis intervention is the premise that services, either specific (e.g. a counselling centre for sexuality concerns) or generic, should be established on a 24-hour basis.

Small[82] has maintained that, during the crisis period, there is a "propitious moment" at which the crisis intervention will be most successful. The implications arising from this are that sufficient mental health personnel should be available during the period of the crisis for all the opportunities to be utilized and maximized. Hence there should be no waiting list for treatment.

Crisis intervention also makes strategic use of the fact that the crisis and its accompanying anxiety represents a turning point for the individual, i.e. a crucial point of "no return".

In utilising the propitious moment, or the critical stage, as well as the individual's readiness to help himself (through intervention) in seeking a solution to the crisis event, it is possible to resolve the crisis on a higher level of emotional and cognitive functioning.

This view has been expounded by Zimbler and Barling[83] who suggest that the critical stage has to be successfully negotiated in order to make use of the growth-facilitating potentialities of the crisis, and not necessarily the moment of crisis itself. It is apparent that the moment of crisis is metaphorically likened to a "first aid" or emergency setting, where, in the case of the client in crisis, an immediate warm, empathetic and supportive stance is required from the therapist. The critical stage allows for a more directive approach, using the strategies associated with the intervention model. This process, which has been described in the present study, will be cited hereunder in the following comparative table.

TABLE 8: THE DIFFERENTIATION BETWEEN THE CRISIS MOMENT, ANXIETY, AND THE CRITICAL STAGE

	CRISIS MOMENT	ANXIETY	CRITICAL STAGE	TERMINATION
Time Perspective	A scanning of the last 24 hours Understanding the precipitant factor	Heightened, and related to the build-up of the crisis state	hour/days/ weeks	1. Time limited 2. Open door policy
Emotional content	Confused, helpless and disoriented. Feelings of loss are apparent.	Anxiety is presented as confused, i.e. as related to the crisis, to therapeutic commitment and a fear of the outcome or future gains.	1. Direct and specific feelings 2. Discussing the anxiety as a response to the crisis and its associated problem area	Full emotional repertoire experienced, and reported upon.
Major therapeutic objectives	1. Risking the relationship 2. Offering support, and a clarification of objectives 3. Sustaining the client 4. Allowing for no time limit in the first interview.	1. Placing the anxiety into perspective 2. Beginning to isolate the crisis anxiety from the therapeutic anxiety 3. Emotionally bonding the therapist and client.	1. Contracting in order to solve problem 2. Sharing responsibilities 3. Placing precipitant factors into perspective.	1. Outlining future goals 2. Testing out new directions 3. Discussing levels of gained insight.

Table continues ...

TABLE 8 (Contd.) THE DIFFERENTIATION BETWEEN THE CRISIS MOMENT, ANXIETY, AND THE CRITICAL STAGE

	CRISIS MOMENT	ANXIETY	CRITICAL STAGE	TERMINATION
Therapeutic commitment and the process of prognosis	Full realisation of the loss and its associated pain.	1. The understanding of the emergence of true or real anxiety. 2. Projecting this onto future situations with the full acceptance of the normal range of feelings.	1. The major input of therapy takes place 2. It is action oriented with maximum levels of confrontation 3. Tasks are offered to test the level of manageable anxiety.	Process of gain
Therapeutic styles	1. Unconditional positive regard 2. Breaking down of rôle barriers 3. Nurturing person 4. Therapeutic "capture" offering the client constructive suggestions, and giving a sense of security to him.	1. The ability of both therapist and client to contain the anxiety 2. Reflecting to the client that the anxiety is a normal consequence of the crisis moment. 3. Responding in an "adult to adult" way.	1. Re-evaluation of the contract 2. Time limited sessions 3. Possible referral (if necessary) 4. Dealing with fantasies and the probable residues of transference, and "unfinished" material 5. Preventing the client from leaving with a feeling of being "empty".	Constructive Terminatory

The above table illustrates the characteristics of the crisis sequence, incorporating the elements of anxiety as well as differentiating the crisis moment from the critical stage period. The crisis moment is passed when the client moves from feelings of total helplessness (which is a characteristic of the crisis) either because

a) he has been able to express his feelings fully, specifically his anxiety associated with the loss inherent in the crisis; or

b) he, without the appropriate facilitative assistance, defends against the danger of his chaotic experience by avoidance or denial of relevant feelings.

In (b) above, the growth potential of the crisis experience is lost. In respect of the present study, it was found that the "chaotic experience" was a combination of the following factors.

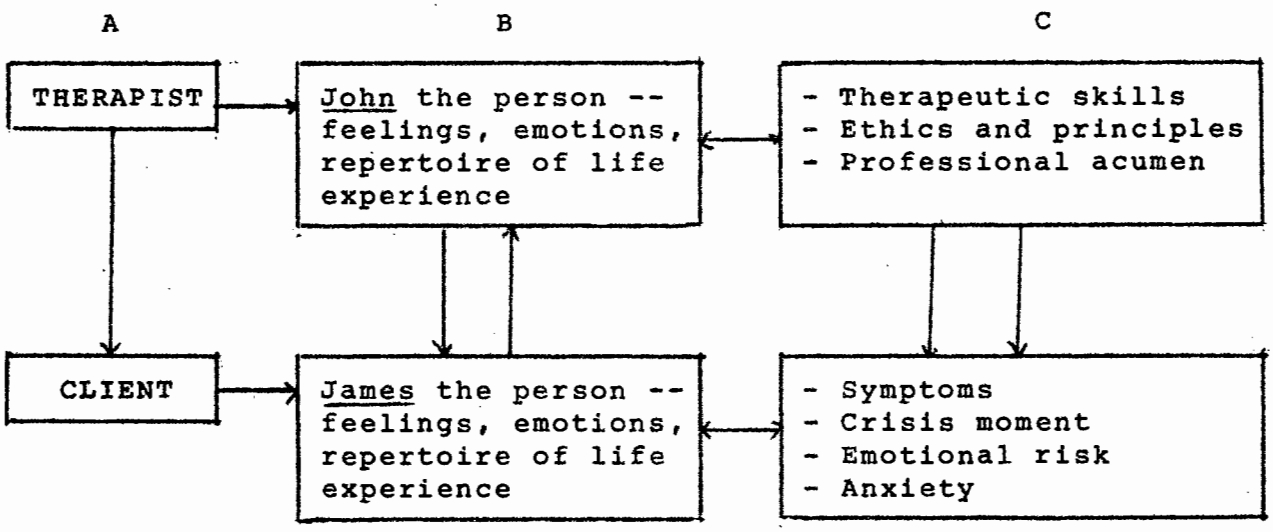
- The presentation of homosexual feelings or behaviour was in itself a precipitant of mixed or ambivalent anxiety manifestations.
- The anxiety emerged in three categories (as discussed in the findings) and needed to be clarified.
- The "chaos" was the client's last right to claim attention, the crisis moment having been used as a "last resort" defence.

This last point has important considerations. If the therapist deals indiscriminately with the client's defences, he (client) will feel totally vulnerable, and the possibility of his not returning for further therapy could result. Thus the moving out of the crisis moment into the critical stage is marked by the client's beginning to reflect on what has been happening to him. This is the mutual process of client-therapist interaction, where the therapist (a) facilitates, or

acts as a semi-catalyst, by simply moving with the client from the moment of crisis into the critical stage, (b) by placing the crisis moment and its accompanying anxiety into perspective, and (c) by partialising the problem and its related emotional variables into manageable doses. The basic premise underlying this delicate process is the rather creative principle that the therapist does not "gorge" himself on the client's experience. He does not leave the client feeling empty and totally transparent. In fact the critical stage is simply a palpable change in the quality of tension and anxiety release within the client.

This anxiety release, as well as experiencing an acute response to one's homosexuality, is in a way an opening for self confrontation. Therapy, in fact, offers the individual a second chance, and the intervention programme makes full use of this. It allows the individual to resolve both his present dilemma and to be able to work through major unresolved or confused conflicts in the "here and now".

As crisis intervention is non-labelling, it deals with the person in the reality situation. The modis operandi is to separate the person from his problem. This apparent dichotomy has important implications for the total therapeutic process, and can best be illustrated in the form of a chart which follows.



Column A

This represents a traditional client - therapist form of interaction. Role description is in operation, which in fact enhances the therapeutic distance between the two individuals. If one remains the "social worker" (or therapist), and the client is made aware that he is a "client" and put into a position of being a recipient of care-giving in a purely clinical sense, then the clinical or medical model is reinforced, and this perpetuates the role for the client of being "sick". Conversely, if the therapist adheres to his label, it does not allow for his "person" to emerge -- often the label of therapist protects him from his own "insecurities" within the given context of therapy.

Column B

The removal of the label (in a symbolic sense) from the client and the therapist is apparent. The client is acknowledged foremost as a person; and furthermore, the therapist may reveal in an appropriate way those aspects of his person which may enhance the therapeutic partnership. Thus the removal of labels facilitates mutual interaction between the persons involved. This process helps to break the client's misconception of his problem, as well as his probable bias in

respect of his fantasies about therapy. The following extract from a therapeutic dialogue serves to illustrate the above point.

Therapist: "You look extremely anxious at the moment. Can you tell me what is bothering you?"

Client: "You will not understand me."

Therapist: "Your anxiety is making me feel particularly tense. It seems as if you do not want me to understand. Let's both risk your concern together."

Client: "Well . . . I'm, you see, homosexual. I cannot handle my situation."

Therapist: "I see you now, as a person, who is experiencing real emotions. I do not see you as a homosexual as you have labelled yourself. Can we speak about those aspects of homosexuality which at this moment are causing you so much pain?"

This process also has the added advantage of producing a "meta-crisis" for the client, i.e. a crisis within the therapeutic situation. The problem with which he presents is usually his last defence mechanism. When the therapist confronts him with his "person", this is usually the most threatening aspect of therapy, as he becomes more acutely transparent and susceptible, and in fact this is the area that needs to be explored. Thus the therapeutic anxiety is raised, and becomes a focal point for intervention. An added feature in the person to person process is that, by acknowledging the client's dignity and worth, as a separate issue from his self-labelling or the personification of his problem, the area of symptomatology becomes manageable. The client is forced to look at himself.

This clearly has considerations for the type of person who acts as an intervenor. The writer, in a Paper entitled The Principles of Crisis Intervention and Application Thereof[84] lists the

following qualities and skills necessary for intervention according to the above-stated parameters:-

a) An ability to feel the person on an emotional level when he comes in for help

b) An ability to give support immediately

c) A degree of self-knowledge about the therapist's limitations and self-security

d) An ability to facilitate the person's own potential and resources -- the intervenor does not solve the problem for the client but holds him up while he solves it for himself

e) Willingness on the part of the therapist to take an active and sometimes directive approach rôle in intervention

f) Maximum flexibility in the therapist, who, when working within the model of crisis intervention, can make full use of diverse techniques such as acting as a resource person, information giving, and utilising other community resources

g) Acceptance of the efficacy of the crisis model as an essential pre-requisite for effective help

h) Knowledge of homosexuality and its subculture as an added function of the skilled intervenor.

Column C

This serves as an "umbrella of protection" for both the therapist and the client. It is necessary for the therapist to reflect to the client that he is in apparent control, and that, because of his knowledge, skills, and secure feelings, he is able to assist the client. The client, on the other hand, is made aware that his accompanying feelings or symptoms are justified and that through the process of RISK, i.e. both

therapist and client involving themselves within an optimal level of interaction, the skilful use of intervention can be directed towards the understanding (not necessarily the total removal) of the symptoms with which the client presents.

In this way, the traditional disease model is broken down, and the rôle ascription of patient (client) and therapist (social worker) is eliminated, making place for a health model, where the focus is on growth, latent strengths, and potential. This approach seems to limit many of the pitfalls and stigmas attached to "conventional" therapy as practised by traditional agencies and clinicians. The individual is forced, often due to the "task-orientatedness" approach of the therapy, to take responsibility for himself as a person. Because his crisis - homosexuality - anxiety triad is seen as normal and a natural response to stress, the problem of severe regression, and the self-labelling as "mad" or "deviant" that often accompanies traditional modes of treatment, is greatly diminished.

Both this approach, and dealing with sexuality, are essential components in social work. From his experience and the clinical findings, the writer feels that training in this area for clinicians is an essential feature that should be taken into due consideration.

In conclusion, crisis intervention would seem to offer a fruitful approach to clinicians, including social workers, in attempting to help people with their sexual and related concerns. In this age of rapid change, with its growing demand for quality in mental health care services (both from a preventive and curative point of view) crisis intervention offers a fresh, economical, and often highly effective alternative to costly long-term psychotherapeutic approaches. It also has the definite object of removing an atmosphere of stigma and illness from the repertoire of social pathology, thus offering new perspectives and insights. It is on this note and with such plea that the writer reports on his work. It is hoped that

this small contribution towards improving the mental health and emotional well-being of fellow men has helped to increase understanding, and may thus contribute to future research within this fertile field.

> The dead are the only people
> to have permanent dwellings.
> We, nomads of the Revolution
> wander over the desolation of many generations
> And are reborn on each other's lips
> To ride wild mares over unfathomable canyons
> Heralding dawn, dreams and sweet desire.
>
> EPISTLE TO TASHA
> Rita Mae Brown
> (Out of the Closets)

* * * * * *

APPENDIX A

GLOSSARY OF HOMOSEXUAL ARGOT (VERNACULAR) CURRENT IN SOUTH AFRICA

AC/DC: A person who has bi-sexual tendencies.

ACTIVE: Usually referring to a person who is sexually active, with the underlying assumption that his major preference is anal penetration (intercourse).

ADA: Refers to the buttocks area, usually in relation to tight pants.

AGATHA: A person who gossips, usually with a malicious overtone.

AGGIE: Homosexual gossip.

AGGRO: An aggressive person.

AFFAIR: Two people in a homosexual relationship.

BELENIA: A physically attractive man.

BELLA: To be beaten up, or to be known as a person who physically attacks homosexuals.

BEULAH: An aesthetically beautiful man.

BETTY: Referring to the arse, or size of the buttocks.

BIT: A general description of a homosexual.

BITCH: A derogatory word usually referring to a person who has a sharp tongue, and who normally causes strife within a clique.

BLISS: Referring to a person or a situation that arouses physical, erotic, or social excitement.

B.M.: A heterosexual person. (Abbreviation of "baby-maker.")

BUTCH: Masculine qualities in a man as opposed to feminine traits.

CAMP: (adjective) A description of a person who dresses or behaves in a manner which advertises his homosexuality. It also refers to extravagant or "kitch" decor, clothes, jewellery, etc.

CAMP: (verb) This refers to specific courting or hustling behaviour to attract attention, or specifically to attract a person with the intention of becoming sexually involved.

CELIA: Refers to offering a cigarette to a passer-by with the intention to "camp" him.

CHICKEN: Refers to young boys who prostitute themselves. May also refer to men who enjoy the company of younger boys.

CHUBBY CHASER:	Refers to a person who is physically attracted to fat or extremely large men.
CLORA:	Refers to a 'coloured' homosexual.
CLOSET:	Refers to a person who has or is known to have homosexual tendencies but has not acknowledged them.
CLOSET QUEEN:	A person who indulges in homosexual activities, but in a clandestine way. Also CUPBOARD QUEEN.
COME:	The ejaculation of semen. Also CUM.
COMING OUT:	Refers to a person who has been introduced to the homosexual "world" and is beginning to participate actively therein.
CONNIE:	Refers to the moment of orgasm, and ejaculation.
CORA:	Refers to a person who is common.
COTTAGE:	Refers to the lavatories where homosexuals frequent in order to indulge in sexual acts.
DELIA:	Refers to an excessively dramatic person. Also known as a DRAMA QUEEN.
DORA:	Refers to alcohol, or to a person who is drunk (dora'd).
DORIS:	Refers to a person who is fickle and particularly stupid.
DRAG:	Refers to female attire when worn by a male, whether in fun or because of transvestism.
DYKE:	Refers to a Lesbian.
FAGGOT:	A derogatory term (in South Africa, but not in America) referring to a homosexual man.
FAG HAG:	Refers to females who are basically heterosexual, but who move almost exclusively within homosexual social circles
FEMME:	Refers to a person who is usually passive and feminine in a homosexual relationship; this includes both attributes of emotional and sexual passivity.
FIONA:	Refers to wanting to fuck a man; to fuck.
FREAK:	In the homosexual context, referring to a person who is radical, and a non-conformist, particularly in respect of dress and attitudes towards society.
F.S.Q.:	Refers to a person who has "film star qualities".
GAY:	The generic description and widely accepted term to describe both male and female homosexuals.
HIGH CAMP:	Referring to obvious homosexual behaviour, i.e. dress, body movements, the content of a movie, home decor, etc.

HILDA: Referring to a person who is physically unattractive.

LETTIE: Refers to a Lesbian.

** LUNCH: Referring to the genitalia; the size and shape of the penis.

MOFFIE: A common South African expression referring to a male homosexual (usually used with sarcasm, or with contempt, but is gradually losing its pejorative connotation).

NORA: Refers to a person who is not intelligent.

NUMBER: A colloquial expression, referring to a person one is either attracted to or involved with.

MARIE: Refers to a person who is eccentric or "mad".

MONICA: Refers to a woman have menstrual periods; or a "send-up" (teasing) of a "femme" person.

OLGA: To be obviously gay.

OLIVE: A very beautiful man.

PASSIVE: Referring to a person who prefers to have anal intercourse practised on him.

PENELOPE: To piss or urinate.

PIECE: Referring to another homosexual person.

POLY-PARANOIA: A person who has a poor self-image or who lacks confidence

POUFF: A derogatory word referring to a homosexual; usually used by non-homosexual persons.

PRISCILLA: Referring to the police or the law.

QUEEN: Referring to a homosexual who has basically absorbed female characteristics into his every-day behaviour.

QUEER: (as noun or adjective) Referring to a homosexual person.

RENT: A male prostitute, or a homosexual who charges for his services.

RITA NUMBER: A homosexual who charges for sex, but who usually goes for older men.

SALLY: To suck someone off, i.e. to perform oral sex.

SCENE: In the sense of belonging to the homosexual sub-culture; a person is referred to "being on the scene" when he is known amongst his peers as a practising homosexual.

STELLA: A person who has a reputation for stealing, and who may be involved in illegal procedures.

** LAURA: Refers to a lover.

S. and M.	(Sado-masochistic): Refers to a group of people who belong to an exclusive culture, involving leather fetish, and brutal sexual acts, e.g. "fist fucking".
SUZY:	To "send a person up", i.e. playfully tease him.
TILLY TOSS OFF:	To masturbate, either alone or mutually.
TRADE:	To have indulged in sex, usually to the point of orgasm, but denoting a transitory experience.
T.B.H.:	Refers to a person who is potentially gay, but mixes with heterosexual persons; it means "to be had", and that the person has the potential to enter the homosexual world.
URSULA:	Refers to a heterosexual person who understands and accepts homosexuals.
WADA:	Refers to pointing out or staring at an attractive person.
WANK:	To masturbate.

APPENDIX B

STEPS TO TAKE IN THE FIRST INTERVIEW

1. Greet, usher person into room.

2. Introduction: aim at creating rapport.

3. First leading question: aim at eliciting presenting problem.

4. Defining what problem is: aim at assessing what real problem is -- if the real problem is presenting one.

5. Emphasis on here and now: aim at bringing out relevant, pertinent, and real feelings.

6. Partialise problem/focus on a specific area : aim at:-
   a) reducing anxiety
   b) finding precipitating area (stress)
   c) helping to bring on controlled catharsis

7. Fact-finding with view to discovering what alternatives the person has : aim to assess coping techniques or hidden ego strengths.

8. Presentation by therapist of extra alternatives (basically on interpretation/clarification of facts) : aim at providing a broad base for client's self determination and give security (client feels he is making his own decision -- hence growth.)

9. Ascertain movement or change : aim at reflecting on here and now -- how is client feeling, does he have any insight, defences, etc?

10. Future planning : aim at assessing goals of treatment.

11. Termination : aim at giving client a guideline as to his problem area; finalise interview and equip him with possible new resources until next interview (if he so desires) -- also facilitate independence on the part of the client.

APPENDIX C

CRISIS DIAGNOSTIC REPORT

(To be completed after initial contact and appraisal and at final session)

_____ _____

Client Date

_____

Age

_____

Crisis Counsellor

A. Presenting problems: (Briefly describe client's problems as initially presented)

_____

_____

_____

_____

_____

B. Appearance and manner in interview (Use one or more words to describe each of the following and motivate your answers where appropriate)

1. Body appearance: _____
2. Dress: _____
3. Movements: _____
4. Speech: _____
5. How client relates to you: _____

C. Psychological functioning (Evaluate client's functioning in the following areas)

1. Perception: _____

2. Thinking: _____

3. Affect: _____

4. Other: _____

_____

_____

5. Tentative estimate of intelligence:

High ( ) Average ( ) Low ( ) Defective ( )

D. Diagnostic Impression:

1. a) Drug and/or alcohol _____

b) Emotional distress (describe) _____

_____

c) Family discord (describe) _____

_____

d) Sexual conflict (describe) _____

_____

e) Marital disharmony (describe) _____

_____

f) Psychiatric disturbance (describe) _____

_____

g) Legal or statutory problems (describe) _____

_____

h) Other (describe) _____

_____

_____

i) No diagnosis made _____

2. Impairment: Mild _____ Moderate_____ Severe_____

3. Are biological changes a factor in the client's present adjustment?

Yes _____ No _____

If YES, indicate which:

Adolescence ____ Pregnancy ____ Menopause____ Old Age ____

Other (specify) _____

_____

_____

E. Recommendations:

1. Return for one or more visits? Yes_____ No _____

2. Is medication necessary? Yes_____ No _____

3. See other persons in connection with this case (e.g. specialist)? Yes_____ No _____

4. At this time are you planning referral elsewhere?

Yes_____ No _____ Maybe _____

5. Other specific measures: (Do not include treatment goals here) _____

_____

F. Disposition:

1. Client accepted treatment recommendations and contract?

Yes _____ No _____

2. Note in detail client's rejections of recommendations:

_____

G. Previous treatment (if any, including facts pertaining to past history) _____

_____

H. Criminal record: _____

I. The Crisis:

1. Dynamics of crisis:

a) What recent loss, threat of loss, or other hazard has occurred in the client's life? _____

_____

_____

b) What are the symptoms of the crisis that have developed from this hazard? _____

_____

_____

_____

c) What long-term problem areas are being reflected in the current crisis? _____

_____

_____

_____

d) What are the coping mechanisms which have been utilized previously which are no longer effective?

_____

_____

_____

e) What are the potential new coping mechanisms which may be used in working with the crisis?

_____

_____

_____

f) Who are the significant other persons in the client's life space who may be used in achieving successful resolution?

g) If no crisis can be identified, what circumscribed problem area has been chosen to deal with the intervention?

2. State how your treatment goals relate to these dynamics. Include your initial assessment; process of interview; your contract plan; dealings with pertinent feelings; and how client was prepared for termination process.

K. Discuss your (counsellor's) needs in respect of supervision:

L. Evaluation after supervision:

M. Final summary (after last contact):

a) Movement or change

b) Qualifying assessment or social diagnosis

c) Final recommendation re treatment model

N. Supervisor's comment:

APPENDIX D

KINSEY'S SEVEN-POINT RATING SCALE

Please write down the number of the statement which applies most closely to you.

1. I am entirely heterosexual: that is I have no homosexual responses (that I am aware of) and I do not engage in any homosexual activities.

2. I am heterosexual, but I do have incidental responses to members of my own sex, and/or have incidental contacts with my own sex, but these are very infrequent and/or do not mean much.

3. Most of my psycho-sexual responses and/or actual experiences are heterosexual, but I do respond definitely to homosexual stimuli.

4. I accept and/or enjoy equally both homosexual and heterosexual contact and have no strong preference for either one or the other.

5. I prefer contact with my own sex, but I do definitely respond to and/or maintain a fair amount of actual contact with members of the opposite sex.

6. I am homosexual, but I do have incidental responses to members of the opposite sex, and/or have incidental contacts with the opposite sex, but these are very infrequent and/or do not mean much.

7. I am entirely homosexual: that is I have no heterosexual responses (that I am aware of) and I do not engage in heterosexual activities.

Answer: .....

Age: .....

Sex: .....

Home language: .....

Religion: .....

Marital status: .....

Occupation: .....

Highest education qualification: .....

APPENDIX E

SELECTED ITEMS FROM THE MANIFEST ANXIETY SCALE

1.	Not calm and easily upset	---,---,---,---,---,	usually calm and not easily upset
2.	Great restlessness, cannot sit long in chair	---,---,---,---,---,	feels rested and comfortable
3.	Very self-conscious	---,---,---,---,---,	not unusually self-conscious
4.	Lacking in self-confidence	---,---,---,---,---,	feeling self-confident
5.	Sweats easily (even on cool days)	---,---,---,---,---,	minimal sweating
6.	Feels useless most of the time	---,---,---,---,---,	does not feel useless at present
7.	Feeling of going to pieces	---,---,---,---,---,	does not have feeling of going to pieces
8.	Shrinks from facing a crisis or difficulty	---,---,---,---,---,	faces crises or difficulties
9.	Thinks of himself as no good	---,---,---,---,---,	has feelings of self-worth
10.	Sleep is fitful and disturbed	---,---,---,---,---,	sleeps easier with less disturbance

Maximum anxiety - 10 (High anxiety = low score)

Average anxiety - 30

Minimal anxiety - 50 (Minimal anxiety = high score)

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