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**AN ANALYSIS OF CLIENT TRENDS IN A GAY AND LESBIAN
COUNSELLING SERVICE**

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Master of Arts (Clinical Psychology)**

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ABSTRACT

Due to experiences of homophobia encountered within mainstream mental health services, sexual minorities have established mental health services that address their needs. This study explored client patterns and trends at Triangle Project, a counselling service, aimed at gay, lesbian, bisexual and transgendered (GLBT) individuals. The data was collected and analysed by examining existing documentation that contained clients' information. This method of secondary analysis also included looking at the Organisation's annual reports and an evaluation report. The findings indicated that GLBT communities favour counselling services aimed specifically at meeting their needs. Furthermore, GLBT individuals do not necessarily present with concerns relating to their sexuality, but there are commonalities with heterosexual individuals' presenting concerns. In addition, it was apparent that gay men and lesbians presented with different concerns. Lesbians expressed their primary concern as relationship difficulties, followed by depression, while gay men reported issues such as loneliness and other situational concerns. White gay men made use of services more so than other sexual minorities of colour. The findings also revealed that youth, lesbians and gay men of colour, were not well represented, and that youth, particularly, were at risk of possibly experiencing mental ill health. This study recommends that it is crucial for mental health workers to be equipped to provide effective mental health services for GLBT communities and that interventions are designed to facilitate and promote the mental health of GLBT individuals. It is also imperative that the GLBT community is not viewed as a monolithic group and that mental health workers are sensitive to differences of culture and ethnicity.

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CHAPTER ONE: INTRODUCTION

1.1. INTRODUCTION

Lesbians and gay men have been branded in our society as "sick", "evil" and "criminal", and have been labelled as "deviant". It is the notion of deviance that creates boundaries between that which is acceptable and unacceptable by the society in which we live. The deviant is, as Klein (1991) succinctly worded it, "...outside the pale of acceptable society". (p.11). The very nature of being outside of what society deems acceptable, results in the attribution of negative perceptions and beliefs, upon which actions and behaviours are based. This is often the experience of lesbian and gay men.

Being labelled as mentally ill is but one of the stigmas attached to lesbians and gay men. Vine (1982), a historian of health care and health advocacy, defines stigma as that which is "based on a culture's consensus that a certain attribute is inherently worthy...it may be any characteristic that is used to differentiate those who are socially acceptable from those who are not" (p.227). She continues to explain that the dysfunctionality of stigma is society's way of protecting itself against dangers that it falsely perceives. This process serves a function in that it grants permission for the humiliation and dehumanisation of the individual. The word "homophobia" has offered an explanation for the hatred and fear homosexuality arouses in many people (Kitzinger, 1996).

Previously, stigmatisation and homophobia was institutionalised and it was only in 1973 that the American Psychiatric Association, due to ongoing lobbying from gay rights activists, removed homosexuality from the list of mental disorders (Hidalgo, 1995). Prejudiced and biased theories and the application of physically and or psychologically damaging "cures" led lesbians and gay men to form their own mental health delivery services which aimed to recognise the gay person's legitimate mental health needs. Counselling services specialising in gay and lesbian issues have been in existence for just over three decades and have originated from gay movements who responded to the inability of the mainstream mental health institutions to accommodate the needs of the gay community. It was recognised that there is more common psychological ground between homosexuals and heterosexuals, and that seeking psychological assistance by no means indicates pathology associated with being gay itself. Counselling services therefore need to be sensitive to and understanding of the issues pertaining to homosexuality.

Parry and Lightbown (1981) argue that lesbians and gay men, need counselling services that provide acceptance and non-judgmental attitudes from service providers, and above all, an understanding and knowledge of the issues of the client. Klein (1991) states that the need for a gay mental health delivery system based on the premise that gayness itself is not a sickness, grew, as did the realisation that the gay individual could not be pathologised because of his/her sexuality. Like heterosexual individuals, lesbian and gay individuals may have mental health needs that are not related to sexual preference and which might well be in spite thereof. Counselling services for lesbians and gay men thus sprang up in response to the need for positive and affirming services and practises for and by gay people (Klein, 1991).

A gay counselling service was established in Seattle, USA, in 1969, and in the early eighties an initiative of a similar nature took place in South Africa. Since the needs of gays and lesbians were not being met by the established mental health system in South Africa, it became imperative to provide mental health services to gays and lesbians. Structures or forums serving the needs of gay men and lesbians formed in the eighties, although homosexuality was still criminalized at the time. It was only after the adoption of the South African Bill of Rights, that these structures were able to function without institutionalised discrimination. One of these structures is now called Triangle Project, and constitutes the focus of this study.

1.2. THE ORGANISATION - TRIANGLE PROJECT

Triangle Project is a non-governmental organisation that aims to provide services, including a counselling service, for the gay, lesbian, bisexual, transgendered and intersexed members of society. In order to provide the reader with a clear understanding of the context, an outline of the Organisation, its history and services is provided. Triangle Project situated in Cape Town, South Africa, like many counselling centres servicing the needs of the GLBT¹ community globally, was developed out of the gay movement in South Africa. The Organisation does not only provide a counselling service for gays and lesbians, it also implements other programmes that both inform and are informed by the counselling service. Other services like public education and training, for example, will be discussed briefly later.

¹ GLBT refers to gay, lesbian, bisexual and transgendered individuals as a collective.

The overall purpose of the Organisation is clearly defined in terms of its mission statement, which reads:

"Triangle Project's goal is to empower gays, lesbians and other sexual minorities, through health and social development programmes, which promote individual and community well-being and pride, and build individual and community capacity"

(Annual Report, 1997; 4).

Triangle Project derives its mandate from the GLBT communities to address issues of homophobia within a society where prejudice and sexual taboos against homosexual identity and relationships are still strongly felt. Despite a clause in the South African constitution prohibiting discrimination on the basis of sexual orientation, a lack of tolerance and non-acceptance for gays and lesbians still pervades every level of South African society.

The Organisation attempts to achieve its aim as set out in the mission statement, through providing a range of services, which include both medical and social services. At present the Organisation functions as a service provider with a dual purpose; firstly it provides direct client services to the GLBT communities, and secondly, it provides services that address homophobia, in the general public. The direct client services consist of the face-to-face counselling service, and a phone-in service dealing primarily with callers who are in a crisis and in addition, provides information regarding other services in the region available to the GLBT communities. The direct client services include medical services, as well as medical trials aimed at people living with HIV. Other services provided by Triangle Project are public education, consisting of awareness and sensitivity raising workshops that deal with homophobia, and advocacy and

lobbying to ensure the representation of the GLBT communities and the Organisation in other forums and structures.

In order to understand the present functioning of the Organisation and the services provided, it is important to examine the history of the Organisation. The usage of Triangle Project's services has changed over time and is reflective of the broader changes in the South African context.

1.2.1. A HISTORICAL OVERVIEW

Triangle Project has a historical mandate derived from the work of its two predecessor organisations in the Western Cape, namely, Gay Association of South Africa 6010² (GASA 6010) and the Aids Support and Education Trust (ASET), both of which provided medical and counselling services. An overview and history of the services available at Triangle Project will briefly be touched upon here, as the counselling service needs to be understood not as a separate service but as one that is partly informed by and informs other programmes and projects.

Prior to 1990, the counselling clinic was run under the auspices of the Gay Association of South Africa 6010 (GASA 6010), which began in response to the need for a support and social group for, at the time, predominantly gay white men. At the time, due to discrimination against gay individuals, this forum operated covertly and the numbers "6010" was the postal box number used to serve as protection for those individuals running and making use of the service. It should be highlighted that those who held leadership positions within the organisation were white, mostly middle class gay

² 6010 refers to the postal address of the Organisation when it needed to be a covert operation

males, responding to the health needs of a client group that mirrored these characteristics in their demographics. The first 24 - hour gay crisis helpline was initiated in 1982, with face-to-face counselling supplementing the counselling service, as well as providing a referral point for individuals in need of further counselling.

In the 1989 Counselling Service Annual Report the director at the time commented that the provision of highly skilled professional counselling through their counselling clinic was the predominant feature of the work performed by GASA-6010 as an organisation. At the time, other services relating to HIV/AIDS were also offered by ASET (Aids Support and Education Trust) that was formed from GASA-6010 to provide support and education specifically relating to HIV/AIDS. Due to fundraising difficulties experienced by GASA 6010, being an organisation dealing with gay issues, it was envisioned that ASET would be able to obtain funds to facilitate the work with HIV prevention and care among sexual minorities. ASET however, was also denied a fund-raising number and the organisation joined the Cape Mental Health Society to utilise their fund-raising number. This history reflects some of the difficulties encountered by the GLBT community in terms of the discriminatory practices prior to 1994, which prevented access to resources, for example, fundraising opportunities.

In 1994, ASET obtained a fund-raising number and moved away from Cape Mental Health Society. They also severed ties with GASA-6010 and took the counselling and telephone helpline service along with them. The name Triangle Project was coined in 1994 to bring together all of ASET's health programmes targeting gays and lesbians. It was during this time that the Organisation moved to its current office in Salt River.

The year 1995 marked the last year of the Organisation under the name of ASET (Aids Support and Education Trust), with the major focus being HIV/AIDS. The 1995 Annual Report indicates that initial attempts to do prevention work in the townships and rural areas were fraught with difficulties and interventions were centred largely in the city, where strong development programmes and health structures already existed. However, these interventions were not appropriate for township settings in which it appeared that a different set of dynamics existed. It became apparent that the Organisation needed to change its approach and focus of its programmes and unfortunately, it lost many members who did not share this view. The name Triangle Project was only used officially from 1996 onwards, with the understanding that it would better reflect the multi-faceted services offered to the lesbian and gay community. It was also in this year that the Organisation initiated the first gay and lesbian African health project in Guguletu, Cape Town.

The 1997 Annual Report reflected a remarkable shift in Triangle Project moving toward a more inclusive approach, extending their services to minority groups within the GBLT community who had previously been neglected. A key phase of its own transformation was entered into when the Guguletu centre opened with Xhosa-speaking field workers providing psychosocial and development assistance to gay and lesbian individuals in the surrounding areas.

Shortly hereafter however, Triangle Project as a whole fell upon financial hardship as resources were sharply reduced. Funds for crucial HIV prevention, education and care were the focus of bureaucratic tension between national and provincial levels of government, and Triangle Project like other AIDS service organisations, was plunged into uncertainty and strain. The financial strain impacted heavily upon the Organisation's overall functioning and the counselling service too felt the strain. This, together with the resignation of the part-time employed psychologist/counsellor who

was leaving in order to build up his private practice, influenced the number of clients seen at the counselling clinic. The Annual Report reflected that visits to the counselling centre were low for that period.

The year 1998 –1999 was the first full year of providing services such as condom distribution and a women's programme from the new offices in the Guguletu township. This was the realisation of several years of planning, consultation, restructuring and the employment of community-based field workers. It was part of a profound shift in the identity of the Organisation, from predominantly white, English speaking male dominated organisation, to a more representative multi-lingual community-based organisation. The Annual Report (1998/1999) reflects that, *"In some ways Triangle Project mirrored experiences from all over the post-apartheid landscape, and in others it was profoundly unique"* (p.4). The counselling service reflected the changes that were occurring both internally and externally to the Organisation, as it had experienced an overall growth in the number of clients seen, especially in the number of clients of colour.

Triangle Project was consciously attempting to change from being perceived as being exclusively white and male dominated, to achieve a more representative balance of identities, both in terms of race and gender. However, it should be noted that while the structure and face of the Organisation was steadily changing to include those that had previously been marginalized, the perceptions of the community still seemed to be tied to the picture of the "old" Organisation. These perceptions were and are still given as feedback by the black community to the Organisation.

The period 1998 to 1999 reflected an increase in the general counselling service, particularly so when compared to the results of the previous year. The number of cases included those clients seen

for the first time as well as those to whom counselling was provided to on an on-going basis. At this stage the counselling service was available to clients during the week, provided by one part-time counsellor and several volunteer counsellors. An after hours counselling service was also available on two nights of the week, this too was personned by professional counsellors, working on a volunteer basis.

The counselling service has not changed much over the last few years, as it continues to operate from the Salt River office only and does not extend to the Guguletu office. The Guguletu office is thought of as a referral point, with the key intervention there not being any direct intervention in terms of counselling, but rather facilitating the mental health well-being of the GLBT community in other ways (Annual Report, 1999). Presently, clients from townships and surrounding areas therefore need to come to the Salt River offices to make use of the counselling service³.

1.2.2. THE COUNSELLING SERVICE

While much information regarding the counselling service has been covered already, it is important to bring attention to some of the features of the service. Firstly, it is important to emphasise that the structure of the counselling clinic itself had not changed much over the period of 1996 to 1999. The counselling clinic has always had a clinic manager, co-ordinating all the clinic services, including the counselling service. During this period, the counselling clinic continued to operate the helpline service which serves as a crisis call service, that is personned by trained lay counsellors who if necessary, will refer clients to the face-to-face counselling service of

³ A counselling service is in the process of being established at the Guguletu office

Triangle Project, as well as to other appropriate referral agencies.

During the period 1996 to 1999, the helpline changed from being a 24-hour service when it first started in 1982, to a service that operates for a limited number of hours daily, including weekends.

The helpline service is thus seen as an integral part of the counselling service as it serves as the "first stop" for a client who might want to make use of the counselling service. Some clients prefer the anonymity to discuss private areas of their lives and sometimes this may be the first time that they have discussed their sexuality or feelings with another person. Clients are often referred from the helpline service to the Organisation's counselling service to make use of either face-to-face, individual counselling and or couple counselling which are both offered at the clinic.

During the period 1996 to 1999, the clinic also made use of the services of one part-time employed counsellor, while the rest of the counsellors worked as volunteers on the two evenings of the week when the service time was extended. While the number of the volunteers working at the clinic changed, the requirements needed to work there did not. All counselling volunteers need to be registered social workers and psychologists, in order to work therapeutically with clients. At present counselling is provided in English and Afrikaans and is not available in Xhosa, as there is no Xhosa speaking counsellor.

At the clinic, all counsellors work from their own paradigms and theoretical models, although a client-centred approach is the underlying premise to counselling gay men and lesbians. Klein (1991) makes an observational comment that other gay counselling clinics, like the Seattle clinic, all have a client-centred approach to counselling. The importance of a client-centred approach cannot be overlooked. When working within this sector, the labels used to typically describe gays and lesbians

like "sick" and "abnormal" are considered inappropriate and harmful to the client's psychological well-being. It becomes crucial to the process of healing to work with the client's own definitions of their problems, without the stigma that is usually attached to the sexual lifestyle (Klein, 1991). A client-centred approach is therefore necessary in order to ensure a safe and supportive environment for the gay or lesbian client.

Other than having an underlying premise of a client-centred theory, Triangle Project's counselling service, like other centres providing counselling for gay and lesbian individuals, does not take one approach to counselling. The approaches employed at the counselling clinic are therefore as varied as the counsellors who work there, all however, echoing a non-judgemental stance toward homosexuality and an acceptance of the client as an individual. This way of working, can be integrated into a variety of different psychotherapeutic approaches, and has been referred to by Harrison (2000) as "affirmative therapy". This model of therapy aims to acknowledge and affirm the experiences of gay men and lesbian women, and is one, which further acknowledges the unique issues and concerns facing this particular client group.

Face-to-face counselling forms the main part of the counselling service. After the initial interview in which the client gives a brief account of the presenting problem, as he/she perceives it, and a brief history, the client is assigned to a regular counsellor. The client may request a counsellor with specified characteristics, for example, lesbians often request a lesbian or woman counsellor. The counsellor and the client usually meet once a week for a fifty-minute session, although more regular meetings may be required initially for clients who are more severely disturbed or in a crisis. Less frequent meetings are usually made as the counselling starts tapering off. Most clients receive two to eight sessions of counselling, or as agreed upon with the counsellor.

It appears from the study done by Klein (1991), that Triangle Project's counselling service operates very similarly to gay counselling centres like Seattle counselling service. No major structural and operational changes are evident in the period 1996 to 1999 and in the Annual Report (1999), the face-to-face counselling service is described as being "... of a high quality and is consistently rated as effective, thus meeting the organisation's aims " (p27).

1.3. AIMS OF THE STUDY

The aim of this study was to analyse the trends and patterns of clients who made use of the counselling service at Triangle Project in Cape Town, for the period 1996 to 1999. Issues of race and gender that emerge from the study will particularly receive attention as they provide a basis for attempting to understand some of the dynamics that surround the use and/or non-use of gay counselling services, at Triangle Project. In South Africa, little has been written about the needs of gay and lesbian clients. It is hoped that this study will contribute to the dearth of information and encourage more in-depth studies regarding the GLBT communities, particularly those who have been marginalized within this group, for example, lesbians, gay youth and gays and lesbians of colour.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

Since the present study aims to examine the patterns and trends in client presentation at the gay counselling service of the Triangle Project during the period January 1996 to December 1999, this chapter reviews the literature regarding trends and patterns of clients observed in counselling services for gays and lesbians. While the number of studies on gay and lesbian mental health has increased in recent years, existing literature focussing on gay and lesbian mental health issues seldom explores the presentation of gays and lesbians at a counselling service.

This chapter begins by reviewing the need for counselling services for gays and lesbians. It then focuses on relevant studies in terms of the presenting concerns of gays and lesbians at mental health services, as well as the experiences of subcultural groups within the GLBT communities, for example, lesbians, gay youth and, gay males and lesbians of colour.

2.2. IS THERE A NEED FOR GAY AND LESBIAN COUNSELLING SERVICES?

As gays became more vocal in expressing their own mental health needs, it became apparent that gay mental health services were necessary to promote the emotional well - being of sexual minorities. Klein (1991) reviewed the experiences of the Seattle Gay Counselling service. This was the first counselling service for gays and lesbians in Seattle.

As a result of political activism within the gay community, the centre was started in 1969 in response to the lack of appropriate mental health services for gays and lesbians within the established mental health services. Until that time, gays and lesbians in that region needed to utilise general mental health care facilities and they were generally dissatisfied and discontented with these facilities. Seattle Counselling Service resulted from the need for services that would meet lesbians and gay men's mental health needs, and that would not pathologize them because of their sexuality.

Klein (1991) explained that gay men and women in the U.S.A have created a subculture in which they view themselves as healthy. In doing so, they had firstly identified a need for, and created counselling institutions to affirm and promote their mental health. This was necessary because prior to the late 1960's and the early 1970's, the psychiatric and psychological services offered to gays and lesbians may have pathologized them for being homosexual. Homosexuality was seen as a sexual dysfunction and listed as a mental disorder. It was only in 1973, that the American Psychiatric Association removed homosexuality from the list of mental disorders (Hidalgo, 1995).

In a survey conducted at the Seattle Counselling Service, many gays and lesbians stated that they needed their own counselling services, partly because of the prejudiced and discriminatory experiences they had within the established mental health system (Klein, 1991). Gay and lesbian clients felt that mental health workers generally were not able to meet their needs and that their attitudes were not conducive to GLBT mental well - being. Research on homophobia indicates that mental health professionals, and psychologists in particular, generally hold more positive attitudes about gay men and lesbians than the public at large (De Crescenzo, 1984).

However, Fassinger (1991) suggests that mental health professionals often hold heterosexist assumptions. It is very likely that these assumptions are stereotyped and could hamper the therapeutic process as well as the clients' sense of identity as a gay male or lesbian. Studies (Cabaj, 1988; Garfinkle & Morin, 1978) also show that mental health professionals are generally uninformed about gay and lesbian life styles and issues, and that they sometimes hold homophobic attitudes. As can be deduced, this lack of knowledge and misconceptions could lead to distorted clinical judgements regarding clients in GLBT communities, and could impact negatively on the gay male or lesbian's experience of counselling or therapy (Casas, Brady & Ponterotto, 1983). It is of vital importance for mental health workers to develop the attitudes, knowledge and the skills needed to work effectively with gay men and lesbians.

Klein (1991) reported on a survey in which gay males and lesbians stated that they wanted to identify with their counsellor/therapist. It was important to the respondents that they shared a common experience and reality with their counsellor/therapist. For some respondents, it was enough if the counsellor and or the service was perceived as being "gay friendly" as this was felt to contribute to an accepting and supportive environment (Klein, 1991). This attitude could be seen as also contributing to removing the stigma of pathology associated with gays and lesbians.

Klein (1991) also argued that the cultural labelling of gays as mentally ill, is another major reason, accounting for the larger percentage of mental health seeking behaviour by lesbians and gay men at counselling services aimed at them, and not the "mainstream" mental health services. This seemed to occur whether they were seeking counselling/therapy on their own accord, or through the recommendations or coercion of others.

Gay and lesbian individuals appear to make more use of services that are aimed at the GLBT communities than mainstream services because these services are also perceived as agents that serve to minimise and even remove the labels that impact negatively on GLBT individuals. While the general perception holds that gays and lesbians, present for counselling/therapy because of their sexuality, these individuals make use of counselling services for a myriad of reasons. Furthermore, it has been recognised that there is more common psychological ground between heterosexual people and homosexual individuals and that seeking psychological assistance by no means meant pathology associated with being gay. Parry and Lightbown (1981), also argue that lesbians and gay men need counselling services that provide acceptance and non-judgemental attitudes from service providers, and above all, an understanding and knowledge of the issues possibly faced by the gay and lesbian client. While gay males and lesbians present at counselling services with issues regarding their sexuality, they present more so with general mental health concerns and issues.

2.3. CLIENTS' PRESENTING PROBLEMS

While a few studies, albeit abroad and not locally, have been done to explore the mental health problems presented by gays and lesbians, Wilton (1997) highlights that there has not been enough empirical research done thus far to ascertain the mental health needs of gays and lesbians. According to Magnuson and Norem (1995), gay and lesbian clients seek counselling at mental health services for a myriad of reasons. While experiencing the normal daily stresses, gays and lesbians also have to deal with the way in which society reacts to them because they are perceived as different. South African authors, Nel and Joubert (1996) explain that the discrimination and prejudice experienced by gay people take on various forms, subtle and overt, and that this in itself could prove adverse to the emotional well - being of the gay individual.

For the most part, homosexuality is still viewed as a mental illness and this view further hampers investigation into the concerns of the mental health needs of gay and lesbian individuals.

In the study completed at the Seattle Counselling Service, Klein (1991) reported that clients presented mostly with problems of depression (28%), sexual orientation (12%), and self esteem (11%). Ryan and Bradford (1988) explored participants' various presenting problems when they sought counselling. Among those who sought counselling, 50 percent stated that they wanted to deal with feelings of sadness or depression, 44 percent with relationship/lover problems, 34 percent with family problems, and 31 percent with stress or anxiety. Only 21 percent reported that they wanted to deal "with being gay". It would appear that more lesbians present at counselling because of feelings of depression firstly, and secondly, due to problems with their relationships. Here it should be highlighted that studies consistently demonstrate that women generally present more with depression than men (Doyal, 1995). Wilton (1997) reported that this is a cross-cultural phenomenon, affecting women from diverse communities. Studies such as Ryan and Bradford (1988) stated that lesbian women sought counselling at a greater rate than a general sample of women.

In Klein's (1991) account of the Seattle Counselling Service, data for gay males (the author being unaware of comparable data for females) indicated that a large portion of them had seen a psychiatrist or psychologist regarding homosexuality as their primary concern. When considering the differences in the presentation of gay men and lesbians, it becomes evident that gay males and lesbians due to their different experiences, and ontology of how they perceive the world in which they live, could possibly have different mental health needs.

Very little has been studied in terms of the differing mental health needs and concerns of gay men

and lesbians, particularly the mental health needs of gay males.

While not much literature is available on the differences in the mental health needs of gays and lesbians, Chrisman (1977) proposed a theoretical model for the health-seeking process. This model, while it does not focus on exclusively mental health needs per se, discusses the variation of health-seeking behaviour in different cultures and sub-cultures. He argued that, like other subcultural minorities, there are also intra-cultural differences between and within groups of gay men and lesbians, and that gays and lesbians could be understood as having different health-seeking patterns. Furthermore, it can be deduced that gays and lesbians while having different mental health needs from one another, also have different mental health needs as compared to heterosexual individuals.

Both gay men and lesbians have the experience of living in a heterosexual society that is largely homophobic, and this brings challenges and concerns that could possibly hinder their emotional and psychological functioning. As within a heterosexual context, heterosexual men and women have differing mental health needs and concerns due to the various contributing factors, for example different societal expectations for males and females. The GLBT community is not monolithic, there is diversity between and within gay and lesbian groups, and studies undertaken therefore need to highlight the different needs of these two subgroups.

2.3.1. Lesbian Mental Health

Risman and Schwartz (1988) as well as Kritzinger and van Aswegen (1992) observe that female homosexuality and/or lesbianism has been a somewhat neglected area of research and studies thereof are seldom included in prominent international sociological journals. Even the work of feminist

authors tends to focus on heterosexual women. According to Wilton (1997) a great silence exists in recording lesbian experiences, specifically in terms of mental health. She explained this silence as being two-fold; that lesbianism, like being labelled as mentally ill, carries a stigmatising label and that lesbian individuals who have been labelled mentally ill tend to remain hidden. Furthermore, even when this research is underway, it is poorly funded and generally depends on the support and efforts of lesbian clinicians or researchers.

The literature available, although limited in the number of studies done, shows a varied picture of the presentation of problems of lesbians at a counselling service. Similar to Ryan and Bradford (1988), Sorensen and Roberts (1997) suggest from the results of their study, that the focal issues for lesbians in therapy, as for heterosexual women, are depression and relationship/partner concerns. Studies done by Browning, Reynolds and Dworkin (1991) reflect that lesbian clients also present with problems such as domestic violence. Morrow and Hawxhurst (1989) report that lesbians also present with unresolved trauma from abuses suffered during childhood, and confusion regarding spirituality has been reported (Browning et al, 1991; Ritter & O'Neill, 1990). Furthermore, lesbian clients commonly present with heightened levels of anxiety (Falco, 1991; Lappierre, 1990), fear, loneliness, and career problems (Browning et. al., 1991; Hetherington & Orzek, 1989).

In comparison studies with heterosexual women, lesbians seemed to display a more positive and favourable attitude towards seeking mental health services. Morgan (1992) compared the attitude towards seeking psychological help of lesbian women with heterosexual women, and found that lesbians had significantly more positive feelings towards seeking counselling than non-lesbians. Reasons accounting for this remain unclear. It could be hypothesised that lesbians, like other sexual minorities, seek mental health services because of their awareness of the stigma of their sexual

orientation often being seen as an indication of pathology, and that in attempting to maintain good mental health, counselling services are utilised.

Research has also shown that a higher percentage of lesbians obtain mental health services than their heterosexual counterparts (Falco, 1991). While the evidence of these studies reflect that lesbians generally make use of counselling services more than heterosexual women, according to authors like Dennenberg (1994), lesbians are perceived as being under-represented at counselling centres.

Dennenberg (1994) explained that the reliance on “self-labelling” could be particularly limiting in the studies of women, who might not identify with the label lesbian, and might therefore not present at a counselling centre for gays and lesbians and might instead make use of general services without disclosing their sexuality. Internalized homophobia felt by lesbians as with other sexual minorities could be hypothesised as being a reason for this.

2.3.2. Gay Youth

Chung and Katayama (1998) noted that if adult lesbians and gay males are considered a minority group, gay and lesbian adolescents could be called “the invisible of the invisible” (p.21). Gay youth is seen as a group that is further marginalized within the already marginalized GLBT communities.

Adolescent homosexuality is recognised as being a very difficult experience for the individual.

Cooley (1998) describes adolescent homosexuality as being a “double negative”, and that they therefore are at risk of experiencing ill [mental] health. Because of the lack of attention, assistance and support, gay youth might encounter tremendous difficulty in dealing with their sexual orientation.

Savin – Williams (1990) commented that resources and services for gay males and lesbians, when they are available, are almost exclusively for adults, possibly because it's too controversial and complex to deal with minors. Possible homophobic accusations regarding the "conversion" of youth to homosexuality, contributes to the complexity of providing counselling services for gay and lesbian youth. Gay youth are often left unsupported and studies like those of Fikar (1992), found that whereas 1 in 10 heterosexual adolescents attempt suicide, 3 in 10 homosexual adolescents attempt suicide. Because of the difficulty in developing a healthy identity in a largely homophobic society, gay and lesbian adolescents have therefore been identified as a population at-risk (Chung & Katayama, 1998).

2.3.3. Gays and Lesbians of Colour

Very little has been documented on gays and lesbians of colour seeking gay mental health services. Ethnological studies hint at the possibility that the lack of identification with a gay identity contributes to the mental health seeking behaviour of minority ethnic groups and that this would be reflected in the trends and patterns observed at a counselling service for gays and lesbians. Perspectives anchored in the experience of lesbians of colour, have only been sparsely represented in professional publications. The voice and experience of lesbians of colour is still mostly absent in literature at a time when this group is increasing as clients of service agencies, such as counselling centres (Hidalgo, 1995). While there are various reasons for the increase in the visibility of lesbians of colour at counselling centres, it could be that there is a sense of it being more acceptable to seek assistance with mental health concerns.

By the 1980's the voices and experiences of gay men and lesbians, while still few in number, were no longer completely absent or invisible in the professional literature of the disciplines that help shape the professional practice when dealing with mental health concerns. However, the voices, perspectives, and research were still predominantly anchored in a white, eurocentric, male perspective. So, while more attention was afforded to gays and lesbians as a group, the intra cultural differences, such as racial differences, still remain a neglected area. The absence of gays and lesbians in research is particularly noticeable within the South African context, however the absence of gay males and lesbians of colour is even more glaring, as studies concentrate on white, middle class, gay males.

Chung and Katayama (1998) suggested that ethnic and sexual identity development processes are parallel and interactive and that this could be for other ethnic minority groups as well. The cultural community may not endorse the sexual identity of the gay and lesbian individual thus increasing the chances of homophobic attitudes and practices, as well as rejection of the individual. Akerlund and Cheung (2000) explain that gay and lesbian ethnic minorities are faced with a unique challenge of integrating their cultural and sexual identities in societies that might not fully accept either. This difficulty may manifest in the non-use of counselling services aimed at gays and lesbians, as disclosure of the sexuality could result in possible rejection by the cultural community.

Akerlund and Chueng (2000) highlight that the assimilation into the gay community can be experienced as a difficult task for ethnic minorities. It could therefore be that these individuals have a lesser chance of receiving information and thus gaining access to services aimed at gays and lesbians. Chung and Yatayama (1998) echo this finding and report that similar to the Asian respondents in their study, other gay and lesbian ethnic minorities and those of colour, are not readily assimilated

into GLBT communities.

It becomes apparent that gays and lesbians of colour face additional challenges in terms of their cultural community and that they might be further marginalized both within the GLBT communities as well as within their cultural communities. It is therefore probable that gays and lesbians of colour make use of general counselling services, or that they do not seek mental health services, including counselling services aimed at the GLBT communities.

2.4. THE SOUTH AFRICAN CONTEXT

Within the South African context, gains in achieving the freedom and rights of all minority groups have been made, including the rights of sexual minorities, but gays and lesbians are still largely absent in representation, remaining marginalised by their experiences and therefore reality. Most mental health research in South Africa continues in the context of a male dominated society (de Phino & Jinubhai; 1994), and only a limited number of studies have been done to explore the mental health status of gays and lesbians. Within the broader mental health services, the rights of gays and lesbians remain but a constitutional issue, and unfortunately are largely absent within mental health services, both within state and private professional practise.

As with any other service deliverer, those within the mental health arena, form part of society and are therefore affected by the attitudes, values and beliefs of the particular time period and the cultures surrounding them. It is possible that these attitudes, values and beliefs, are sometimes reflected in the services provided. In South Africa, the established mental health system already stretched financially, has very little resources and appropriately skilled and knowledgeable staff to

accommodate the mental health needs of the majority of people and to a lesser extent the needs of gay men and lesbians. Even those services provided to private patients also often fall very short of meeting the mental health needs of gays and lesbians (Nel & Nel, 1995).

Nel and Nel (1995) reflected that the majority of gays believe that mental health services ought to be established to deal specifically with homosexual concerns. In a situational analysis for the Policy document for Lesbian Health Issues (1994), the major stress for lesbians was seen as arising from the fact that "normal" is always assumed to be heterosexual. According to de Phino (1994), the homophobia experienced by gays and lesbians, affects individuals in ways that might result in internalised feelings of being deviant and abnormal. These feelings have a great impact on the individual's sense of self and general well - being, and could result in increased stress and disease. It is possible that these internal processes could have an adverse effect on the individual, thereby contributing to the need for seeking gay affirming counselling services. Because minority rights is still largely only evident on a policy level, the mental health seeking patterns of gay and lesbian individuals, particularly those of colour, could be influenced negatively.

2.5. IMPLICATIONS FOR THE MENTAL HEALTH WORKER

Research on homophobia indicates that mental health professionals, and psychologists in particular, generally hold more positive attitudes about gay men and lesbians than the public at large (DeCrescenzo, 1984). However research also suggests that mental health professionals often hold heterosexist assumptions, and mental health professionals are generally uninformed about sexual minorities' life styles (Fassinger, 1991; Cabaj, 1988; Garfinkle & Morin, 1978).

This lack of knowledge could lead to distorted clinical judgements regarding the GLBT communities (Casas et al, 1983). It is of vital importance for mental health workers to develop attitudes, knowledge and skills needed to work effectively with gay men and lesbians. Atkinson, Morten and Sue (1983) suggest that mental health professionals should borrow from the paradigm of cross-cultural counselling to assist their work with the GLBT communities, for just as they would in any cross-cultural situation, they need to remain conscious of the effects of societal pressures on their clients' lives.

For most people seeking mental health services, a safe and accepting, non-judgemental environment is crucial to facilitate the therapeutic process. Authors like Harrison (2000), have begun to theorise about this therapeutic approach, grouping it as "**gay affirmative therapy**". The attitude of the service deliverer is thus integral to the individual's decision to make continued use of a service. According to South African authors, Nel and Joubert (1996), the attitudes, beliefs and values of society at large, are often carried into the therapeutic process and affect the manner in which clients are worked with. Therapists' own perceptions and issues have a great impact on how the therapeutic situation is managed. Service providers are not free from the attitudes and perceptions held by the rest of society and these attitudes and perceptions could easily hamper the counselling and or therapeutic process. Psychologists and other mental health care providers "...[they] do not work in a vacuum ", and have a duty and personal responsibility to afford gays fair, equal and proper treatment (Nel & Joubert, 1996; p.2).

It has been recommended that mental health care workers and professionals employ techniques to facilitate and improve their interactions with their clients. In an in-depth study conducted with eight lesbians, Falco (1991) suggested that helping professionals "...be conscious of their own

homophobia, heterosexism, and especially her or his own personal feelings toward members of the same gender" (p.10). Klein (1991) proposes a few strategies that mental health personnel should take into their own practises. These include; to become educated about gays and lesbians and to then educate others and to become sensitive to other sexual minority issues among clients, and to advocate for the reform of legislation harmful to the mental health of sexual minorities. The onus, it would appear, rests upon the service provider to become more familiar with an understanding of the issues regarding gay and lesbian mental health.

It appears that gays and lesbians are far more comfortable in seeking mental health services at which an **affirming stance** is provided and that these services are indeed needed. For many, having to utilise general mental health service, is negatively experienced due to homophobic and misinformed attitudes and beliefs. Gay mental health services are thus sought in an attempt to obtain affirmative counselling. While there is a definite need for counselling services aimed at the GLBT communities, mental health professionals outside of these services also need to equip themselves adequately in order to deal with the mental health needs of gay and lesbian clients.

It becomes apparent that the trends and patterns at a gay counselling service would also be determined by the way in which the clients perceive and experience the staff as well as the organisation. Gonsiorek (1982) discusses organisational and staff problems in gay and lesbian mental health agencies and says that it is crucial to understand the experimental nature of gay and lesbian mental health programmes, and the contexts in which they operate. The development of the organisation together with external developments, impact on the trends and the patterns observed.

It becomes necessary to understand the use of gay counselling services in terms of both internal and external developments, and that the perceptions held of an organisation's image influences the utilisation of the service. It is also then the responsibility of those working within organisations that provide services, particularly counselling services for gay and lesbians, to be sensitive to this and to include this understanding in planning and other strategies used for organisational development.

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CHAPTER THREE: RESEARCH METHODOLOGY

3.1. INTRODUCTION

For the purposes of this study, it was necessary to use previously collected information such as the information on the intake forms that had been completed by the counsellor for each client in the initial assessment session. In addition, Triangle Project's annual reports dated from 1989 to 1999, as well as the evaluation report for the year 1999, were used. According to Neuwman (1991), this is known as **secondary analysis** research, as the data used for the purposes of the study was collected prior to the study for purposes other than research. This method of data gathering is most frequently used for descriptive research.

3.2. METHOD

The use of previously collected documents is central to the process of this study. Documents, like the intake form used for the purposes of this study, provide an alternative way of generating information and have become a useful tool to the social sciences as they have assisted in ways to help gain an understanding of the sample. Garfinkel (1967) has shown that one of the problems of using documents such as medical records for social research is that records are organisationally produced purely for clinical purposes. These are usually regarded as "therapeutic" records and is the "contractual record" between the practitioner and the client or patient. Organisations such as Triangle Project record information for the purposes of the work that is done and not necessarily with the intention for being used as research tools.

The intake records used for this study could also be seen as the contractual or the "therapeutic" record referred to, and had not been intended for research purposes. Instead, the information had originally been collected for the purposes of recording the client's history and other information relevant to an appropriate therapeutic intervention that would follow.

When using documents however, the researcher also needs to take the context wherein they had been collected, into consideration. Scott (1990) differentiated between two ways of using documents, namely, those used as "resources" and those used as "topics". According to Scott (1990) those used as resources, might be used for "constructing valid descriptive statements" about phenomena to which they refer, while those used as "topics" are regarded as "social products" (p.124). For the purposes of and within the context of the present study, documents (the intake form, the annual reports and evaluation report) were used as resources to compile a description of the trends and patterns emerging from the data collected from individuals who had made use of the counselling service at Triangle Project. This method also allowed for the documentation of information that supports and or contradicts prior beliefs about the subject under scrutiny (Neuwman, 1991). In addition, a review of organisational documentation, including the annual and evaluation reports of the Triangle Project was used to gather additional information that would be used in the analysis of the data.

Although Denzin and Lincoln (1994) acknowledge that this method challenges the interactionist view, as information is derived from informants who are not present, they argue that it introduces an "other" against which the analyst's own experience of the situation can be evaluated and extended. They note that, "although the evidence cannot 'speak back' it can confront the researcher and force self-appraisal" (p.121). While a criticism of this methodology is that the informer is not present in

the study, and can therefore not interact with the researcher, the informant's non-presence can however also be seen as presenting a challenge to the researcher.

3.2.1. Instrument

The data for this study was derived from the intake form that is completed for every client who seeks counselling at Triangle Project. (See Appendix. A). The intake form was used as the main instrument for the purposes of this study. It is based on the Maudsley intake form, which is traditionally used in clinical settings to record the client's information, and can be seen as an abridged version thereof. The intake form allows for the client's history and other relevant information regarding the individual's psychological functioning, to be collected by the counsellor/therapist.

During the period 1996 to 1999, the intake form changed slightly in terms of the areas covered with the client in the initial session, and it became shorter. The latest intake form, used in the latter part of the period studied, depicts the same categories as the older form, but seems to have been much better used as an instrument for recording information by the counsellors. Information recorded in the latter part of the study is recorded more effectively than the information recorded within the first two years. In addition, the Organisation's annual reports and one evaluation report were used for purposes of cross-referencing and at times, for gaining more descriptive data. The intake form served as the most important instrument for gathering information. The main categories taken from the intake form and used for the purposes of this study are:

Identifying Data

This section documents the client's demographic details. The name and surname, age and date of birth, address, level of education and occupation are elicited from the client. The remaining questions focus on the client's sexual orientation, relationship status (single, in a relationship, etc.) and the referral source.

Presenting Problem and Related Dynamics

The client is requested to give an account of the problem and this, as well as the significant issues relating to this problem or problems are explored and recorded. In some cases, clients identify more than one problem as the presenting or main problem. For the purposes of the present study, all problems identified and expressed by the client as the presenting problem, were recorded.

Vegetative Features

The vegetative symptoms of depression are recorded if they are clinically observable by the counsellor and further elicited from the client. This category assists the interviewer with a provisional diagnosis that would then inform the treatment or intervention plan of the client. It also serves to assess whether the client is suitable or not for counselling at Triangle Project. In instances where the services offered by Triangle Project's counselling clinic are not suitable for the needs of the client, a referral is made to an appropriate source.

Other Categories

The other categories on the intake form provided additional information. The category **Brief Synopsis of the Problem** is used to briefly record the main concerns and the relating issues of the client, and the way in which these are understood by the counsellor. **Substance Use/Abuse** is a

category used to record the client's drug and or alcohol use and history. Other substances used as well as the frequency thereof, like nicotine and drugs, as well as substances used to self medicate, for example cough mixture, headache tablets, are recorded.

The category **Psychiatric History** is covered by the counsellor, as it allows for information regarding other psychiatric illnesses and or experiences of the client's to be recorded. The client's psychiatric history is taken and this includes information regarding family history in terms of psychiatric illnesses. Previous interventions, treatments and admissions to hospital as well as the client's history of mental health seeking behaviour, are recorded by the category **Previous Intervention/Treatment**. Clients are also asked to identify the areas of their lives, which they perceive as causing the most stress, as this provides information that they might not necessarily have provided. The other categories on the intake form include observational comments about the client's general personal presentation as well as psychiatric presentation. This also allows for the interviewer to assess and record the client's current functioning and hypothesise about possible diagnosis, if this is applicable.

3.3. THE SAMPLE

All the intake forms were collected and read thoroughly. The counsellors had completed the 233 intake forms of clients, who had used the counselling service at Triangle Project, during the period January 1996 to December 1999. The sample of 233 intake forms was counted manually and the number of cases seen at the counselling service was recorded for each year. In 1996, 29 (12.45%) clients made use of the counselling service, 1997 had a total number of 35 (15.02%), 1998 had a total number of 70 (30.04%) of clients, while in 1999 the number of clients equalled 85 (36.48%).

The sample was also divided into male and female, and then into categories of race. The sample consisted of 139 (59,66%) gay men, 78 (33,48%) lesbians, 1 (0,43%) intersexed client and 1 (0,43%) transgendered client. The remaining percentage (6,01%) consisted of clients for whom insufficient information was collected.

3.4. DATA ANALYSIS

The patterns and trends in the presentation of the clients, who had made use of the counselling service for the period 1996 to 1999 were analysed. All intake forms for the period were collected, counted and read thoroughly, and the data from these intake forms was divided into different categories. These categories capture some of the different aspects of gay and lesbian individuals who had presented for counselling and aimed to serve as a means for grouping themes. Each of the main categories, namely Identifying Data, Presenting Problem and Vegetative Features, provided the information needed to analyse the trends and patterns of the client group, thus fulfilling the aim of the present study.

All the categories were examined and information regarding individuals were collated and recorded for each individual. All the data in each category, for each year, was counted and was reflected as a number and a percentage. In addition, the organisational documentation like the annual reports and the 1999 evaluation report proved to be useful in providing annual overviews and an evaluation process that took place by individuals who were external to the Organisation. The annual reports provided succinct information about the Organisation's historical context and issues over the period of time under review. These reports also contain statistical and other relevant information that were

used in addition to the intake forms for purposes of cross-referencing and at times, for gaining more descriptive data.

3.5. ETHICAL ISSUES

According to Neuwman (1991), the primary ethical concern when using existing documents is the privacy and the confidentiality of using information collected by someone else. For the purposes of this study it was necessary to obtain the formal permission of the Management Board of Triangle Project as well as the formal permission of the director of the Organisation. Ethical concerns while they have been considered do not pose a major concern, as those studied were not **directly** involved in the research. Furthermore, all clients' records remain confidential and the respondents remain anonymous, as their names have not been used in any part of this study.

Another ethical concern, requiring some attention for Neuwman (1991) was that that official statistics are perceived as being social and political products. It becomes increasingly clear that when doing a secondary analyses, the data collected has been used and has already been filtered through some previous person, used for other means, or more so, that it has been collected in a particular way, for particular reasons. Neuwman's (1991) reasoning for this is that "*implicit theories and value assumptions guide which information is collected and the categories used when gathering it*" (p.279). A number of intake forms lacked the information needed for the purposes of the present study, as information had been collected and recorded for the purposes of counselling.

The researcher should therefore apply caution when analysing the data, bearing in mind that its previous uses could influence the accuracy of the information gathered.

3.6. LIMITATIONS OF THE STUDY

With all techniques employed in research practice, it is important to view them in terms of their advantages but also in terms of their limitations. With therapeutic records, such as those used for the purposes of this study, the limitations seem to be quite central to the fact that the information used for studies are usually institutional documents, and thus susceptible to institutional bias. Existing documentation, are usually guided by policies, needs and interests of the person, or the particular institution or organisation that created and recorded the data (Hill, 1993). This is particularly relevant to the situation at Triangle Project as existing data regarding clients who had used the counselling service had been recorded and stored, but not in a systematic manner that would aid the research process. The information had also been recorded for the purposes of clinical and or therapeutic interventions.

Furthermore, as stated by Hill (1993), the quality and accuracy of the data collected is not guaranteed because different individuals do the recording of information. In the case of the present study, various counsellors had seen clients in initial interviews in which they had recorded information and completed the intake forms, thus influencing the consistency of record keeping. In addition the data collected was often found to be inconsistent and information was often left unrecorded, resulting in gaps in the data. Poor and inconsistent record keeping was evident, although this seems to have improved over the period being studied. One of the key limitations of this methodology as Hakim (1987) pointed out, is that the scope and content of studies are constrained by the nature of the data available, as there sometimes may be missing data.

In the last two years of the period under examination, the recording of information improved due to several factors. These include; more consistency of counsellors in terms of record keeping, the revision of the intake form – the latest one appears more user-friendly, yet effective in capturing

information necessary for a therapeutic intervention, and the overall general stability of the organisation and more specifically, the counselling service. It should be noted however, that even though information had not been efficiently captured in all instances in interviews with clients, there was sufficient information that allowed for the examination of the trends and patterns of a client group who made use of the counselling service at Triangle Project. In addition to the intake forms, other organisational documents like the annual and evaluation reports also provide useful information. Forster (1990) pointed out that documents can never be analysed in isolation and can only be understood in terms of the holistic view of the organisation. In the following chapter, a more detailed analysis of the data is provided.

CHAPTER FOUR: ANALYSIS OF THE FINDINGS

4.1. INTRODUCTION

This analysis examines the patterns and trends within the presentation of clients at the counselling service of Triangle Project during the period 1996 to 1999. The following sections describe the general trends derived from examining the intake forms of clients presenting at the counselling service, as well as from the various organisational reports, and are discussed under the following headings:

- Client means of referral to the counselling service
- Client intake according to the year of presentation
- Client demographic characteristics
- Client presenting problems

Client information was sometimes incomplete. Even though 233 intakes were done during the period, 14 (6.01%) of the cases did not have complete identifying information for the client.

4.2. REFERRAL ROUTES TO THE COUNSELLING SERVICE

Clients reached the Triangle Project counselling service in the following ways; through media, the helpline, as a returning client, through the referral of a professional, through friends, family, other mental health agencies e.g. the state hospital, from sources internal to the

Organisation, and through other organisations. In some instances the source of referral is unknown due to information not recorded or the client not being able to supply this information.

Table 1. Referral Routes of Clients to the Counseling Service during 1996 to 1999

Referral source	Number	Percentage
Media	15	6.44%
Helpline	17	7.29%
Self-referral	53	22.74%
Professional	28	12.02%
Friends	23	9.87%
Family	3	1.29 %
Mental health agency	6	2.58%
Internal to the Organisation	14	6.01%
Other organisations	22	9.44%
Unknown	52	22.32%

Client referrals can be divided into two groups, namely, those coming from within the Organisation and those from sources external to the Organisation. The helpline (n = 17; 7.29%) and other referrals from within the Organisation (n = 14; 6.01%) contribute to 13.3% (n = 31) of the total referrals to the counselling service. Referrals from external sources are from other professionals (n = 28; 12.02%), mental health agencies (n = 6; 2.58%) and other organisations (n = 22; 9.44%), amounting to 15.45% (n = 56) of the total number of referrals.

Referrals from other sources like the family (n = 3; 1.29%), friends (n = 23; 9.87%), media (n = 15; 6.44%), and self-referrals (n = 53; 22.74%) contribute to 40.34% (n = 94) of the total number of referrals to the counselling service.

The highest number of referrals (n = 53; 22.74%) came in the form of **self-referrals**. This means that clients falling into this category were either previous clients at the counselling service, or that they had some knowledge of the service that had been obtained through none of the other specified categories listed. Self-referral also suggests that the client made use of the counselling service **voluntarily**. The other main sources of referral are from other professionals (n = 28; 12.02%), friends (n = 23; 9.87%) and other organisations (n = 22; 9.44%). These sources indicate that there is a growing increase in the visibility of the counselling service provided by Triangle Project as the main sources of referral stem from sources external to the Organisation. In addition, referrals to the Organisation have increased from 1996 to 1999.

The category of information reflected as "unknown" constitutes 22.32% (n = 52) of the number of referrals. In some instances the source of referral is unknown due to the client not being able to supply information regarding the referral source. This category also represents clients from where the referral source is unknown by the researcher as this data had not been recorded in initial interviews with the clients. It is therefore unclear from where these clients had been referred to the counselling service.

4.3. CLIENT INTAKE ACCORDING TO THE YEAR OF PRESENTATION

Despite under-reporting of client statistics, a general growth of services over the last four years is indicated by the figures. This upward trend is evident in the number of clients that have increased from 29 in 1996, to 85 in 1999.

Table 2. Client intake from 1996 to 1999

Year	1996	1997	1998	1999	Unknown	Total
No.	29	35	70	85	14	233
Percentage	12.45%	15.02%	30.04%	36.48%	6.01%	100%

The increase of more than double in the number of intakes seen at the counselling service can be attributed to several factors. Firstly, it can be postulated that an increase in the overall stability of the Organisation contributed to the increase in the number of clients seen at the counselling service. Furthermore, the separation of counselling and management functions started in 1998 and allowed for the provision of more resources for the counselling service. It could be hypothesized that this also resulted in the increase of clients, particularly from 1998. Secondly, factors such as an increase in the visibility of the Organisation could also have contributed to the observed increase. Thirdly, the 1994 elections and subsequent advocacy for human rights, resulted in the development of a constitution protecting and promoting the rights of sexual minorities, and could have resulted in a larger number of people from the GLBT community making use of services targeting GLBT individuals, like the counselling service at Triangle Project.

4.4 CLIENT DEMOGRAPHICS

While the study examines the trends and patterns of all clients making use of the Triangle Project counselling service, particular attention is paid in this section to the categories gender and race.

Each of these is discussed below.

4.4.1. Client Profile in terms of Gender

With an increase in the overall number of intakes for the period 1996 to 1999, an increase is evident in the number of men relative to the number of women making use of the counselling service at Triangle Project. While the number of men making use of the service has always been higher than the number of women using the service, the number of men using the service has increased and remains higher. During the period studied, men comprise 59.66% of the total number of intakes recorded. Women make up 33.91% of the intakes seen at the counselling clinic between the years 1996 to 1999.

Table 3. Client Characteristics in terms of Gender.

Gender	1996	1997	1998	1999	Unknown	Total
Male	16	20	42	61	-	139
Female	13	14	28	23	-	78
⁴ Intersexed	-	1	-	-	-	1
⁵ Transgender	-	-	-	1	-	1
Unknown	-	-	-	-	14	14
Total	29	35	70	85	14	233

⁴ intersexed refers to individuals previously described as hermaphrodites.

⁵ Transgender describes male and females whose psychological orientation lies with the other gender. They may surgically have their external biological sex changed to fit their psychological identification.

It is noteworthy that the number of men making use of the counselling service is higher than the number of women, as most studies show that more women than men seek mental health services. Perhaps the Organisation's history as well as its founding body, which is embedded in a white, male, middle class image, still influences the ratio of men to women utilizing the services of the Organisation. It would also appear that more men than women are openly gay and would therefore be found in higher numbers in organisations such as the Triangle Project. It is possible that more men socialize in the bars and clubs where Triangle Project's media is distributed, resulting in the usage of the services provided.

4.4.2. Client Profile in terms of Race

While there has been a noticeable increase in the number of⁶ people of colour utilizing the service during the period studied, figures representing people of colour remain very low in comparison to the white client group. According to the data, no black clients, male or female, were seen at Triangle counselling service in 1996 and 1997. Over the following two years, 1998 and 1999, black clients made up 4.29% (n = 10) of the total number of clients seen.

An increase is also evident in the number of clients who made use of the service who were classified as coloured. In 1996, coloured clients seen at the counselling service equaled 24.14% (n = 7) of the total number of clients seen that year. In 1999, coloured clients making use of the service comprised of 24.71% (n = 21) of the number of clients seen that year. There was a substantial increase in the number of coloured clients seen during the period 1996 to 1999, as the number increased from 3% (n = 7) to 9.01% of the total number of clients seen.

⁶ "People of colour" is a generic term used when referring to black, coloured and Indian people as a collective

The percentage of coloured clients seen from 1996 to 1999 equals 21.03% (n = 49) of the total number of intakes recorded.

The two categories black and coloured combined, equaled 25.32% (n = 59), still lower than the number of white clients seen at the counselling service. (The category "unknown" consists of the rest of the amount). White clients consisted of 52.79% (n = 123) of the total number of clients seen in the period studied.

Table 4. Client Characteristics in terms of Race.

Race	1996	1997	1998	1999	Unknown	Total
Black	0	0	4	6	-	10
White	18	21	34	50	-	123
Coloured	7	5	16	21	-	49
Unknown	4	9	16	8	-	37
Total	29	35	70	85	14	233

* The category "unknown" refers to intake forms that carried insufficient and /or incomplete information. There were 233 intakes but 219 cases seen.

It is particularly interesting to note that there is no recorded information of any client classified as Indian. It could be that no Indian clients presented at the service, or that there had been no recording of this information. Reference needs to be made however, to the demographics of the population of the Western Cape, wherein Indians are a minority. While this can account partially for the lack of representation of Indian clients at the counselling service, other clients, who are of colour are also represented by lower numbers than white clients.

It is important that the history of Triangle Project is understood as being a contributing factor to the low numbers evident for clients of colour, as its history is embedded predominantly in the image of the white, middle class male.

4.4.3. Client Profile in terms of Race and Gender

There has been a substantial growth in the number of women making use of the counselling service at Triangle Project. While the numbers of women of colour remain low in comparison to white women, there has been a steady increase in the number of intakes of women of colour.

Table 5. Women according to Race

	1996	1997	1998	1999	Total
Black	0	0	2	5	7
Coloured	5	3	7	4	19
Indian	0	0	0	0	0
White	7	10	16	14	47
Transgendered	0	0	0	1	1
Unknown	1	1	3	0	5
Total	13	14	28	23	79

* 1 transgendered individual who identified as woman was seen in 1999

According to the data, no black women clients presented at the counselling service in the first two years. By 1999, black women consisted of 3% (n = 7) of the total number of clients seen during

the period studied and 8.86% (n = 7) of the total number of women seen at the service for the entire period. There were more black women, however, than black men.

Women classified as coloured consisted of 38.46% (n = 5) of the total number of women seen in 1996, and 17.39% (n = 4) of the women seen in 1999. They represent 8.15% (n = 19) of the total number of clients seen at the counselling service during the period 1996 to 1999 and consist of 35% (n = 24) of the total number of women seen. Coloured women form the second highest number of women seen at the counselling service. As mentioned previously, no Indian women were seen and this could be indicative either of information not being recorded, or that there were no Indian women presenting at the service. White women, 59.49% (n = 47), of the total number of women seen, remain the highest group of women seen at the service. This particular client group increased from 8.86% (n = 7) of the total number of women seen in 1996, to 17.72% (n = 14) of the women seen in 1999. Even though the number of men generally in the client group was higher than that of women, the client group of white women presented more at the counselling service than women of colour.

Table 6. Men according to Race

	1996	1997	1998	1999	Total
Black	0	0	2	1	3
Coloured	2	2	9	17	30
Indian	0	0	0	0	0
White	11	10	18	35	74
Intersexed	0	1	0	0	1
Unknown	3	8	13	8	32
Total	16	20	42	61	140

* 1 intersexed individual who identified as male was seen in 1997.

Black male clients, second to Indian male clients, form the smallest group of clients seen at the service. The intake numbers recorded for black males were extremely low compared to their white counterparts, and consisted of 1.29% (n = 3) of the total number of clients seen during the period, and 2.14% (n = 3) of the total number of men seen for the period. The number of coloured male clients, while also low in number, is substantially higher than that of black male clients. For the period 1996 to 1999, coloured male clients comprised of 12.88% (n = 30), of the total number of clients who had presented at the service, and 21.43% (n = 30) of the total number of males who had been seen during the period. As in the case of the female clients there is no information recorded for Indian male clients, leaving the interpretation that no Indian men presented at the service during the period studied.

The counselling service is and always has been used most by white men who remain the most dominant users in the period of years studied. An increase in the number of white clients utilizing the counselling service is evident over the period 1996 to 1999. Of the total number of clients who made use of the service during 1996 to 1999, white males consisted of 31.76% (n = 74). The total number of white males increased from 4.72% (n = 11) of the total number of clients, to 15.02% (n = 35) of the total number of clients who made use of the counselling service. They therefore remain the majority group utilizing the counselling service.

It was observed in the study, that men form the highest percentage of clients (as compared to women) who made use of the counselling service. It is of particular note however that while this was true for the white and coloured client groups, more black women than black men used the service during the period observed. In both the coloured and white client group, men were seen to use the counselling service more than women.

Factors accounting for the smaller number of people of colour evident may include the geographical positioning of the counseling service, which is not central to black and coloured townships. Also, cultural factors within these groups could influence the number of clients making use of the service. Other factors, such as language and the Organisation's history as being white and for gay males, could also contribute to this. A more detailed analysis regarding the use of the counselling service will be discussed in the next chapter.

4.4.4 Age Range of Clients using the Counselling Service

The age range of clients, who utilized Triangle Project's counselling service during the period 1996 to 1999, was between 14 and 65 years. The table below illustrates that the majority of clients (n = 87; 37.34%) fall within the 26 to 35 years age category. The lowest percentage of clients 1.29% (n = 3), fall within the 56 to 65 year age group, while the youngest age group (14 -17years) consists of 2.58% (n = 6) of the total number of cases seen. Table 7. depicts the age range of clients using the counselling service at Triangle Project.

Table 7. Age Range of Clients using the Counselling Service.

Age group	Count	Percentage
14-17	6	2.58
18-25	56	24.03
26-35	87	37.34
36-45	56	24.03
46-55	17	7.30
56-65	3	1.29
Unknown	8	3.43
Total	233	100

4.4.5 Client Level of Education

Of the clients presenting at the counselling service, most (n = 85; 36.48%) have a matric level of education, while clients with university level of education constitute 15.88% (n = 37), followed by those who hold a technical degree/diploma. A small percentage (0.86%) of clients had obtained their education at specific institutions for people with disabilities, for example, Cerebral Palsy. The category “unknown” reflects a high percentage, 33.47%, (n = 78) of clients for whom information had not been recorded.

Table 8. Client Level of Education

Level of education	Count	Percentage
Primary School	2	0.86
Matric	85	36.48
University Degree	37	15.88
Diploma	29	12.45
Special education	2	0.86
Unknown	78	33.47
Total	233	100.00

4.4.6. Employment Status of Clients

The highest number of clients (n = 91; 39.06%), presenting at the counselling service had some means of employment, while 18.45% (n = 43) were unemployed. Clients who were self-employed consist of 8.15% (n = 19) of the sample of clients and an additional 3% (n = 7) of the clients, reported sex work as their employment. A small number of clients (n = 3; 1.29%) are in receipt of a disability pension, and are therefore otherwise unemployed. Table 9. illustrates the employment status of clients who had made use of the counselling service at Triangle Project.

Table 9. Employment Status of Clients using the Counselling Service

Employment	Count	Percentage
Self-employed	19	8.15
Sex work	7	3.00
Employed	91	39.06
Unemployed	43	18.45
Part-time employment	7	3.00
Disability pension	3	1.29
Unknown	49	21.04
Total	233	100.00

4.4.7. Clients sexual orientation

The majority of clients who seek services at Triangle Counselling clinic are sexual minority persons – lesbians, gay men, bisexuals, transgendered and intersexed people. Statistics on clients' sexual orientation are presented in Table 10.

Table 10. Sexual Orientation as Identified by Client

Sexual orientation	Number	Percentage
Heterosexual	19	8.15%
Gay	105	45.06%
Lesbian	55	23.61%
Bisexual	4	1.72%
Transgendered	1	0.43%
Intersexed	1	0.43%
Unknown	48	20.60%
Total	233	100.00%

Table 10. shows the client statistics by the sexual orientation as identified by the client. Most of the client population identified as gay, 23.61% (n = 55) of the clients identified themselves as lesbian. A percentage of clients identified as heterosexual, namely 8.15%. (n = 19). This figure could account for those either affected by GLBT issues, for example family members, or those who do not identify as gay but their sexual behavior is with those of the same sex. It should be noted that in some cases, clients had also been inappropriately referred to the clinic. Heterosexual people could have presented in the clinic in this manner. The majority of clients making use of the counselling service self identify as gay.

In the previous two years there seems to have been an increased awareness around intersexed individuals. Figures are low for this category and account for 0.43% (n = 1) of the total number of cases seen. This is also the case for individuals termed, transgendered. The category described as 'unknown' accounts for a high percentage of the cases seen. This could however mean that these clients were not able to identify with any of the other categories. This could also reflect the incomplete information recorded on the intake form.

4.5 CLIENTS' PRESENTING PROBLEMS

Clients presented at the counseling service with a variety of problems, and these have been classified into the following categories: sexual orientation, interpersonal relationships, situational problems, crisis, alcohol/drugs, neurosis, and psychosis. Other categories include: HIV/AIDS,

⁷Coming Out, Disability, Couple Counselling, Presenting Problem(s) Unknown, and Other.

⁷ "Coming out" is the term used to describe the process which individuals come to recognise that they have romantic and sexual feelings toward members of their own gender, adopt gay identities, and then share these identities with others.

The presenting problems recorded were those accounted for by the client as their perceived problem. In some cases, more than one presenting problem was recorded.

Clear differences exist between the reported problems of female clients and those reported by male clients. The presenting problem listed most often across **all** the clients was **interpersonal relations**, more specifically relationship problems. Interpersonal problems are defined, for the purposes of this study, as both the intimate, physical relationship(s) with a partner and the relationships with family members. This would include both the family of choice and the family of origin. While both male and female clients rated relationship problems most frequently as their perceived problem, there was a higher percentage for female clients. More female clients than male clients thus reported difficulties in their intimate relationships, as a presenting problem. While this is shown in Table 11, it is important to remember that more than one presenting problem could have been recorded per client. It does not therefore permit for any mathematical inferences to be made.

Other high numbers are also reflected in the category of "Situational problems". Situational problems consist of any legal, medical, economic, and housing problems that the client might have expressed as the presenting problem. It is interesting to note that a higher percentage of male clients report situational problem(s) as their main stressor. More male clients than female clients report situational problems. Loneliness appears to be the most reported problem within that category, with a higher percentage reflected from male clients than from female clients.

Table 11. Clients presenting problems

	Male					Female				
	1996	1997	1998	1999	Total	1996	1997	1998	1999	Total
Sexual Orientation	2	0	10	6	18	2	2	1	2	7
Gender Identity	0	0	0	0	0	0	1	0	1	2
Situational Problems	5	4	7	8	24	1	1	1	2	5
Interpersonal Relations	6	6	18	21	51	14	13	20	18	65
Crisis	1	1	1	0	3	0	0	2	0	2
Alcohol / Drugs	1	1	0	3	5	2	0	0	0	2
Emotional	2	3	3	10	18	1	3	6	4	14
Coming Out	3	3	4	5	15	1	1	1	4	7
Disability	-	-	-	1	1	-	-	-	-	0
HIV / AIDS	1	1	7	15	24	-	-	-	3	3
Couple Counselling	-	2	4	2	8	-	4	3	6	13
Presenting Problem Unknown *	1	4	5	7	17	-	3	2	-	5
Other	3	-	1	-	4	1	2	4	-	7

* Presenting Problem Unknown refers to instances when there was insufficient data recorded.

Depression is also a commonly reported problem for both male and female clients, followed by Coming Out issues. Previous studies such as Ryan and Bradford (1988) with lesbians indicated a high level of depression. The present study has indicated similar outcomes with depression also being rated as one of the most reported stressors for gays and lesbians. For the purposes of this

study, depression was understood as a presenting problem if the client gave an account of the symptoms of depression, without necessarily naming it that.

A significant number of clients present with HIV related problems as their main concern. It would seem that in the latter part of the period of this study, more clients presented with HIV related issues. It is important to note that a much greater percentage of males than females presented with HIV related issues being their main concern.

4.6. OVERVIEW OF THE DATA

The pattern of incomplete client information runs throughout the data. Despite this there is still more than sufficient information from which to make inferences. From the basic analysis made thus far, several trends in terms of the client's demographics as well as presenting needs and concerns, emerge.

A distinctive feature arising across trends over the period of time studied, is the lack of representation of clients of colour. It is possible that this information was not recorded and thus not reflected in the data, therefore contributing to the numbers reflected in the overall study. It is however, unlikely that this would account entirely for the lack of presentation of people of colour. The number of gay men outweighs the number of lesbians who made use of the counselling service during the period 1996 to 1999, and seems to be contributed to by several factors such as the image held of the organization as being one providing services to largely white, gay men. Gonsiorek (1982) stated that organizations' images and development impact on the clients' use and or non-use of a service like the counselling service.

It is also evident that the majority of clients presented at the counselling service with issues relating to interpersonal relationships. These relationships were further divided into intimate, physical relationships and familial relationships. An increase in the number of clients presenting with issues relating to HIV is also noticeable, particularly in the last two years of the study. Issues regarding sexuality and coming out as presenting problems only contributed to a small number of concerns presented.

Lesbians, gay youth, and gay and lesbians of colour, will be discussed in more detail as they have been identified as being more invisible and marginalized in an already marginalized group. Particular attention will be paid to these three groups that have been identified as subgroups within the GLBT communities, as they are seen as groups that are even more marginalized, as sexual minorities, which therefore places them as groups more at risk. All the trends and patterns that emerged from the data will be discussed in more detail in the following chapter.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

5.1. INTRODUCTION

In this final chapter, the patterns and trends that emerge from the data are discussed in terms of other studies that examine gay and lesbian mental health services. Attention is also drawn to issues pertaining to the counselling service at Triangle Project, and recommendations are made that may assist mental health workers who are likely to work with GLBT individuals. Finally, the implications of the research process, its merits and constraints are discussed.

5.2. OVERVIEW OF FINDINGS

5.2.1. Client Means of Referral

Clients are referred to Triangle Project through various routes. During the period 1996 to 1999, most clients presented at the counselling service largely by way of the category "ex-client". This means that clients returned to the service, with the assumption being that they presented voluntarily with their concerns. It appears that the majority of clients could be seen as taking responsibility for their own mental well - being. A study done at the Seattle Counselling Service (Klein, 1991) showed that the highest number of referrals was reflected in the category "ex-client". In both instances, at Triangle Project and the Seattle Counselling Service, clients who had previously used the counselling service formed the highest number of clients who made use of the service.

It could be hypothesised that the short - term, eight session counselling service model could also have contributed to the high number of clients reusing the service as clients would “pass through” the counselling system relatively quickly. It is important to note that the high number of clients who returned to the counselling service indicates that largely the same client base used and reused the service, in comparison to a small percentage of new clients. It could be deduced that fewer new clients, in comparison to returning clients, made use of the counselling service during the period 1996 –1999. The repeated use of clients who had used the service previously could also signify that they found the service useful and beneficial.

The referral category termed as "professional" yielded the second highest number of referrals. Here it could be postulated that the overall gradual growth in the stability of the Organisation, as well as the growing visibility, contributed to the number of referrals from professionals in other settings. Also, many old members of the Organisation when it was still known as Gay Association of South Africa 6010 (GASA 6010) and Aids Support and Education Trust (ASET) were professionals and some are still positioned in different areas within the helping profession. It is possible that former members of Triangle Project, in various sectors within the broader mental health arena, could also have contributed to the number of referrals to the counselling service.

The counselling service is staffed by volunteer counsellors who are registered social workers or psychologists, who are also employed within the private and public sectors. Client referrals sometimes originate from these sources, as they might not have been able to afford the private rates for counselling and/or therapy. Since Triangle Project counselling service implements a sliding fee scale, clients are able to pay what is affordable and reasonable thereby making it accessible particularly to indigent gay people.

Klein (1991) argued that the cultural labelling of gays as mentally ill is another major factor, contributing to mental health seeking behaviour by gays and lesbians. This seems to occur in instances both when they seek therapy on their own accord or through the recommendations or coercion of others. Gay and lesbian individuals seem to make use of services that serve the GLBT community since these services are also perceived as agents that minimise and even remove labels that negatively impact on GLBT individuals. It is possible then that gays and lesbians, because of being labelled and perceived as mentally ill by virtue of their sexual orientation and preference, seek mental health services aimed at them. This could be one of the reasons contributing positively to the overall number of clients seen at Triangle Project's counselling service. However, it could also be postulated that due to the cultural labelling of gay and lesbian individuals as mentally ill as well as the other stigmas attached to a homosexual identity, these individuals seek counselling services in the mainstream without disclosing their sexual preference. Not making use of a counselling service aimed at gays and lesbians could also be a way of not risking the disclosure of sexual identity.

5.2.2. Client Intake According to Year of Presentation

There was a noticeable increase in the number of clients who made use of the service within the period 1996 to 1999. This increase could be attributed to several factors, which could be seen as being partly the result of broader socio-political movements and developments in South Africa during that time. The 1994 democratic elections created the vehicle for the beginnings of the protection and for the advocacy of human rights, of which the rights of sexual minorities are included. It was only in 1996 that Triangle Project could obtain a fundraising number, an achievement that had not been possible before because of it being a gay and lesbian organisation.

The Constitution allows for organisations, people and thus clients to become more aware of their rights and of the resources, such as health services, available to them. This could be said for only a percentage of clients, for although the Constitution provides the social and legal framework for Human Rights, this does not translate into the lives many. Klein (1991) outlines a similar process of the development of counselling services such as the Seattle Counselling Service and explains how services originated from and were shaped by developments that took place within the broader society and the gay movement.

The organisational transition in 1996 seemed to have had a negative impact on the number of clients who made use of the services, particularly the counselling service. Statistics from the counselling services reflects a relatively low number of clients making use of the services. In 1998, the number of intakes had more than doubled since 1996. Increase in the visibility and internal stability of the Organisation could possibly have lead to the increase in the number of clients seen, as well as the increased number of referrals from professionals outside of Triangle Project. In addition, a new clinic manager was appointed in the counselling service, and this seemed to get the counselling service prioritised with added effectiveness (Annual Report, 1997). The changes within the staff component and the reprioritisation of the counselling service that occurred in 1997 could also be seen as having a significant impact on the delivery of services and the number of clients making use thereof. The number of clients increased substantially from 1998.

5.2.3. Client Profile and Demographics

It is of great importance to examine the profile of the client group who made use of the counselling service at Triangle Project during 1996 to 1999 as it provides insight to the clients who generally

make use of the counselling service. Particular attention is given to the patterns that emerge regarding the race and sex of clients.

Age

For the purposes of this study the category ⁸“youth” is understood as those clients who are below the age of 19 years. Within the South African law, gay men can only give consent to sexual relations (with other men) after age nineteen years. Sexual relations with a gay man below the age of nineteen years, is criminal. This is an important consideration when discussing the results of the present study in terms of age. The results showed that a small percentage (2,58%) of clients, who had made use of the counselling service, fell into the category termed “youth”. Special consideration needs to be taken with this particular group as they have been identified as a minority group with different needs, within the larger GLBT group that in itself is a minority group. While it is understood that clients of different age groups could present with similar issues, gay youth have certain issues related to the developmental stage they have to deal with, in addition to being gay.

In studies done in the USA by Chung and Katayama (1998) it is reflected that younger gay and lesbian individuals are usually dependent on their parents and may not firstly, have the autonomy of making use of counselling services. Secondly, they might not feel comfortable about being open about their sexuality to another adult or parent figure. Furthermore, by virtue of their developmental stage, adolescent youth might not necessarily acknowledge the need for counselling.

It is possible that these individuals do not present at gay counselling services because of stigma attached to seeking mental health services, more particularly gay counselling services, as well as the

⁸In South Africa, youth is defined as persons under an including age 35.

possibility of their parents and others becoming aware of their sexuality. Because of the difficulty in developing a healthy identity in a largely homophobic society, gay and lesbian adolescents have therefore been identified as an at-risk population (Chung & Katayama, 1998).

Cooley (1998) identified that health risks was one category of the five major presenting problems of adolescents. While this was not the focus of the present study, it is important to note that suicide was identified as one of the health risks facing gay and lesbian adolescents. Studies done by Fikar (1992) found that three out of 10 homosexual adolescents attempt suicide. Gay and lesbian adolescents are not unlike their heterosexual counterparts in experiencing what has been identified as one of the most chaotic periods in one's life. However, the gay or lesbian adolescent also has to deal with in addition to other potential developmental difficulties, issues regarding sexuality. While the low visibility of adolescents at gay counselling centres such as Triangle Project, can be understood, it appears that interventions and services aimed at supporting gay and lesbian adolescents are needed. The high suicide rate of gay and lesbian youth indicates that GLBT youth face many challenges and problems for which they need support.

Gender

There has been an increase in both the number of gay males and gay females that presented at the counselling service of Triangle Project. However, more gay males than gay females made use of the counselling service during the period 1996 to 1999. Studies like Doyal (1995) indicated that women usually present for counselling more often than men and studies such as Ryan and Bradford (1988) showed that lesbians sought counselling at a greater rate than the general sample of women.

The findings reflecting that more gay men, than lesbians, use the counselling service at Triangle Project could be analysed in a number of ways. Firstly, it is imperative that the counselling service and the use thereof is seen in relation to the Organisation's strong history and the possible image

associated with it. The Organisation is embedded in a history that is white, middle class, and that gay men co-ordinated and made use of the services provided. It could be speculated that the general perception held of Triangle Project is one that provides services to white, gay males, and that it is "male" organisation. Since the counselling service had also been initiated by several white, gay men in response to meet the mental health needs of similar men, this service particularly could be viewed as being one for gay males.

Interestingly though is that findings from studies of other gay centres, that compare males and females making use of counselling services indicate that gay men generally make use more of gay counselling services than gay women or lesbians (Klein, 1991). Of the twelve counselling centres in the study, only one centre showed more females than males, using the counselling services. From the data of the present study, it is evident that more gay men than lesbians made use of the counselling service and the increase in the number of gay males who had made use of the service is evident on an annual basis.

The under-representation of the number of lesbian women at the counselling service could be accounted for by several factors. According to the present study, clients' sexual orientation was recorded from self-identification. (See Table 10. Sexual Orientation). Denenberg (1994) however stated that reliance on "self-labelling" could be particularly limiting in the studies of women who might identify with a variety of labels other than lesbian, even if they are involved in same gender relationships, or if they engage in same sex intimate relationships. This also seems to be noticed with men and as Hays and Samuels (1989) comment, not all men who engage in sex with other men identify themselves as gay either, especially married men and as stated by Greene (1994); Peterson and Marin (1988); and Zamora-Hernandez and Patterson (1996), ethnic minority men.

By not identifying themselves as gay or lesbian, these individuals could make use of general services and not services aimed at the GLBT community. By using general services, gay individuals are less likely to volunteer their sexual preference and orientation as information. It is possible that lesbians make use of counselling services where they do not have to necessarily disclose their sexual orientation and in this way remain invisible.

Race

While more gay men than gay women presented during the 1996 to 1999 period, it was white gay men specifically who contributed a large percentage to the overall total number of gay men who made use of the service. White gay men outnumber both black and coloured men who used the service. It should be highlighted that as with the increase in the overall numbers of the client group making use of the service, the numbers for individuals of colour using the counselling service has also increased steadily. The number of coloured gay men increased from 1996 to 1999 by 7.85 %.

This increase contributes to the overall percentage of coloured gay men and women, and it would seem that the last two years (1998 and 1999) reflect an increase in the number of both gay coloured men and women who used the service. Coinciding with this period was the opening of the township office of Triangle Project, the appointment of black field – workers, and later the appointment of a part-time counsellor of colour. It could be hypothesised that the increase in the number of people of colour indicated a gradual change in the way in which the Organisation had been perceived in terms of race. Of interest is the number of black men who had made use of the service in relation to the number of black gay women, as more black gay women presented at the service. How could we understand and explain the lower number of lesbians and more so lesbians of colour making use of counselling services?

Lesbians of colour are faced with "triple jeopardy", as they must cope with oppression due to their race, gender, and sexual orientation (Greene & Boyd-Franklin, 1996). These individuals fall within groups termed as minority groups in instances of race, gender as well as sexual orientation, and could possibly experience increased discrimination and negative attitudes held by society. According to Chrisman's (1977) model of health seeking behaviour, intra-cultural differences, for example those that exist between gay men and women of colour, impact on health seeking patterns of individuals. Certain beliefs and cultural practices impact heavily on sexual minorities, exerting great pressure on the individual to conform to the norm of the particular culture. Making use of Triangle Project's services could be perceived as a possible threat to being ⁹"outed" and then having to deal with the consequences this might have. This could be speculated for minority groups within the broader GLBT community, for example, lesbians, and gay males of colour as well as lesbians of colour.

The cultural community of the individual may not respond favourably to issues regarding sexual orientation other than heterosexual, thus increasing the chances of discrimination and homophobic attitudes and practices. Remaining "invisible" appears to be a measure of safety for the individual and might further be entrenched by the individual's own cultural beliefs. The non-use of services provided for gays and lesbians, of colour particularly, could be understood partly as being a response to the fear of disclosing sexual identity, which could result in the possible rejection by others, for example, family and or the larger cultural community. The potential stigma of making use of a gay service could pose as being too threatening for the individual who then chooses to use a more discrete service for his/her mental health needs. It is likely that these individuals make use of other general services at which their sexual orientation could remain hidden.

⁹ "outed" refers to the individual's gay sexual orientation being forcibly disclosed.

In a study focusing on gay ethnic minority groups, Chung and Katayama (1998) suggested that because heterosexism and homophobia are so intense in Asian cultures an openly homosexual lifestyle is often not an option, and the consequence of disclosing one's sexuality is just too threatening. They added that this could possibly be reflected within other ethnic minorities as well. Perhaps this could be used to understand the dynamics surrounding the lack of use of gay counselling services by people of colour in South Africa as well.

Akerlund and Cheung (2000) highlight that the assimilation into the gay community could be a difficult task. The literature also describes a process wherein gay individuals of colour are assimilated into the gay and lesbian community and how this process is crucial to the individual's general sense of well - being. Non-assimilation into the community could result in individuals having a lesser chance of receiving information and thus gaining access to services such as Triangle Project's counselling service. Like the Asian respondents in the study by Chung and Yatayama (1998), other ethnic minority group members and people of colour might not readily be assimilated into a gay community, if it is largely white, for example. Gay individuals of colour thus stand a chance of non-acceptance in both their own cultural groups as well as in the white gay community, resulting in possible alienation. This could also be seen as a reason contributing to the low numbers of people of colour, both in terms of gay men and women who made use of the service. Hidalgo (1995) made reference to the ethnological studies that hint that a lack of identification with a gay identity contributes to the mental health seeking behaviour of minority ethnic groups, and could thus reflect in the trends and patterns observed in the clients presenting at the counselling service. As an organisation, Triangle Project, as discussed earlier, has its roots in a history dominated by white, middle class, male figures and this image still seems to

image still seems to be impacting on the counselling service, as clients who are of colour might not feel comfortable approaching the service.

Gonsiorek (1982) discussed organisational and staff problems in gay and lesbian mental health agencies and stated that it is crucial to understand the experimental nature of gay and lesbian mental health programs, and the social contexts in which they operate. The development of the organisation as well as broader development external to the organisation has an impact on the patterns and trends observed. This is reflected both in the findings of the present study which show how changes within Triangle Project impacted on the patterns evident in the client group who made use of the counselling service. The nature of the Organisation and its service growth is largely impacted upon by external developments. The findings of the study show an increase in the number of people of colour from the year 1996 to 1999 and confirm findings from other studies that allude to the notion that changes within broader structures created change for GLBT issues.

Gonsiorek (1982) further explained that the 1970's had been a decade in which major reconceptualisations and accumulation of new data about homosexuality took place. These changes were reflected in community mental health service, diagnosis, and the role of mental health in political and social change. This could be held true for the South African context in which political change influenced the human and legal rights of gay individuals, on a policy level and the implementation that followed in the latter part of the 90's. The changes visible within the client group who made use of the counselling service at Triangle Project, for example, the increase in the number of clients who are lesbians of colour, during the period 1996 to 1999, could well be indicative of changes experienced more broadly.

Klein (1991) states that although concerns with sexism, racism and classism are definitely part of the milieu of most gay counselling services, the results achieved are often not impressive. Most centres reported little effort to attract racial minorities and that these efforts were largely unsuccessful. The findings reflect that Triangle Project counselling service also seems to attract mostly individuals who are not representative of racial minorities. It could be said that they too have difficulty in attracting racial minorities to the service, thereby experiencing similar difficulties as organisations elsewhere.

5.2.4. CLIENTS' PRESENTING PROBLEMS

According to Magnuson and Norem (1995), gay men and lesbians seek counselling at mental health services for a myriad of reasons. It has been observed from the present study, that most clients understand and express their two main presenting problems as **depression** and **relationship difficulties**. However it should be noted that gay males and lesbians expressed different presenting problems, thus indicating their different needs.

Depression

Sorensen and Roberts (1997) reported depression as one of the main reasons why lesbians would seek a [counsellor] therapist. In the present study, this pattern was confirmed. This was followed by relationship problems. These problems (depression and relationship difficulties) were also the stated problems for which most clients sought therapy [counselling]. This of course contradicts the belief that gay women seek mental health services with issues regarding sexual identity and/or sexual orientation as being their main concern. While it is acknowledged that issues regarding sexual orientation are indeed presented by the client, these issues are often not presented as the client's main concern.

In the present study, while gay men presented with homosexuality as a concern, it was not reflected as being one of the most often reported reasons for seeking counselling. It could thus be said that gay men presented for reasons other than issues regarding their sexuality, in the same way as the gay women represented in the study. Gay men described their main concerns as being those linked to situational problems, for example, housing and economic concerns. Loneliness was also expressed as one of the frequent presented problems of gay men in the present study.

Relationship Problems

Ryan and Bradford (1988) commented that their study reflected that the second most reported problem was relationship difficulties experienced by lesbian clients. The relationships referred to were physically and emotionally intimate relationships. Relationship problems are well reported in the data and while both males and females rated highly in this category, lesbians reported relationship problems more often than gay men had. More lesbians than gay men reported having relationship difficulties as their presenting problem. In the present study men's situational problems were reported more often than relationship difficulties. While men reported less regarding relationship difficulties, they reported experiencing more difficulty with problems such as loneliness.

An important observation is the growing number of those clients who had used the service for concerns regarding HIV. The present study reflected that the gay men had presented more with issues regarding HIV and that there had been a steady increase in these concerns over the period 1996 to 1999. Other presenting problems, as articulated by the client were those around "coming out". Few clients reported the process of "coming out" to be their primary concern. This is also reflected by other studies such as Sorensen and Roberts (1997), confirming that coming out is not reported as often as other presenting problems, and is in fact not the focal issue in counselling for gay

and lesbian individuals. The GLBT community is likely to present with similar issues to their heterosexual counterparts and the two groups, as mentioned by Parry and Lightbown (1981) have some common psychological concerns.

Gay males and lesbians, in the light of what has been discussed, make use of gay counselling services for a myriad of reasons. They do not however, express their main reason for needing to make use of the service as being their sexuality. A range of expressed problems by gay and lesbian clients could be quoted, with depression being regarded as the most expressed reason for counselling, followed by relationship difficulties.

5.3. RECOMMENDATIONS FOR COUNSELLING SERVICES

A number of underlying contextual issues, which may be impacting on the capacity of counselling services, to meet the needs of gays and lesbians, were revealed by the analysis. In the light of these findings, this section provides some thoughts and recommendations about how these issues may be addressed.

The analysis suggests that awareness regarding gay and lesbian issues is needed on all levels of decision-making, for the purposes of implementing models of counselling, for example.

Efforts to raise awareness and provide education regarding GLBT communities, particularly those further marginalized within the GLBT communities, are crucial. It is important that there is a bridging mechanism such as this between different sectors and that sexual minorities, are reached in various ways that will promote well-being.

In the context of a counselling service, a good understanding and awareness of the issues regarding GLBT communities, are prerequisites for the counsellor. Helping professionals need to have achieved a degree of skill, knowledge and personal sense of comfort in working with the GLBT communities, and in knowing the characteristics and needs that a particular client group may have. Furthermore, as Falco (1991) suggested, helping professionals also need to be conscious of their own heterosexism. It is important that all mental health workers not only those working in gay counselling centres, but those working in other mental health providing sectors know how to deal with sexual preference issues as well those other issues, presented in a non- judgmental and supportive way. Harrison (2000) recommended that gay affirmative therapy be implemented when working with GLBT individuals.

In working with gays and lesbian persons of colour, social workers and helping professionals need to be familiar with cultural values and factors that affect the process of identity and resulting behaviour (Akerlund and Chueng, 2000). It is great importance that an understanding of the dynamics surrounding the complexities of the formation of a cultural and sexual identity is achieved. This could assist the mental health worker of understanding the difficulties and experience of a gays and lesbians of colour. Atkinson, Morten, and Sue (1983) suggest that mental health workers should borrow from the paradigm of cross-cultural counselling to assist their work with the GLBT communities. For as they would in any cross-cultural situation, they need to remain conscious of the effects of the societal pressures on their client's lives. Furthermore, the awareness of cultural identity formation as well as gay and lesbian identity formation, will improve the practitioner's ability to assist clients in navigating this intersection (Ankerlund and Chueng , 2000). More in-depth research, examining and analysing the issues relevant to gay and lesbian mental health, on various levels is strongly encouraged, as research in this area remains largely unexplored.

The present study has also raised the question regarding working with gay and lesbian youth in terms of the needs of this particular group. The very low representation of youth making use of the counselling service requires further analysis as it could be accounted for by several reasons. This should prompt organisations such as Triangle Project and others to design interventions that would encourage youth to make use of assistance and support with regard to issues regarding sexuality. A strong advocacy role by the Organisation and other role players is also needed so as to prioritise the needs of gay youth.

5.4. RECOMMENDATIONS FOR TRIANGLE PROJECT'S COUNSELLING SERVICE

The broader South African context as well as the history of the Triangle Project and dynamics of minority experiences seems to be inextricably linked and therefore the history of Triangle is challenged by making use of the aspects of work to create a new image. The creation of a new image for the organisation seems crucial, to reshape the associations and perceptions held by the larger community regarding the services provided as well as the Organisation. Due to the limited resources and person power in the Organisation, the use of therapeutic and or support groups could function well for problems such as relationship difficulties, interpersonal skills and personal growth for gay and lesbian individuals.¹⁰

The actual mechanism of the counselling centre requires attention. Other services provided by the Organisation could be strategically developed towards supplying a clientele for the counselling service. Perhaps more conventional methods of working with different client groups need to be

¹⁰ At the time of submission of this study, support groups were being planned.

explored, as traditional methods of counselling, need to be adjusted to the client's needs. The service needs to use its energy to attract people of colour. Perhaps the employment of an additional counsellor of colour who is able to speak the indigenous language of the region would be instrumental in achieving this.¹¹

While the present study and ones such as Ryan and Bradford (1988) reflect an overall view of the clients' presenting problems, it is important to acknowledge that the GLBT community is a diverse one. Extreme caution is therefore necessary when referring to this community in terms of having common experiences and common struggles. Perhaps this study will contribute to an understanding of the role of intra-cultural difference in health care. Klein (1991) makes reference to the precarious relationship of annihilation and acceptance between mainstream mental health agencies and gay counselling services and comments that through persistent struggle, many gay counselling services succeeded in gaining credibility and a foothold in the larger mental health system. This in itself gives testimony to the argument that there is a need for gay counselling services where in gays and lesbians can have a safe, accepting environment. More importantly though is that these services play a consultative role to the mainstream mental health service in providing information for best practise towards meeting the needs of gays and lesbians. This is a crucial service needed and perhaps Triangle Project could offer this kind of consultation as part of their clinical services.

In sum, there is a definite need for gay and lesbian counselling services. While some might choose, for several reasons, not to make use of gay counselling services, for many it is important to have counselling services especially for gays and lesbians. It could be seen as attempts to meet the needs of those who might feel alienated because of sexual preference, by established mental health

¹¹ At the time of submission of this study, a black male had been employed to provide counselling.

institutions. There has therefore been a call for both integrated and separate services, which would be able to serve the needs of gays and lesbians and members from other sexual minority groups.

5.5. LIMITATIONS OF THE STUDY

The study should by no means be seen as one that could be used to make generalisations regarding the broader gay community but as one that provides insight into the client group who made use of the counselling service at the Triangle Project. The research methodology in some ways was limiting as secondary analysis that was used in this study, uses data not intended for research purposes.

Furthermore, the manner in which information had been gathered about clients for the initial intake session did not have a consistent record keeping standard. Record keeping at the Organisation however, seemed to have improved in the last two years looked at by the study and a further recommendation would be to impress the importance of documentation within the counselling service at Triangle Project.

5.6. CONCLUSION

A dearth of information exists regarding the GLBT community and very little information is held on this group who are beginning to make increasing use of mental health services. Without research-based knowledge, little more than a superficial knowledge and understanding of the needs of this population are gained. The results could assist in providing effective services to members of this population. Researchers, who choose to study the GLBT community, provide an important service to education and practice by expanding knowledge about this population and also by providing a foundation on which other researchers could build. With comparison of this study to other

counselling contexts, it is hoped that the study will generate further discussion and encourage similar research to be carried out.

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APPENDIX A

THE INTAKE FORM

INTAKE INTERVIEW SHEET

SURNAME: _____ **FIRST NAME :** _____

BIRTH DATE: _____ **AGE:** _____ **GENDER:** _____

ADDRESS: _____

TEL H: _____ **W:** _____

OCCUPATION: _____

EDUCATION: _____ **REFERRED BY:** _____

SEXUAL ORIENTATION: _____ **SINGLE/INVOLVED:** _____

PRESENTING PROBLEM AND RELATED DYNAMICS:

BRIEF SYNOPSIS OF PROBLEM SITUATION:

VEGETATIVE FEATURES PRESENT: _____

SUBSTANCE USE/ABUSE: _____

PSYCHIATRIC HISTORY: _____

PREVIOUS INTERVENTIONS/TREATMENT: _____

SIGNIFICANT STRESSORS: _____

PERSONAL PRESENTATION (subjective/objective mood, appearance): _____

COGNITION (clarity of thought, insight, flexibility): _____

EMERGENT AXIS II TRAITS: _____

BRIEF ASSESSMENT: _____

SUITABILITY FOR COUNSELLING AT TRIANGLE: _____

DATE OF FIRST APPOINTMENT: _____ **with** _____

AGREED FEE R _____ **per session**

INTAKER's NAME: _____ **DATE OF INTAKE:** _____