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Art Therapy Considerations with Transgender Individuals

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Loyola Marymount University

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RUNNING HEAD: ART THERAPY CONSIDERATIONS WITH TRANSGENDER INDIVIDUALS

ART THERAPY CONSIDERATIONS WITH
TRANSGENDER INDIVIDUALS

by

Bryan A. Schnebelt

A research paper presented to the

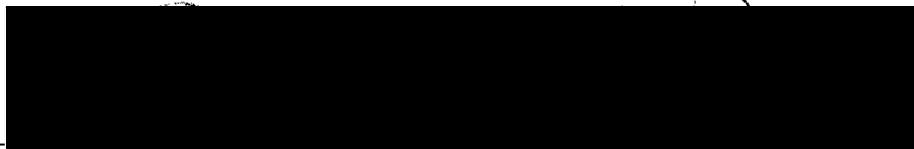
FACULTY OF THE DEPARTMENT OF
MARITAL AND FAMILY THERAPY
LOYOLA MARYMOUNT UNIVERSITY

In partial fulfillment of the
Requirements for the degree
MASTER OF ARTS

May 10, 2015

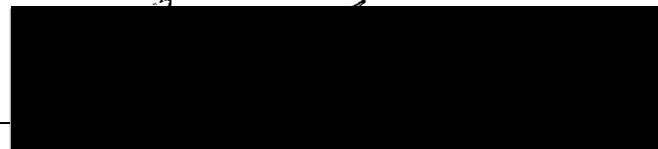
Signature Page

Researcher's Signature:

A large black rectangular redaction box covering the signature of the researcher.

Bryan A. Schnebelt, M.A. Candidate, Art Therapy and MFT Researcher

Research Mentor's Signature:

A large black rectangular redaction box covering the signature of the research mentor.

Dr. Paige Asawa, Ph.D., LMFT, ATR-BC

Abstract

This qualitative research study examines the use of art therapy as a treatment modality with transgender individuals, as well as provides a brief background into transgender identity, in order to recognize considerations for enhanced care of this population. A semi-structured interview approach was applied with art therapists who have utilized art therapy with transgender clients. This study focuses on areas of identity development, aspects of trauma and transphobia and their effects, treatment approaches, and cultural components to working with transgender individuals. Through this research, a recognition of transgender identity as its own cultural entity was found to be important in providing increased awareness and visibility of transgender treatment concerns.

Dedication

This research paper is dedicated to transgender individuals who bravely struggle to find identity and authenticity in the world, and hopes to recognize their continuous courage and determination. The researcher would also like to dedicate this paper to the art therapists and clinicians who have been advocates for the transgender community, and have provided them with the therapeutic tools and resources to help them find their own voice. In the words of Marcel Proust, “Only through art can we emerge from ourselves and know what another person sees.”

Acknowledgments

The researcher would like to acknowledge, first and foremost, Dr. Paige Asawa, for always being a source of support and encouragement, especially in pursuit of this research topic. It was her enthusiasm and passionate stance on research that made it possible to finish this endeavor. Secondly, the researcher would like to thank the fellow members of the trauma research group for contributing a strong sense of community that facilitated important conversations, constructive feedback, and thoughtful accountability. Lastly, the researcher would like to acknowledge close friends and family for providing strength and inspiration to overcome challenging times.

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Introduction

Study Topic

The purpose of this research is to explore the use of art therapy with the transgender population, and specifically what considerations and techniques art therapists can employ when working with this population. This study focuses on therapeutic needs of transgender individuals through a qualitative method, utilizing a semi-structured interview with art therapists who specifically work with this population. This research plans to address how art therapy can be incorporated as a treatment modality, what clinical recommendations have been actively employed in the field by art therapists, and what cultural considerations should be recognized to better serve this population.

Significance of the Study

From the literature explored, it is often noted how mental health practitioners are not properly trained in the specific concerns and challenges of the transgender population to provide appropriate standards of care. The art therapy literature is especially absent of relevant cultural competency information and, while there are a few recent examples of how art therapy can be used with this population, does not offer much guidance for the art therapy clinicians in particular. This study seeks to inform art therapists how they can better serve the needs of the transgender population through more thoughtful practice and become more attuned with what is currently happening in the mental health field with transgender clients. The researcher is interested in how art therapists and other types of mental health clinicians can work together to better aid this underserved population and help them overcome their unique obstacles and find self-empowerment.

Background of the Study Topic

The issue of understanding transgender considerations for treatment and services is still emerging as an area of much needed direction and opportunity in the mental health field (Benson, 2013). The general psychological literature regarding the transgender population has been heavily increasing in the past few years, but there is still a determination to understand how to better suit the needs of this population through the use of art therapy and its practices. According to Benson (2013), clinicians aren't properly trained in the needs of transgender clients, which often produces clinical misunderstanding and insensitive care. Due to higher incidences of physical and sexual violence, suicidal ideation, substance abuse, stigma, and discrimination, it is important for clinicians to be aware of the challenges this population faces (Belluardo-Crosby & Lillis, 2012; Collazo et al., 2013; Cruz, 2014; Flentje et al., 2014; Hendricks & Testa, 2012; Levitt & Ippolito, 2013; Mizock et al., 2014; Nadal et al., 2014; Singh et al., 2014). The DSM-5 implemented changes to begin to reformulate the language used with transgender clients, and appears to lessen the previous focus on pathology and marginalization (Belluardo-Crosby & Lillis, 2012; Collazo et al., 2013) As transgender clients attempt to deconstruct their own personal experiences and ideologies related to gender, clinicians can also provide a means to deconstruct the cyclical nature of concealment and distress (Testa et al., 2012).

In art therapy, the importance of an affirming therapeutic environment for clients who identify as transgender, as well as being cognizant of their unique obstacles of marginalization within the art therapy process is beginning to emerge as a topic for study (Addison, 2003; Beaumont, 2012; Pelton-Sweet & Sherry, 2011). Addison (2003)

mentions the importance of consistently staying informed of the issues and concerns of the transgender experience, as artwork might only be comprehended through a particular awareness. While this awareness is highlighted, there is not enough information available for how to instigate this with clients. Further research is needed to adequately prepare art therapists to be more aware of how to specifically address treatment concerns and develop culturally appropriate interventions.

Literature Review

The transgender community is increasing in visibility as a population and in seeking mental health services; therefore, it is necessary to address the lack of information and sensitivity to providing them with the appropriate care (Benson, 2013). This paper seeks to identify the major aspects of the transgender experience, such as terminology, identity formation, specific trauma factors, psychological treatment concerns, and ways to improve cultural competency for clinicians. In addition, approaches within the field of art therapy will be explored to examine how the field has expanded and how approaches have been modified over time.

Terminology and Transgender Identity

Transgender is a broad term often used to recognize individuals whose gender assigned at birth is inconsistent with how they identify themselves (Bockting, 2014; Collazo et al., 2013; Cruz, 2014; Drescher, 2010; Hendricks & Testa, 2012; Lev, 2004; Mizock & Lewis, 2008; Nadal et al., 2014; Singh et al., 2014). This term also comprises alternate categories of gender expression, including genderqueer, transsexual, gender non-conforming, gender variant, bigender, and gender questioning (Bockting, 2014; Collazo et al., 2013; Donatone & Rachlin, 2013; Mizock & Lewis, 2008). While some individuals might position themselves under the transgender umbrella, others might not acknowledge it at all, and it is important to recognize how each person articulates their own particular definition of gender (Donatone & Rachlin, 2013). Many transsexuals, for instance, “do not identify with transgender because they do not want to challenge gender norms, they want to conform to gender norms- in their affirmed gender” (Donatone & Rachlin, 2013, p. 201). While the descriptors used to acknowledge variations in gender expression change on a continual basis, a majority of the literature seems to find

consensus on the term transgender, which will be used throughout this paper as well.

In addition to evolving terminology, theoretical perspectives on transgender identity formation have changed over time as well. In the last decade, however, the sustained approach to understanding the transgender experience has been understood primarily through looking at an individual's sexual identity. Lev (2004) and Bockting (2014) both describe the importance of understanding sexual identity, which is an involved juxtaposition of natal sex, gender-identity, gender-role expression, and sexual orientation. Natal sex, or biological sex, is the physiological composition of an individual's anatomical and genetic make-up, and is what is often determined at birth based on external or internal genitalia. Lev (2004) defines gender identity "as the internal experience, how one experiences his or her own sense of self as a gendered being," (p.81) whereas an individual's gender-role expression is the socially-constructed aspect of identity that focuses on the public "appearance, behavior, and personality" of gender (p.84). Sexual orientation is the last component of sexual identity, and refers to one's sexual and emotional attraction, which is perceived through an individual's self-expressed gender identity, rather than their biological or natal sex (Bockting, 2014; Lev, 2004).

Changes in the DSM

In previous editions of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM), starting with *DSM- III* in 1980, transgender identity has been viewed through a pathological mind-set (Drescher, 2010). *DSM-IV-TR* transitioned from three separate diagnoses into the singular diagnosis of Gender Identity Disorder (GID), with various criteria that differed for children, adolescents, and adults. In the *DSM-5* (APA, 2013), Gender Dysphoria succeeded GID, and the descriptor of "disorder" was

replaced with the term “incongruence.” Belluardo-Crosby and Lillis (2012) state that this change allows for a possible reduction in marginalization, through offering more humanized language, especially for individuals who have already successfully transitioned to their preferred gender. Similarly, Collazo et al. (2013) agree that the fluctuation in language present in the *DSM-5* helps promote transgender identities in a more affirmative and supportive manner, rather than focus on pathology. One of the key revisions from GID to Gender Dysphoria that helped facilitate this viewpoint was a transition out of the Sexual Dysfunctions and Paraphilic Disorders section into the creation of a newly distinguished, separate chapter (Collazo et al., 2013). One of the concerns for transgender clients is that they might not meet enough of the new criteria, which could possibly affect medical insurance coverage dependent on a diagnosis for approval (Belluardo-Crosby & Lillis, 2012). Benson (2012) similarly suggests that modifications in diagnostic criteria in the DSM can immensely affect transgender people’s ability to receive treatment and the manner in which standards of care are administered. Benson also asserts that “the ongoing revisions of gender diagnosis in the DSM, as well as who has agency to create those changes, exemplifies the socially constructed nature of how gender is defined and decided” (pp. 20-21).

Trauma

The transgender population is widely cited through out literature for being more susceptible to higher incidences of physical and sexual violence, suicidal ideation, substance abuse, stigma, and discrimination. (Belluardo-Crosby & Lillis, 2012; Collazo et al., 2013; Cruz, 2014; Flentje et al., 2014; Hendricks & Testa, 2012; Levitt & Ippolito, 2013; Mizock et al., 2014; Nadal et al., 2014; Singh et al., 2014) Studies related to transgender individuals have often been conducted as a means of comprehending this

exposure to trauma and subsequent behavior changes. One particular theoretical framework widely utilized within transgender trauma research in the last few years has been Meyer's 2003 minority stress model. Flentje et al. (2014), Hendricks and Testa (2012), Levitt and Ippolito (2013), and Mizock et al. (2014) have each adapted Meyer's focus on the unique stressors related to lesbian, gay, and bisexual (LGB) individuals to extend to the transgender population as well. Meyer's model was first introduced as a way to identify the increased occurrence of mental health concerns and maladaptive coping in LGB populations as a result of external stress, and while transgender individuals have their own distinct concerns, there are many parallels (Flentje et al., 2014; Hendricks & Testa; 2012; Levitt & Ippolito, 2013; Mizock et al., 2014). In addition to overt minority stressors, Nadal et al. (2014) cites various types of microaggressions that range "from hate crimes, systematic bias, and subtle forms of discrimination and injustice" that affect the psychological health of many transgender individuals within "the criminal justice system, health care, family, employment, education, and other service providers" (p.72). Similar to the adaptation of Meyer's minority stress model, Nadal et al. (2014) appropriated Sue's 2007 microaggression theory to transgender individuals that had previously been directed toward African Americans, LGB populations, and cisgender (non-transgender) women. Through the inquiry of emotional, behavioral, and cognitive aspects of microinsults, microassaults, and microinvalidations toward transgender individuals, Nadal et al. (2014) proposed that these categorical instances of microaggressions might appear minimal at first, but would cause significant psychological damage as they accumulate over time.

Violence toward the transgender population has been correlated to gender identity and expression, with a higher intensity and frequency dependent upon the level of

exposure of gender expression (Testa et al., 2012). Belluardo-Crosby and Lillis (2012) found that individuals within the transgender population were more likely to encounter numerous forms of violence, yet were also less likely to report these experiences to police, or receive medical care related to their resulting injuries. Due to high levels of susceptibility to violence, constant fear pertaining to forced discretion of gender identity often causes increases in suicidal ideation among transgender individuals (Levitt & Ippolito, 2013). In 2010, the National Center for Transgender Equality conducted a survey of over 7,000 transgender participants, in which 41% disclosed previous suicide attempts (Levitt & Ippolito, 2013). This number was raised considerably to 51% when “history of bullying, harassment, expulsion, or sexual/physical assault” was involved (Levitt & Ippolito, 2013, p. 47). Another major proponent for suicidal ideation in transgender individuals is an inclination toward self-harming behaviors that stem from previous victimization and heightened tolerance of physical pain (Donatone & Rachlin, 2013; Hendricks & Testa, 2012).

Donatone and Rachlin (2013) conclude that transgender individuals often use substances “to self medicate and dull gender dysphoria, feelings related to internalized transphobia, confusion about being trans, and fears regarding self-expression and disclosure” (p. 206). Mizock and Lewis (2008) agree with substances being used as a coping mechanism to counteract transphobia, but also state that substance abuse is often related to the relationship-oriented stress, working within the sex industry, and low social economic status. Most research points to a higher occurrence of substance abuse by the transgender population, except for a study done by Flentje et al. in 2014. This was the first large-scale study to comparatively analyze substance abuse behaviors between transgender and cisgender populations starting a recovery program. Unlike previous

studies of limited sample sizes, this extensive study discovered that substance abuse behaviors of transgender individuals were essentially equal to their cisgender correspondents (Flentje et al., 2014). The one exception, however, was found in transgender women, who were six times likelier to seek treatment for methamphetamine use than transgender men and cisgender men and women (Flentje et al., 2014). More studies need to be conducted to substantiate or repudiate these claims.

Coping and Resilience

While the literature points to minority stress as an obstacle for the transgender community, there are also avenues for support that enable resilience. Mizock and Lewis (2008) outline that one of the most helpful sources for healing among transgender individuals relates to peer support through social and informational networking. Flentje et al. (2014) also reinforce this recommendation as a way to build “community cohesiveness.” Social support not only reduces severity in anxiety, stress levels, and PTSD-related symptoms, but it allows transgender individuals a community to explore gender and trauma related issues in a safe environment, since family support is often not available (Mizock & Lewis, 2008). Testa et al. (2012) and Mizock and Lewis (2008) collectively highlight concealment, internalized transphobia, and expectations of potential violence as prohibitive barriers from connecting an individual with community resources that would otherwise facilitate resilience. Collazo et al. (2013) accentuate social isolation and rejection from family as risk factors that can cause negative outcomes for transgender individuals. These factors can also intensify reluctance to seek assistance for many transgender individuals, which can increase distress (Testa et al., 2012). Recently, Mizock et al. (2014) discovered that forming a “positive sense of identity in the face of homophobia and transphobia may facilitate acceptance of mental illness and positive

identity development” and “may reduce the impact of stigma on psychiatric symptoms and maladaptive coping” (p. 336). As transgender clients deconstruct their own personal experiences and ideologies related to gender, clinicians can also provide a means to deconstruct the cyclical nature of concealment and distress (Testa et al., 2012).

Psychological Treatment Concerns

Access to care for the transgender population is diminished in capacity in comparison to the general population, as half of transgender individuals postpone needed treatment (Cruz, 2014). According to Benson (2013), clinicians aren't properly trained in the needs of transgender clients, which often produces clinical misunderstanding and insensitive care. The focus on existing treatment seems to ignore gender identity, opting instead for continued examination and concentration on sexual orientation (Benson, 2013; Collazo et al., 2013; Rutherford et al., 2012). Collazo et al. (2013) notes that the transgender population is often assimilated into the same category as LGB populations in order to alleviate clinicians from feeling uncomfortable. As sexual orientation and gender identity both rely on a two-gender binary, Benson (2013) suggests that, “they are connected yet different in that sexual orientation is determined by who a person is attracted to, while gender identity is based on a person's belief about who they are” (p.19). Mizock et al. (2014) found that while both transgender and LGB populations experience discrimination and stigma, transgender individuals surpassed their sexual minority counterparts in psychological stressors and mental health concerns, thus providing encouragement for enhanced consideration. In a phenomenological study of LGBT-identified mental health service providers across the disciplines of psychiatry, social work, psychotherapy, and psychology, it was found that there was immense gap of insight and understanding for transgender client narratives (Rutherford et al., 2012) This

study also addressed the lack of available training, in which mental health providers involved had often taken initiative to develop workshops and training materials in response to a vast inadequacy across mental health disciplines (Rutherford et al., 2012). Mizock et al. (2014) describe the burden placed on transgender clients to educate mental health professionals, which at times can be empowering, but can also deviate from allowing transgender clients to concentrate on their treatment. As part of an advocacy and strengths-based model, Lev (2004) proposes that diversity within gender expression is comprised of three tenets:

Everyone has a right to make his or her own gender expression, everyone has a right to make informed and educated decisions about his or her own body and gender expression, and everyone has the right to access medical, therapeutic, and technological service to gain the information necessary to make informed and educated decisions about his or her own body and life. (p. 185)

Establishing language that is free of stigma is a vital aspect of culturally competent care with the transgender population (Mizock et al., 2014) While many clinicians agree that it is important to use culturally sensitive identifiers when working with the transgender population, Collazo et al. (2013) clarify that it is also important to inquire about the client's own preference, especially when a client has already transitioned into their preferred gender. 'MTF' (male-to-female) or 'FTM' (female-to-male) could be considered inappropriate if an individual perceives their transition as genuine (Collazo et al., 2013). Cruz (2014) illustrates the varying degree of transgender self-identifiers in a quantitative study in which over 6,000 responses were collected and separated by preference. The notable finding in this study was a realization that there were a high

number of participants that identified outside of the male-female binary (Cruz, 2014). Mizock and Lewis (2008) recommend that clinicians be educated about the history of discrimination and transphobia within healthcare settings to be knowledgeable about mistreatment of transgender clients, as well as to learn a more culturally sensitive approach to treatment of these individuals.

Art Therapy Treatment Approaches

Early art therapy approaches began in the 1970s and were primarily focused on the pathological aspects of gender variance and transsexuality (Cohen, 1974; Cohen, 1976; Nathans, 1979). For example, due to the perception of transgender identity being a choice, Cohen (1976) encouraged parents to “show disapproval of feminine interests and cease to encourage these interests” in order for their child “to help accept his maleness and feel safe with this acceptance one day” (p.66). Art therapy, however, was still considered “a clear way to express a fantasy world without fear of shame, humiliation, condemnation, or misunderstandings” (p.67). Fleming and Nathans (1979) acknowledged a lack of presenting information on the topic of transsexual identity and explored issues of gender variance through the lens of adolescence as a way of comprehending what was deemed as a “psychosexual conflict and experimentation with social rules” (p.26).

Art therapy approaches began to develop into more specific modalities over time. Beaumont (2012) developed an art therapy treatment model specifically for gender-variant clients called Compassion-Oriented Art Therapy (COAT), in which mindfulness techniques are combined with self-soothing to produce artwork that processes threat-based emotions to deconstruct the shame as a result of gender nonconformity. Beaumont (2012), like previously mentioned transgender researchers, adapted a pre-existing model to specifically fit the transgender population. COAT is an adaptation of Gilbert’s 2010

Compassion Focused Therapy model, which contends that a client's lack of self-compassion is a result of shame and internal criticism, and can be regulated through increased awareness and acceptance of the self and others (Beaumont, 2012). It is proposed that using COAT techniques with gender-variant individuals by an art therapist in tune with the transgender experience can "result in decreased shame and self-criticism and increased self-compassion and self-soothing skills for dealing with future psychosocial stresses" (p.4). Sherebrin (1996) also uses client-centered therapeutic techniques, yet focuses on a holistic, team approach. Sherebrin argues that, "the therapist's task is to facilitate the client's recognition of their own issues through visual communication and to help resolve those issues through building on the individual's strengths" (p. 48). One notable perspective that differentiates Sherebrin's approach is the assertion that the purpose of the artwork is not intended for the therapist to deconstruct or find meaning in, but rather acts as an informed exchange between the client and his or her own self (Sherebrin, 1996).

A recent phenomenological art therapy research study by Maher (2011) focused on the process of gender transition of three African American transgender women, utilizing the bridge drawing technique of Hays and Lyons (1981). Hays and Lyons (1981) had originally used the bridge drawing technique with 14-18 year olds as a way to document the challenges of developmental transition experienced in adolescence. Maher utilized this directive to "aid transgender clients in verbalizing their social and psychological experience of their gender transition," (p. 173) which helped confront personal experiences with transphobia and provided the ability to externally express their true self.

Cultural Competency

Addison (2003) mentions the importance of consistently staying informed of the issues and concerns of the transgender experience, as artwork might only be comprehended through a particular awareness. Addison maintains that a “lack of practical knowledge can act as a major obstacle to satisfactory, successful therapy” (p.62). Despite this statement, there seems to be a scarcity in the art therapy literature about what to look for in artwork to create this awareness. Addison (2003), and Pelton-Sweet and Sherry (2008) both begin to recognize the obstacles of being transgender, yet also amalgamate the transgender population under the LGB umbrella, despite their unique challenges. Most art therapy articles, however, stress the importance of an affirming therapeutic environment for clients who identify as transgender, as well as being cognizant of their unique obstacles of marginalization within the art therapy process (Addison, 2003; Beaumont, 2012; Pelton-Sweet & Sherry, 2011). One of the notable inconsistencies presented in the literature, is conflicting use of appropriate transgender identifiers that are consistent with client’s preferences. For example, in a study conducted by Piccirillo (2013) with male-to-female transgender participants, two out of three clients were still referred to by their natal sex instead of their preferred gender. Piccirillo (2013) recognized the need to identify one of the participants by their self-identified gender, but didn’t demonstrate consistency through out the research study. Sherebrin (1996) similarly worked with a male-to-female transgender client in her case study, and managed to acknowledge the client’s preference to present as a female.

Since the art therapy field is still attempting to connect with culturally informed approaches, Talwar (2010) offers an intersectional framework that provides more direction for art therapists to understand the multiple layers of a client’s narrative. This

framework extends beyond limited dimensions of oppression such as gender or race, but extends to age, sexual orientation, social economic status, religion, and disability as well (Talwar, 2010). Talwar (2010) also advocated that “for current and future generations of art therapists to advance theories and practices of the therapeutic enterprise, we must become more skilled in confronting, challenging, and contesting hegemonic ways of seeing and representing others” (p. 16). Future art therapy literature needs to explore an intersectional approach to transgender identity, in order to see it as a multi-faceted issue, and expand the levels of culture present within it.

Conclusion

While there is still much to be understood of the transgender experience within both community mental health and the field of art therapy, the awareness of treatment concerns for this population is starting to emerge as an area of concentration. As the visibility of this population grows, and the issue of transgender identity becomes more pronounced, it is essential for clinicians of all types to become informed to properly address the unique challenges that this population faces. Art therapy has been used in different ways to help transgender clients in a variety of approaches and techniques, and upon further investigation and cultural competency, can be strengthened and improved to alleviate some of these challenges. Art therapy can become an avenue for change and reconciliation with this population, if there are progressive steps taken to inform clinical practice and recognize the clients as they identify themselves.

Research Approach

Creswell (2014) defines qualitative research as a “means for exploring and understanding the meaning individuals or groups ascribed to a social or human problem” (p. 246). Researchers who focus on qualitative methods tend to be interested in comprehending the context for how certain individuals interact within a defined environment (Merriam, 2002). Merriam (2002) suggests that qualitative data is collected using inductive strategy to identify recurrent patterns, in order to provide a descriptive outcome. This outcome helps the researcher build a theory based on observations and instinctual leanings from direct experiences of participants (Merriam, 2002). Semi-structured interviews, specifically, are utilized as an exploratory method for uncovering systemic challenges implemented in the mental health field, in order to understand areas for improvement. After the interviews are conducted, it is essential to develop a systematic categorization of themes that are organized to illustrate a conceptual relationship (King & Horrocks, 2010). King and Horrocks (2010) contend that the purpose of constructing a thematic structure for analysis is to help explain the data in a “well defined and distinct” manner that is “clear and comprehensible” (p. 151).

Kapitan (2010) states that art therapy research consists of “how to observe, how to place our observations in context so that we can see more accurately, and how to return again and again to the evidence we see in order to validate our understandings” (p.31). According to Merriam (2002), in qualitative research, words and pictures take precedence over statistical numbers to communicate a researcher’s findings. This directly relates to the purpose of art therapy research, and seems to support the descriptive elements present in subject artwork.

Methods

Introduction to Methods

This section of the paper will cover a list of definitions to help provide an essential understanding of transgender identity necessary to comprehend this study. This section also outlines the framework of this study, which consists of how research participants were recruited, and how the collection of data was prepared and assembled. The process of how the semi-structured interview method informed the analysis of data is characterized as well.

Definition of Terms

Transgender- a broad term used to recognize individuals whose gender assigned at birth is inconsistent with how they identify themselves (Bockting, 2014)

MTF- A transgender individual who identifies as male-to-female

FTM- A transgender individual who identifies as female-to-male

Gender identity- the “internal experience of how someone experiences his or her own sense of self as a gendered being” (Lev, 2004, p.81)

Natal Sex- the physiological composition of an individual’s anatomical and genetic make-up, and is often determined at birth based on external or internal genitalia (Bockting, 2014)

Gender-role Expression- Socially-constructed aspect of identity that focuses on the public “appearance, behavior and personality” of gender (Lev, 2004, p.84)

Sexual Orientation- Sexual and emotional attraction based on perceived through an individual’s self-expressed gender identity, rather than their biological or natal sex. (Bockting, 2014; Lev, 2004)

Design of Study For the purposes of this research, subjects will all be familiar with the use of art therapy as a treatment modality. For each of the interviews, the same art materials were offered to the subjects, including colored pencils, markers, oil pastels, and collage images. The interview procedure was centered around the following questions: 1. Describe the experience you have using art therapy with clients who identify as transgender, 2. Which treatment modalities (theoretical orientation, etc.) have you found to be particularly effective in the treatment of transgender individuals and issues of gender identity? 3. How do you believe that art therapy can be incorporated into the treatment of transgender art therapy, specifically? 4. Describe any common physical, mental, or emotional characteristics you have found in transgender individuals? How do you see these in the art? 5. Describe any clinical recommendations that you have for the use of art therapy in the treatment of transgender individuals? 6. Are there any particular cultural considerations you have noticed in working with transgendered individuals?

Sampling. The two subjects interviewed were both art therapists who either currently or have previously worked with the transgender population, and were assembled using a snowball technique. The first participant was referred to the PI through research mentor, Dr. Paige Asawa. The second participant was found through a referral by the first subject interviewed. One of the limitations of the study is a lack of clinicians in general who are aware of the unique concerns of this population.

Gathering of Data. Data was gathered using a semi-structured interview format in which the researcher recorded and conducted over the course of 60 to 90 minutes. The beginning of the interview encouraged art making with the subjects

to compare how they each viewed working with this population through the same art directive. After briefly describing the content of their art, subjects were asked the same questions to determine similarities and differences of how art therapy can be used as an appropriate intervention with transgender clients.

Analysis of Data. After the interviews were conducted, the primary investigator transcribed and reviewed the content for accuracy. Upon investigation of the responses given, categories were established to assess for similarities. These categories were then divided into emergent themes of how art therapy can be used with this population. The pieces of artwork made at the beginning of each interview were analyzed to explore the connections between the imagery and the textual data.

Presentation of Data

Clinician Interview #1: “Janette.”

The interview with Janette was scheduled on a Friday afternoon at 2:30 P.M. at her private practice office located in the South Bay area of Los Angeles. Janette started the interview informing the researcher some introductory information about her private practice as an art therapist. She indicated that she hadn't worked with transgender individuals since 2001, but she suspects that one of her current clients might be transgender. The researcher asked the participant if she would be willing to complete an art directive related to her experience working with transgender individuals before beginning the research process. The directive was to: “show your thoughts and feelings about working with transgender individuals.”

The researcher provided the participant with an array of art materials, which included colored pencils, oil pastels, markers, Sharpies, and collage images. Janette opted to make a collage and selected a square piece of red paper to work with. The researcher brought an 8” x 10” plastic container with random images and words cut out from magazines. Janette worked for 10 minutes on selecting different images. As she was trying to figure out where how to arrange them on the paper, she asked if only art therapists were being asked to participate in interviews with the researcher. The researcher asked if she might have any possible referrals of other art therapists that have also worked with the transgender population. Janette mentioned another LMU alumni who had graduated before her that also works in the South Bay area of Los Angeles with transgender clients.

As she was gluing down images, Janette mentioned that she was glad to have started with the art, because she was having a hard time remembering some of the aspects

of working with the transgender population, since it had been 14 years prior. She stated that working visually allowed her to “access that part of her memory.” Once she had finished her piece, the researcher asked her to share what she had made. Janette explained that her work with transgender clients took place in her practicum during her graduate program, at a gay and lesbian treatment facility for adolescents. She described her art as being centered around “being super, duper different.” She started by addressing the image of tangled wires, and stated, “For them, it felt like something inside the wiring was wrong, and that is a really hard thing for people to articulate and explain. It is something that you feel and know.”

The next image contained a man’s chest with body hair, and also showed his arm with a tattoo on it. Janette discussed the physical body and body image being a major focus, and how the clients were often at conflict in the relationship with their body. Janette mentioned that her clients often dealt with this conflict through self-medication through alcohol and substance use. Janette stated that the self-medication also related to the “huge amounts of rage” that they try to cope with. Lastly, Janette mentioned the rainbow colors in her art piece, because she said there was a lot of confusion between sexual orientation and gender identity, not only for clients but also the people around them. Many people weren’t sure if they were gay or transgender, and were often verbally harassed or assaulted. Janette recounted how anger and rage of her transgender clients was often projected onto them by other people, and it was intense for them to experience.

After looking at the art, the researcher asked Janette if she utilized a specific theoretical orientation or treatment modality with her transgender clients. She mentioned that her approach to working with clients, then and now, tends to be from a psychodynamic, or family systems, framework. She questioned the goals in people

working with transgender individuals, and that while transgender is part of the issue, it is also about the family “being able to accept and have harmony with it.” The adolescents she worked with at treatment center didn’t have family involved, however, which caused her to focus more on self-esteem, such as “dealing with anger, depression, and self-worth issues.”

The researcher asked the participant how art therapy could be incorporated into the treatment of transgender individuals. Janette referred back to what she views as one of the primary goals of transgender adolescents, which is identity development. She discussed the benefit of using art to help her clients explore and being a helpful tool for them take ownership into the process of figuring themselves out. Janette also described the benefit of her clients engaging in art therapy in the context of a group setting, which allowed for an externalization of different group members to see the spectrum of people in various stages of transition. She stated that the art allows them a safe space and a respectful engagement with their peers. The researcher asked about the type of directives that seemed successful, and one of the most powerful directives involved introducing themselves. With most populations this might seem like a basic, standard directive, but with adolescents struggling to identify if they are gay, or transgender, both, or neither, it is an important question. One way she allowed the clients to implement identity into the directive further, was to encourage them to create a name to use in their art. These names often correlated to a specific gender, and allowed for a fun, yet relevant way for them to express their identified gender.

The researcher was curious about what type of training was provided to the clinician to help in working with that population in particular. Janette mentioned that this was her first clinical experience in her graduate program, and that there wasn’t any

formal training. She had gone to supervision prior to starting there, but she had to learn to adapt to the population and figure things out through trial and error. The researcher asked her what clinical recommendations she might provide now that she has a better understanding of the needs of this population. Janette stated that she felt it was important to provide a complete range of materials, despite what orientation or identity someone is. She mentioned that it is not about something special being done, but more about how therapists carry themselves and their energy in relation to biases, assumptions, and preconceived ideas. She believes that art therapists are specifically trained in avoiding assumptions, especially in terms of artwork, in keeping an open mind to a full range of expression. This led the researcher to ask about the cultural considerations that therapists should be aware of. She referred to the Hispanic, Caucasian, and African American each having a “different energy and experience in comparison to each other.” She said that African American individuals often had “a much harder time, got beat up a lot more, because of being in either a gay or transgender situation” due to less acceptance and safety collectively across cultural communities. She also identified the coming out process as being important for therapists to have an open mind and “be able to hold and tolerate, and help clients move through whatever those things are.” She feels that art therapists tend to be more open with this and not just the transgender experience, but other topics as well. The researcher thought it would be helpful to ask the participant to clarify ways in which she felt a therapist could tangibly do to keep an open mind for a client. She said that therapists could ask questions, be curious, and be humble in a willingness to acknowledge a lack of knowledge in someone’s specific experience. Janette felt that “sometimes we have to acknowledge our differences,” especially in the

manner of privilege in ways that might not even be recognized. Janette goes on to say that:

When it comes to gay, transgender, bisexual, fetishes, or anything remotely close to sex and sexuality, there are a lot of biases and rigidity, and conservatism that block therapists from being really good at it, and by being really good at it, I mean just being open and curious.

The researcher asked the participant to recall if there were any common symptomatology that transgender individuals might share, such as physical, mental, or emotional characteristics, and how they might come out in the art. Janette discussed how the research for her Masters thesis involved the transgender identity development of adolescents, focusing on exploring the stereotypical male and female gender identity. One of the key elements noticed in the art of transgender adolescents in her research, was that their art displayed traits of stereotypical gender expression. For example, one of her clients identified as MTF, and all of the art created consistently represented stereotypically feminine imagery and content. This client enjoyed playing with dolls and dressing up as a princess for Halloween. Janette mentioned that she has an aversion to the use of the word “symptomatology,” and that “its not a point of criticism, it’s more of a point of discussion.” She specifically didn’t use gender pronouns when referring to clients in her research, which she said was challenging, but she wanted to keep it neutral and avoid the use of labels. She asked why it is considered symptomatology if an individual feels they are the opposite gender, as if it were a cold. The researcher stated that his question might have been phrased better to be more sensitive.

Janette brought up the rage she mentioned earlier, and how people often become upset and angry when people don't fit in the proper way, which leads to violence. She stated that, "its something that we, as people in mental health, have to deal with, whether it's a disorder or not." She said that often in order to categorize it, "we use the templates already in place," which often comes down to symptoms. It is a parallel to what society is doing, as "they don't know how to fit it in either." The researcher addressed that the question could have been rephrased to inquire more about common traits in their backgrounds, such as type of trauma. Janette stated that most of the transgender adolescent clients at her facility had some sort of sexual trauma in their history, which is part of why they were there. She questioned which came first, but also stated that she didn't think it was a cause for them to question their gender identity. The researcher asked about the self-medication that she had mentioned previously, and she said that alcohol and illegal substances were not allowed in the treatment program, but they might have snuck off to do those types of activities.

Janette was asked by the researcher to reflect upon one experience using art therapy that might have stood out for her, but she said that working with that population, it is all powerful, "because its all so intense and there's so much conflict inside of them, and outside in the world. And families, just throwing kids away because of it." She brought up the MTF client who liked to play with dolls and dress up as a client that stood out to her, because the client was also most likely on the Autism spectrum. The client had a very supportive family, but "the real problems came out when dealing with society, because this boy clearly looked like a boy, very much so, so when he wants to dress up as a princess for Halloween, people think that's weird." The client ended up having to deal with other people's reactions to how he identifies. The art therapy allowed him the

freedom to address it however he wanted to, so “it became this sort of safe haven to explore who he is and have that be accepted.” Janette discussed how being on the Autism spectrum also created some difficulties for him, but the art was used to develop a sense of mastery in session, for him to “walk out the door with that under his belt.”

The researcher asked Janette if there was any clinical or art therapy advice she would have looking back at her experience. She stated that her being new as a clinician at that time in her career was part of the process of growing and learning. She stated she might have been more aware of safety concerns with art, such as working with scissors. Janette said one thing she would recommend is not to be afraid of what content might come up in session with a client, and that “it is scary and intense working in the beginning with that kind of situation.” She stated that it is important to embrace their experience with them, because it is scary for them too, and it allows clinicians to provide containment. She also referenced being brave about recognizing possibly not knowing what a client is experiencing, and having them teach you. Janette went back to the research she did for her thesis, and how it helped her realize her own beliefs and biases approaching gender identity. She advocated knowing what your beliefs are as a clinician, to prevent stereotyping and projecting her own values onto a client. In her research, she realized that she didn’t fit some of the gender stereotypes, which she felt she shared in common with some of her transgender clients, but also recognized the differences. She said, “It’s important to know what’s mine and what’s yours, and to know what we connect on too.” Janette gave the example of being gay and working with gay and lesbian clients, and sharing knowledge “in a way that a straight therapist isn’t going to get.” She said this could also be extended to parenting and relationships. She stated that there is a way for clients to non-verbally connect and know without the need for disclosure, but it

“can be felt in your energy” and “without needing a whole lot of words to go into detail and background.” She added that even having this connection still does not help a therapist know the perspective of the client, but it can help. She said that knowing the areas of connection, while differentiating “what is mine and what is yours” has grown and evolved with her age and experience.

The researcher ended the interview by asking how the participant’s perception of gender has changed. She said that working with transgender adolescents provided her an incredible amount of empathy, and stated:

The amount of pain that these kids were going through and had gone through, and will continue to through, if they live, is out of control, simply because they feel like a different gender, and it seems disproportionate to me.

She also added that her experience working with transgender clients was a long time ago, and a lot has changed and continues to change. She discussed how the things she has “seen and experienced personally in terms of societal biases and prejudices are slowly dissolving.” She believes that the younger generations are much more open and accepting toward gender identity and sexual orientation. She talked about how living in Los Angeles, it is probably more accepted than society as a whole, but that eventually, it will become more accepted.

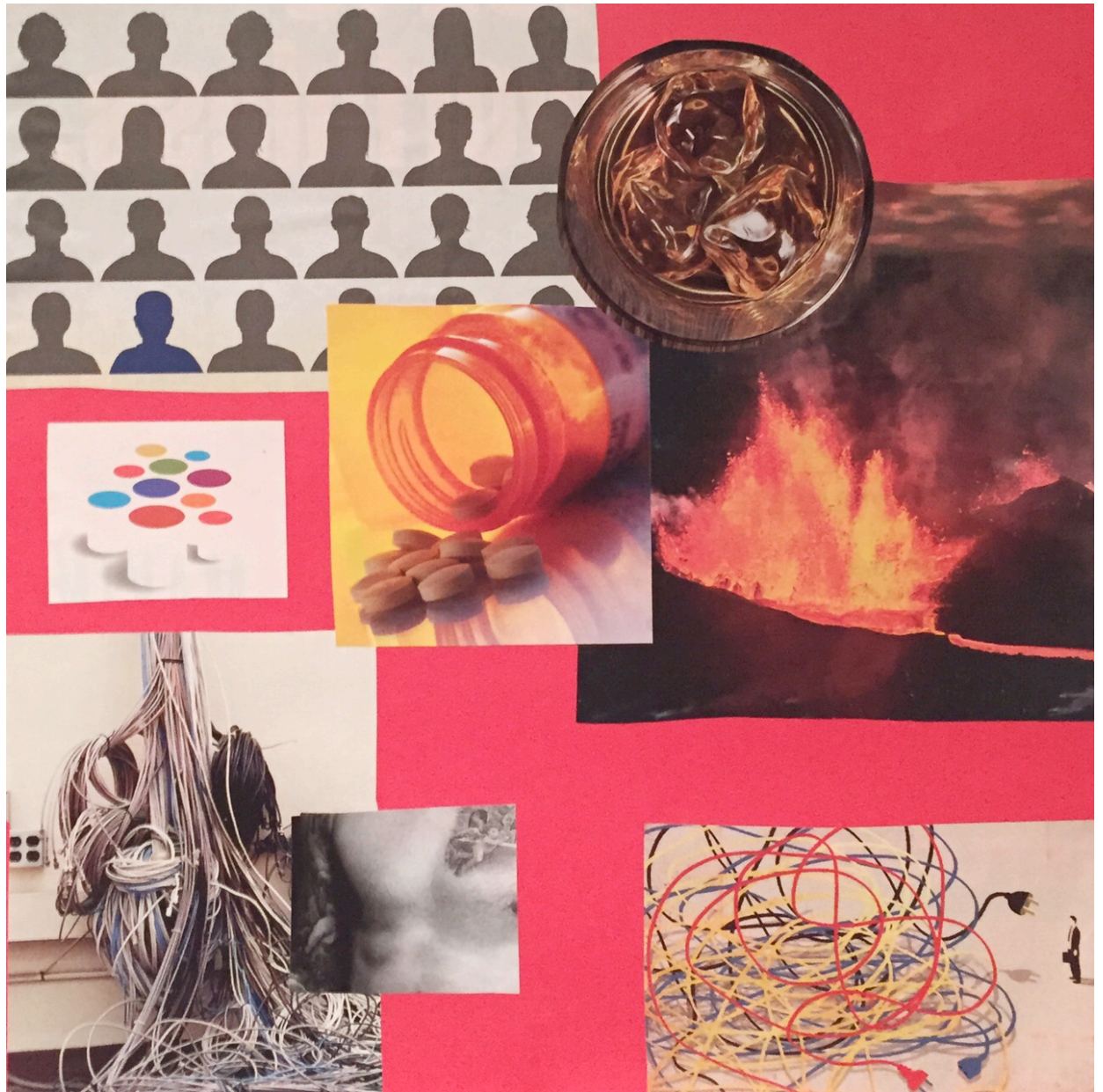


Figure 1.1

Clinician Interview #2 “Brenda.”

The interview with Brenda was scheduled on a Friday afternoon at 4:00 P.M. Brenda began the interview discussing how she has been operating her private practice out of the South Bay area of Los Angeles since 2005, and sees between 22 and 27 clients a week. Brenda talked about how she discovered art therapy as a treatment modality, and how she ended up becoming a marriage and family therapist. In addition to her MFT license, she is also a LPCC (license professional clinical counselor) and an ATR (registered art therapist). The participant recognized that she doesn't know what it is like to be transgender, but she does identify with being gay. Brenda discussed how her work with the LGBT community started through the formation of a gay and lesbian resource group when she worked in aerospace industry, before graduate school. She was also an advocate speaking on panels, and experienced a lot of homophobia in the 1980s due to coming out at a young age. Brenda also briefly went out with someone who later believed she was transgender. Before starting her private practice, Brenda worked as a clinician in community mental health agencies. Brenda explained that she has always worked with gender-variant individuals in her practice, and has worked hard to open her practice the LGBT community. She described doing her thesis research on children raised in gay, lesbian, and transgender families as living in intersecting cultural backgrounds, such as bi- or tri-culture. Brenda utilizes art whenever she provides workshops on the coming out process, which initially related to sexual orientation, but has also grown to include loved ones of orientations that don't fit the norm, as well including different expressions in gender identity. She has often worked at a well-known inpatient treatment center in California for adolescents with eating disorders. The treatment center had several

individuals that identified as transgender, and she was asked to come and facilitate them to make art.

The researcher transitioned into the art directive, which was: “show your thoughts and feelings about working with transgender individuals.” The researcher offered the participant colored pencils, Sharpies, markers, oil pastels, and collage images. The participant opted to use her own art materials in her office, which consisted of chalk pastels. Before Brenda started on her artwork, the researcher asked her if she had received a copy of the interview questions, and that there was an extra copy in case she needed one. Brenda worked for several minutes on her drawing, which was a bridge. She stated that:

I feel like I provide a bridge over to being in a state of mind where they feel more comfortable in their skin, and that they recognize, or hope to recognize, even if their friends and family don't understand, that they still matter and that they still have a place in the world that I live in.

She stated that many of her clients come to her depressed and in crisis, and “whatever they have done to cope with feeling different is no longer working, and some of them feel like they've hit a wall, or are suicidal.” Brenda recently visited Joshua Tree National Park, and her art was inspired by the scenery that she saw there. The researcher asked how the landscape reminded her of the work with transgender individuals, and she said that desert is “everywhere you look around you, and there's no where to go. All you have is land and a horizon line, and it can feel so vast and unconquerable.” Brenda also mentioned that she does mediation work, and the logo she created is “two hands that are open with a figure in each hand,” and opted instead to draw without a preconceived idea.

The researcher asked the participant about ways that she has used art therapy with her transgender clients. She discussed mainly using drawing and collage “usually around self-symbols and also allowing them to create a visual narrative in the correct gender.” She tends to use a collage timeline that the clients use to identify when they started feeling different or “realized they were different than they imagined they were.” The clients begin the timeline through photocopying their own personal photographs, and using these photographs to inspire the creation of other artwork. This process also allows them to be in their preferred gender from the beginning of the narrative, and initiate a conversation with a caregiver or loved one to obtain certain photographs, which can be challenging. While the idea of the timeline originated with the participants work with survivors of domestic violence, she has used it for differing issues. She states:

The ability to tell a story in its chronological order can be very reparative. People that have been traumatized tend to dislodge their stories, and not have it be in order. The better they can tell their story, the more accurate the chronology can better their perspective and the outlook on the event.

When asked about how long she has worked with transgender clients specifically, Brenda stated that she has mainly been working with transgender clients for the past four years. Most of her clients are referred through word-of-mouth, but occasionally, someone will try to contact her regarding a diagnosis confirmation letter, which she doesn't do unless she knows them. Brenda follows the WPATH (World Professional Association for Transgender Health) standards and Harry Benjamin protocol in her practice, which requires clients to be in therapy with her and follow the expectations of the protocol. This prompted the researcher to ask about the theoretical orientation she uses as a clinician.

Brenda works from a family systems point of view, and her goal “is for the client to be able to have better relationships with people that are important to them,” but also to address the issue of being transgender. She also that it is also about helping them understand that “even though they might not be able to identify any one else in their family that has ever had this gender issue, they can still identify a means of coping.” This also includes identifying alcoholism, anxiety, depression, as well as types of boundaries, such as rigid, inappropriate, or lack of boundaries. Brenda stated that it is often important to provide context of a bigger entity, as transgender clients often feel “stuck inside a vacuum.” This prompted her to discuss how she often has conversations with clients that pertain to whether or not they will disclose their transgender identity to their families. Brenda also approaches clients with an attachment theory perspective and why clients have chosen certain partners, which is not only related to potential transgender identity, but how they are affected by early relationships with caregivers.

In addition to the timeline directive, Brenda mentioned that art therapy could be used to help clients “feel as if they are able to master something,” such as the development stage of mastery vs. inferiority. She could see how an art therapy group could portray characteristics from this stage of development through a sculpting exercise. The participant brought up the example of working with adolescent boys in art therapy groups making phallic imagery, and how it is often appropriate through the explorative aspect of the latency stage of development. The art could be used to accentuate physical characteristics of transgender clients, who are also revisiting their adolescence in a sense. Most of the transgender clients Brenda has worked with are between 25 and 45 years old, and have already passed the latency stage. They are being provided an opportunity to go back in time to be that child or teenager in a way that they were allowed to before.

Brenda thought it might be helpful to adapt the timeline directive, along with education of how art therapy is used to identify drawing characteristics in children, to provide them the avenue to relive those younger years in their preferred gender. She discussed the benefit of doing therapy with transgender clients in a group setting, due to the isolation they often face. The group dynamic would provide them with structure to potentially bring them all to the same level of development.

Due to working with transgender clients at various ages and stages of development, the researcher asked the participant if there were any noticeable similarities or characteristics that they all share. One thing that stood out for the participant was sexual orientation. Her FTM clients believed they were gay women at some point, whereas the MTFs viewed themselves as heterosexual, and any same gender exploration was done out of curiosity, and “not out of conviction of identity.” For the FTM clients, she stated, “Because of lack of words and experience, they end up looking at the more masculine, lesbian community that they end up feeling like they belong, and as time has evolved, more language is being offered for gender variance.” For her MTF clients, many of them came out later in life, and did not have relationships with other men, so they did not consider themselves to be gay prior to coming out as transgender. In addition to orientation being the most common characteristic with her clients, Brenda states that they are often jealous of the younger generations who are able to identify being transgender earlier on. The jealousy she referred to was not in a negative sense, but more out of “envy and sadness that they didn’t have the same opportunity.” Brenda then briefly talked about how relationships with partners and parents have affected her transgender clients. Sometimes, family members or partners will be okay with some aspects of the transition, as long as they don’t change their genitalia. Some partners have blamed therapy as

causing the end of the relationship, while others “see that there was an end pass to either allow them to engage with their bodies they were uncomfortable with, or accept the limitations they were asserting.”

The researcher asked the participant about clinical recommendations when working with transgender clients. She stated that anyone using art therapy needs to be “well-versed with art therapy as a treatment modality,” and specifically with materials. She referred to the chalk pastel she had used while making her art, and said that it was a medium that was hard to control, so you wouldn’t give it to someone needing containment or working on affect containment. She said that she would use a more controlled medium instead. For the art therapist who is already experienced, it would be helpful to become “better versed in transgender issues and the transgender community.” One of the things she learned is that “there are some gender variant characteristics of some gay and lesbian individuals during early childhood, and she described an instance in her own childhood where she experienced that.

She also indicated that it was important to acknowledge that it is a client’s choice whether or not to transition, which may include full, partial, or no transition, depending on where they are coming from. She stated that it is about what they need to do to feel better. If they opt for no transition, she tries to help them not feel so alone, and incorporate how they will relate to other people. Brenda communicated that in addition to art therapy knowledge, and awareness of transgender issues, a clinician needs to be capable to talk with someone comfortably about their body, and “not being too self-conscious about talking about vaginas and penises.” Brenda recommends allowing the client to inform how they want their genitalia to be identified, so “even though clinically, it looks like a vagina and works like a vagina, once your client identifies as the opposite

gender, you have to allow them to define their genitalia by what they're going to call it." Examples of this might be "their junk, genitalia, or that thing." She described one client who she is afraid "won't be around in ten years, unless they come up with an appropriate surgical solution to not having a penis," as a "phalloplasty isn't acceptable to him." Brenda described how phalloplasty procedures work and how other countries are more progressive with reassignment surgeries, but that the United States is more accepting when it comes to transgender acceptance. She said there is a movement "to see gender identity as a birth defect and not a mental health issue," and that is how she refers to it. She also thinks that society is "still a bit conservative, and would have an easier transition with changing out someone's brain and personality than allowing someone to change their gender."

Next, the researcher asked about cultural considerations she has noticed with her transgender clients. She talked about in "communities of color with respect to gay and lesbian identity," there is more cultural acceptance "as long as the relationship is similar to straight relationships in that there is a man and a woman." She stated that the cultural community still might not be comfortable with the sexual orientation, but is more comfortable if gender roles are enforced. She said that this also translates to transgender relationships as well. Brenda discussed noticing that the most disenfranchised members of the transgender community are often Hispanic or African American, and that Caucasian individuals can often afford reassignment surgery, therapy, and hormones. She believes that Hispanic and African American, specifically MTF, transgender individuals tend to have a higher rate of homelessness and are more likely to have to sell sex to afford hormones. Brenda described an interaction she had with a neighbor of hers who was the mother of an African American transgender MTF who had died of AIDS from

doing sex work to pay for hormones. Her daughter had tried to keep the transgender identity a secret, but was diagnosed with HIV and began to get sick. The mother had wanted to find a support group for parents of transgender adult children, but Brenda said she could only find ones that were parents of transgender children.

Brenda had asked about how much information the researcher had found regarding transgender art therapy, and assumed that there probably wasn't much, due to what she perceives as "still a significant amount of discomfort with the LGBT community." She talked about how the LGBT community is the most diverse culture she has known, as it is has "it's own sub-cultures, and such distinct sub-cultures, and it's the only minority group that has every minority in it." She talked about her love for art therapy and how she hopes that "see more programs and people be willing to reach outside of their comfort zone and reach out to an oppressed group that they may not understand, but can at least appreciate." Brenda ended the interview talking more about her personal journey, and what has led her to work with the transgender community. She says that the harassment, "being gay-bashed, and then dating someone who was trans made me definitely more vocal, made me more dedicated."



Figure 1.2

Analysis of Data

Upon completion of recording the interviews between both participants, the researcher transcribed the conversations that took place. Once the transcription process was completed, the researcher read the transcripts several times. He began to facilitate a process similar to axial coding, in order to underline key concepts and recurrent words present in both interviews. The researcher examined what was underlined through out the text to distill the information into appropriate, concise themes that attempted to accurately represent the essence of what each participant seemed to convey in their words. The four themes that emerged were identity development, coping, treatment approaches, and cultural considerations. Art therapy was considered to be its own theme, but was present in each of the themes, and seemed to relate better when evenly dispersed through out.

Identity Development

Within the scope of identity development, both participants described ways in which the art therapy process was utilized with their transgender clients to encourage them to embrace their transgender identity as they attempt to deconstruct it for themselves. In her thesis research, Janette explored stereotypical male and female identity development and found that art and gender expression of transgender individuals often coincide with stereotypical characteristics of art made by individuals of the gender they identify with. For example, she had an adolescent MTF client whose art and personality mirrored the style and content of a stereotypical female adolescent. This adolescent was able to engage in art making as her preferred gender in the safety of the therapeutic space. Janette's interview artwork addressed how many of her transgender clients struggle to identify the inconsistencies in their internal wiring, and the difficulty in being able to

articulate something that is misunderstood by others. Allowing clients to be able to externalize this process through the art in an exploratory, safe manner seems to be a goal of the participants. Both Janette and Brenda offered their own interpretations of how to apply art as a tool to provide clients with a corrective experience that is empowering and helps them better express their gender identity. Janette's clients were able to create their own unique name to use in their artwork, and these names appeared to correlate with the specific gender that her client's identified with. Brenda also used self-symbols with clients to help them re-create their own narrative through a chronological timeline. Through replicating their lived experiences through the perspective of the gender they identify as, clients were able to reconstruct lived events in a chronological manner that was also reparative in nature. The timeline directive allows a client to determine the point in time that they felt different or at conflict in their body, in order to reframe their perspective through the creation of symbols, colors, and photocopies of their own photographs. This directive was adapted from the participant's trauma work with domestic violence to fit the trauma and identity development that is often experienced by her transgender clients. As they begin to change and restructure their perspective towards their own lived experiences in their accepted gender expression, they are able to have a more grounded understanding of themselves and the conflict they have been experiencing.

Another aspect of identity development that surfaced was a focus on adolescence. Both participants have worked with adolescents in different capacities, both within the context of in-patient treatment facilities, as well as in their private practice. The participants acknowledged similar concepts related to their transgender clients in connection to adolescence, including body image, and the acknowledgement of physical

characteristics. Since transgender clients are typically at conflict with their bodies, the art was central in allowing clients to accentuate their own physical characteristics in a way that adolescents tend to in art therapy groups. Brenda illustrated that in her experience, adolescent males in a group dynamic will often resort to making phallic imagery as a way of addressing the changes they are going through in puberty. In a similar context, art can be used to create imagery for transgender clients to understand the physicality of their identity. This was introduced through discussion of the latency stage of development as the time when exploration and experimentation takes place with the body. If a transgender client is an adult or past the latency stage of development, the art can be used to go back and revisit that time in their life to also implement a corrective experience.

Navigating between sexual orientation and gender identity was an also important aspect of identity development discussed by both participants. They addressed how the line between transgender and gay is often confusing for everyone, from clients to therapists, to the people around them. This also relates to a lack of understanding and the ability for clients to articulate their experience. For Brenda's clients, the sexual orientation and gender identity confusion was different when looking at FTM clients versus MTF clients. FTM clients tended to initially identify as gay women, because she felt they related with masculine traits found in the lesbian community, but more variety in gender expression allowed them to comprehend that their identity was more about gender than sexual orientation. Her MTF clients typically did not view themselves as gay, so their own concept of their sexual orientation has remained more consistent. Brenda addressed the how the confusion between gender identity and sexual orientation can occur for many gay and lesbian individuals during early childhood, and used her own experiences as an example. Early attractions to the same sex are often rationalized through the belief that

they were born as the wrong gender, and can be one of the first indicators between orientation and gender identity.

Coping

Through out the interviews, the participants recognized aspects of coping, such as self-medication, emotional reactivity, and how transgender individuals often internalize societal projections that are placed onto them. Both participants mentioned alcohol and substance use as common forms of adjusting to the overwhelming feelings that are associated with trying to adjust to transgender identity. The emotions that were emphasized were anxiety, depression, and rage. Janette noted that anger and rage would be placed onto them by other people due to a lack of acceptance, which often caused violence towards the transgender individuals. Brenda noted one of her FTM clients projected homophobic and misogynistic thoughts and feelings about having been born and viewed as a female. As this client has internalized negative emotions about this experience, the client has become a perpetrator for the same types of things that he has experienced. Janette observed that the challenge for the transgender individuals she worked with tended to be less about how they saw themselves and was more concerned with the processing of other people's negative reactions to how they identify themselves. This negative projection is not only placed on transgender clients, but can be put on the therapist as well, for being accepting of their identity. Brenda noticed that many of her clients sought treatment with her in a moment of crisis when their coping mechanisms were no longer effective, which also included struggling with suicidal ideation. She illustrated this in her drawing of a desert, which represented the unconquerable vastness that many of her clients feel they are going through. One positive aspect of coping that was identified by the participants was the ability for some transgender individuals to

adapt to their environment and create an identity for themselves, despite possibly not being accepted or recognized.

Treatment Approaches

The theme of treatment approaches included aspects of theoretical orientation, group therapeutic interventions, and maintaining empathy and curiosity with clients as a clinical methodology. The participants acknowledged family systems as their primary theoretical approach, due to an emphasis in promoting acceptance and openness for the client's transgender identity among relationships they are in. Even if the clients aren't able to identify other gender issues in their family, there is still a need to process various types of boundaries that the client has learned from their family, such as rigid, inappropriate, or lack of boundaries. For Janette's adolescent, transgender clients, many of them didn't have relationships with family members, so it became more of a psychodynamic approach to address anger, depression, and self-worth issues. In addition to family systems theory, Brenda incorporated attachment theory as a modality, in order to recognize how the partners her clients choose correlates with unfinished business from relationships that clients have with their caregivers. WPATH and the Harry Benjamin Protocol were also mentioned as being integrated into treatment with clients. For art therapy as a treatment modality, the participants highlighted being the importance of being trained in how materials are used with clients. This includes awareness of the affective quality of the materials utilized, as well as providing proper containment allowance of control for clients.

Both participants recommended group therapy as an effective treatment approach when working with transgender individuals, and have both seen how groups can provide much needed social support for transgender clients. Groups can be helpful in reducing

isolation, which is often related to a lack of seeing other individuals in the same situation. Being in a group setting can provide transgender individuals with the ability to see other individuals at different stages of development and transition. This can allow group members to share what their current process, and inform other people who might also be at a similar stage. This can also educate group members who are at a less advanced place on better ways for them to adjust. Group cohesion can bring structure and containment for transgender clients, and assist in bringing them to similar places in development.

Empathy and curiosity were both considered beneficial treatment approaches addressed by the participants. Janette highlighted that one thing a well-trained art therapist displays is the necessity to keep an open mind due to the subjective nature of the art, and how art therapists are taught not to make assumptions about why a client might choose or create an image. This openness to the content and process allows clients a full range of expression, and isn't limited to preconceived ideas and biases of the clinician. This also translates to work with clients in the transgender coming out process to be able to tolerate and move with them in an understanding way as they transition through that process. It is also important to recognize, however, that it is up to a client whether or not they decided to transition or not. Through an empathic approach, the clinician can help avoid pressuring the client to fully transition to one determined gender or another, and help them acclimate to full, partial, or no transition. If they decide to transition or not, it is about helping them navigating how to help the client adjust, and how their partners can adjust as well. One of the key ways in which clinicians can communicate empathy and curiosity is how they carry themselves and the energy they give off in a session. The participants recognized that it is okay to ask not to always have the answer, and ask questions to be informed by the client. Due to the intensity of the work, it can be

intimidating if a clinician doesn't have the answers, but part of joining with the client is trying to understand where they are coming from. Curiosity from the therapist can allow a transgender client the ability to be open about who they are, and define how the therapist can better empathize with their life experiences. While answering questions and informing the therapist can be empowering for the client, the participants also talked about the importance of not having to always explain where they are coming from as well. It can be helpful for a clinician to be informed of the challenges and issues affecting their transgender clients prior to treatment, so that the clients don't always have to be the ones to educate the therapist. An empathic connection where the client feels like the therapist understands them without having to go into a lot of detail about their background can be helpful in building rapport and the therapeutic relationship. In addition to awareness of the transgender community, it is helpful for clinicians to be able to talk comfortably about body parts openly, since that can be a main concern for transgender clients. The ability to have these honest, direct conversations in a curious, understanding manner can provide the client with containment and clinical direction.

Cultural Considerations

In working with transgender individuals, the cultural lens seems to add another layer of complexity for how clinicians can provide more effective treatment. The theme of cultural considerations relates not only to race, but how different cultural communities approach transgender individuals, as well as the therapist's awareness of their cultural understanding related to gender identity. Both participants seemed to consider the differences between Caucasian, Latino/a, and African American experiences within the transgender population, and assert that African American transgender clients face the most opposition. There also seemed to be more violence, disenfranchisement,

homelessness, and sex work related to buying hormones for transgender clients who were either Latino/a or African American. Caucasian transgender clients seemed to have more resources available to them, and could typically access therapeutic services easier. The participants described a greater lack of safety and less cultural acceptance for transgender individuals that were either Latino/a or African American, as opposed to Caucasian. Brenda discussed how similar how some cultures are more accepting transgender couples in a similar way to same-sex couples, if the dynamic of stereotypical heterosexual couples were displayed, such as having traditionally masculine and feminine features and gender roles. This doesn't mean that the culture fully embraces the relationship, but has an easier time conceptualizing it based on traditional norms.

Much of the cultural considerations displayed related to language and how to define certain words and concepts, such as body parts or self-identifiers. Both participants talked about sensitivity to how they use pronouns with their clients. Brenda also mentioned the significance of how clinicians refer to client's genitalia, and to allow them the opportunity to define it how they see it. This can be a way for the therapist to begin to process the client's body image in a respectful way, and avoid triggering negative feelings.

Both participants also recognized how culture often sees transgender identity as being categorized as a mental health concern, but they personally do not perceive it in that manner. They see it more as a situation that needs to be worked out and approached with care. One of the ways that the participants recommended this was to be aware of gender biases and people knowing their personal and cultural beliefs tied to gender. Through this awareness, clinicians can avoid unintentional prejudice and societal biases.

Findings

This section of the research paper explores the connections between preexisting literature and information presented by the research participants through four significant findings: engaging in art therapy as a means to establish a visual gender narrative, developing an intersectional approach to cultural considerations, establishing community as a means to overcome trauma and promote resilience, and promoting transaffirmative practices for art therapists and other clinicians. Each of these findings provides art therapists with considerations that can guide their work and assure quality of care for the transgender community seeking art therapy services.

Art therapy was utilized as a treatment modality to facilitate the exploration of client narratives as a means for developing identity, processing decisions related to transitioning, and deconstructing experiences of internalized transphobia to find self-acceptance. The act of creating an accurate gender narrative is one of the ways that art therapy can be used to empower transgender clients, establish a corrective sense of self, and begin the process of addressing diverse trauma backgrounds. The creation of self-symbols, such as a fictitious name to use in artwork, or establishing a visual timeline using appropriated photos of clients in their identified gender were recognized by the participants as ways to engage clients in using art to establish a corrective, gender narrative. Nagoshi (2014) states, "Finding a way to convey our own personal narratives helps in the self-construction of lived experiences and ultimately reinforces health" (p.136). Art therapy can be utilized to facilitate this empowerment with transgender clients to discover a more genuine sense of self-identity, through creatively exploring their bodies. Depending upon a client's desire to transition, art therapy can be employed to document the transition process and provide a visual method to articulate and

document that experience (Barbee, 2002; Maher, 2011). Self-portraiture has been used with transgender clients “to explore gender narratives and gendered self-presentation” (Beaumont, 2012, p.3). Self-portrait driven art therapy interventions can be created during phases of the coming out process, which could be adjusted to use with the transition process as well (Pelton-Sweet & Sherry, 2008). Art can be valuable in creating balance between clients’ public and private self-image through the experimentation of different identities, by “emphasizing their strengths and affirming diversity, art therapy supported them in this process toward actualization and integration” (Picarillo, 1996, p.45).

Developing an intersectional framework to address the complex, cultural considerations of transgender clients seems to be a vital approach to seeing a client not simply from a transgender perspective, but through a collective identity that incorporates their unique experiences and identifying factors, such as racial background, social economic status, age, disability, cultural affiliation, etc. This multi-layered framework allows art therapists to understand a client’s narrative and how they have been impacted on a variety of cultural dimensions (Talwar, 2010). “Intersectionality perspective maintains that multiple identities construct novel experiences that are distinctive and not necessarily divisible into their component identities or experiences” (Parent et al., 2013, p.640). This corresponds with the theoretical orientations of the research participants, who both viewed work with transgender clients through a psychodynamic and family-systems perspective. The participants conceptualized their client’s experiences within the context of relationships, cultural acceptance, racial considerations, socio-economic factors, among others. An intersectional framework fits with the subjectivity of art therapy, through avoiding bias and assumptions about what a client’s artwork means for

them. Approaching a client through an intersectional understanding and recognizing the complex diversity they embody can “offer art therapists a means to identify and deal with cultural complexity and issues of power from personal, national, and global perspectives” (Talwar, 2010, p.16).

Establishing community and group cohesion can provide transgender clients with a secure environment to examine gender and trauma related issues to provide healing through social support and informational networking (Flentje et al., 2014; Mizock & Lewis, 2008). The culmination of assumptions and societal biases projected towards transgender individuals in the form of minority stressors, microaggressions, and transphobia seems to affect transgender individuals in the form of negative emotional reactivity and maladaptive coping, such as suicidal ideation, self-harm, and substance use (Flentje et al., 2014; Hendricks & Testa, 2012; Levitt & Ippolito, 2013; Mizock et al., 2014). Group cohesion and related therapeutic interventions can help transgender clients reduce anger, depression, anxiety, and concurrent maladaptive coping through expressing feelings and fears related to transphobia, self-expression, and disclosure. Since isolation and rejection from family are often risk factors that cause negative outcomes for transgender individuals (Collazo et al., 2013), providing group art therapy could implement social support and allow exploration of transgender treatment concerns in a safe, therapeutic community. The research participants both recognized group art therapy as providing clients with the opportunity to use art in a cathartic manner to explore body image and illustrate variations in gender expression. The ability to feel part of community that understands what they've been through can help clients feel more confident, find more appropriate ways of coping, and begin to process their trauma history.

Transaffirmative treatment practices are prominent in both literature and in the approaches of the research participants. One of the essential components of a transaffirmative perspective involves intentional, client-identified language with transgender clients. “Our language choices often communicate gender identity oppression and prejudice as it typically reinforces the gender binary. Language can be very validating or quite hurtful” (Nagoshi, 2014, p.137). The words and identifiers related to transgender identity are constantly growing and evolving, so it is important for clinicians to join with their clients through use of client-specific pronouns and terminology that reinforces their unique gender expression (Collazo et al., 2013; Hendricks & Testa, 2012; Mizock et al., 2014; Singh et al., 2014). This extends to the recognition of how clients describe their bodies, such as genitalia, even if the client decides not to transition (Collazo et al., 2013). Transaffirmative treatment is aligned with the basic concept of therapy, which is to create a therapeutic environment that demonstrates support and feels safe for the client (Beaumont, 2012). A client’s gender expression might not necessarily fall under the gender binary of male or female, and extends to other expressions as well, which is significant for clinicians to be attentive to (Donatone & Rachlin, 2013). Affirmation of identity and recognition of life experiences are vital for transgender clients to view a clinician as helpful and able to join them in the therapeutic process (Benson, 2013). Clinicians need to be aware of their own gender biases and assumptions to better acknowledge transgender clients and provide them with a higher level of care. Avoidance of pathologizing clients, or expecting clients to be at a certain identity development stage, aids in establishing a transaffirmative approach (Benson, 2013; Mizock & Lewis, 2008).

The DSM-5 has started to reduce the focus on pathologizing transgender individuals through the fluctuation of diagnostic language to be more accepting and

lessen stigma (Collazo et al., 2013). These changes in terminology offer more humanized language and a possible reduction in marginalization (Belluardo-Crosby & Lillis, 2012). The DSM-5 also altered the categorization of Gender Dysphoria from the Sexual Dysfunctions and Paraphilic Disorders section of the DSM-IV TR, into its own separate chapter (Collazo et al., 2013). Due to the confusion between transgender identity and sexual orientation for clients and clinicians, it is also essential for clinicians to be informed of the unique treatment concerns that specifically affect transgender clients (Addison, 2003). An insufficient degree of training pertaining to gender identity has led to confusion for many mental health professionals, who often don't know the distinction between gender identity and sexual orientation (Benson, 2013). Transgender issues are often amalgamated with lesbian, gay, and bisexual treatment concerns, which might be related to a lack of understanding and a discomfort addressing these differences for some clinicians (Collazo et al., 2013). This research suggests the radical notion that the transgender community be considered their own separate culture and be removed from being aggregated with lesbian, gay, and bisexual populations, out of respect, rather than exclusivity. This shift might begin to establish the transgender community as its own cultural identity, through recognizing the vast differences in life experience and gender identity, instead of being classified in the same grouping as sexual orientation. While there are some shared experiences, such as the coming out process, minority stressors, and a lack of cultural acceptance, the transgender community deals with identity development in a different capacity. In order for medical and mental health professionals to become better informed and aware of these considerations, a cultural shift needs to take place to establish and recognize transgender culture and identity in a new, redefined manner. Once this unique culture is authenticated, there might be more room for the

various spectrum of gender expressions, including those that move away from the male-female binary, such as genderqueer, bigender, gender fluid, gender variant, and other types that have yet to be defined.

Conclusion

This research focused on the use of art therapy as a treatment modality with the transgender population, in order to provide art therapists with considerations to enhance awareness in the treatment and care of these individuals. Research was compiled using axial coding from interviews conducted with art therapists who have utilized art therapy with transgender clients. Insight into various art therapy treatment approaches and transaffirmative techniques for clinicians were discovered through the synthesis of data and thematic elements from current transgender literature. The study was limited to art therapists in the South Bay area of Los Angeles, and expansion of this study to a larger sample size would help gain more insight into transgender treatment considerations and the transgender population in different areas.

This research is significant in the field of art therapy, as there is insufficient information related to art therapy with transgender individuals. Some of the art therapy literature that does address the transgender population is limiting, as the focus is on the LGBT population as a whole, instead of recognizing transgender culture as its own entity. There are a handful of art therapy articles that do acknowledge the transgender experience, but there have not been any in the last few years. This research starts the conversation to advocate for transgender individuals to be respected outside of the lesbian, gay, and bisexual landscape, in order to appreciate the uniqueness of transgender identity and variations in gender expression. In order for art therapy to advance and remain current in the mental health field, future research must be done to discover ways to engage the needs of transgender and gender non-conforming clients, as their visibility increases. The researcher proposes future research using art therapy to continue the

dialogue of how to respectfully engage transgender clients with the process of understanding their identity in a manner that is comfortable and empowering for them.

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