Beyond the Dominant Paradigm: Integrating Expressive Arts Therapy and Narrative Therapy to Best Serve the Needs of Trans and Gender Non-conforming People: A Literature Review

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Beyond the Dominant Paradigm: Integrating Expressive Arts Therapy and Narrative Therapy to Best Serve the Needs of Trans and Gender Non-conforming People: A Literature Review

Capstone Thesis

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Expressive Arts Therapy

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Abstract

In this paper, I reviewed the past, present, and what I argue is the best possible future for clinical practice with TGNC clients. I began with an overview of the broad approaches to deviance from the norm in the field of mental healthcare: starting with approaching trans people with a pathologizing model; continuing on to a cultural competence model, which was an improvement but did not ultimately challenge the larger colonial framework that led to the pathologization in the first place; and ended with the humanity-affirming paradigms of decolonization and cultural humility.

The literature review was concerned with narrative therapy and its roots in post-structuralism; expressive arts therapy and its core ideas of client agency, Jungian active imagination, and the intermodal transfer; and combining NT and ExTH to meet trans clients’ needs. The biggest area of overlap in NT and ExTH is the intervention of externalization. By externalizing a problem in NT or placing feelings into a sculpture or art piece in ExTH, the client can gain the distance to realize “I am not the problem, the problem is the problem”. Narrative therapy is focused around one’s own power and agency to tell one’s own story, which inherently challenges exploitative systems.

My conclusion was: if we can embody the principles of decolonization and cultural humility, we can support the growth and transformation of a vibrant, beautiful, irreplaceable subset of humanity. And, I argue, narrative therapy and expressive arts therapy are two of the best ways to accomplish this.
Beyond the Binary: Integrating Expressive Arts Therapy and Narrative Therapy to Best Serve the Needs of Transgender and Gender Non-conforming People: A Literature Review

Introduction

This paper aims to provide a review of literature for how expressive arts therapy and narrative therapy can uniquely address the specific needs of transgender and gender non-conforming (TGNC) clients. My selection of this topic is informed by my lived experiences as a nonbinary person, both as a consumer of mental healthcare and as a future clinician. I argue that this topic is relevant and important to the field of mental health because this is a population in dire need of mental health support (Valentine & Shipherd, 2018), yet several factors mean that this population faces disproportionately high barriers to access mental healthcare in comparison with other populations (Snow, Cerel, Loeffler & Flaherty, 2019). Many of these factors relate to aspects of mental health treatment that involve an imbalance of power between institution and/or clinician and client (Snow et al., 2019). Cobb and Negash (2010) note that both expressive arts therapy (ExTH) and narrative therapy (NT) place the clinician and client on equal footing. For this reason, I argue that integrating these two modalities may help TGNC clients, and that this is a worthy area for further research.

A Note on Language

Part of the apprehension untrained clinicians may feel about treating trans clients is a lack of confidence about the right terms and fear of saying the wrong thing or offending a client. In hopes of bolstering confidence and to let you know what to expect in this paper, I have provided some basic terms and information below. However, I want to stress the following three points.

1. While these are the terms that were in widespread use at the time of this writing, language is alive and will continue to evolve.
2. Transgender people are not a monolith. Language, terms, and pronouns are intensely personal. It is likely that at some point in a mental health clinician’s career they will encounter a client who personally identifies in a way that contradicts this list and/or generally agreed-upon current linguistic practice. For example, you may counsel a client who firmly identifies as transsexual, or transgendered (instead of transgender) despite the fact that both of those terms have been largely retired for their harmful aspects. Or they may say “my preferred pronouns are x” when it is now considered best practice to omit “preferred” from pronouns and identities, as it gives the impression that referring to people accurately is optional. All of this is to say: when in doubt, always defer to self-determination and refer to people the way they would like. (ALGBTIC, 2009). If you’re not sure, ask!

3. Missteps do happen and the best thing to do if you, for example, misgender a client by using a pronoun they do not identify with, is: quickly correct yourself, quickly apologize, and move on. The absolute worst thing to do is to stop and belabor the mistake, placing your client in the uncomfortable position of having to comfort and reassure you, when in fact they are the client!

Here are some quick definitions offered by Whitman and Boyd (2020). A **transgender** person is a person who does not identify with the gender they were assigned at birth. They may have taken, or plan to take, steps to socially, medically, and/or surgically transition, or they might not. A **cisgender** person is someone who *does* identify with their assigned gender. **Gender non-conforming**, **gender variant**, **gender nonbinary**, **gender diverse**, and **nonbinary** are all umbrella terms for identities that fall outside the gender binary but are not necessarily pursuing a
linear journey from one binary gender to another, such as genderqueer, genderfluid, agender, two-spirit, or neutrois. For example, I am nonbinary, and consider myself part of the GNC umbrella. There is also movement toward “trans” being an umbrella covering both binary trans people (people transitioning from female to male or male to female) and everyone outside the binary. “TGNC” and “trans” will be used interchangeably for the purposes of this paper to refer to the same population.

Clinicians should not conflate gender identity with sexual orientation. Gender identity is identity. Sexual orientation (homosexual, bisexual, heterosexual, etc) is who one is attracted to.

For the purpose of this paper, “queer” and “LGBTQ” will be used to refer as an umbrella to all people who are non-normative gender-wise and/or sexual orientation-wise.

From Pathologization to Cultural Competence to Cultural Humility and Decolonization

I started this literature review with the question “how can narrative therapy and expressive arts therapy be used with TGNC clients?” However, as I explored the literature, I realized that questions of cultural competence, power privilege and oppression, and a decolonial lens were too intertwined and too important not to include. I found that a decolonial lens was necessary for therapy of any kind with this population to be affirming and effective. Therefore, these issues will be woven throughout this paper.

Treatment of transgender people started (and, sadly, largely continues) with a pathologization and disease-based lens, which I will elaborate more on in the literature review. Then, “cultural competence” and “multiculturalism” came into vogue. However, even though this was an improvement, as Gorski and Goodman (2015) caution, “Too often ‘multicultural’ counseling and psychology are practiced or theorized in ways that actually replicate the power arrangements they ought to be dismantling” (p. 2). Epston (2016) shared a similar concern:
“Without careful consideration, narrative therapy could, against its own will, participate in the same colonization [that it aims to combat]” (as cited in Health, 2018, p. 51).

Gorski and Goodman (2015) posit that superficial “cultural competence” ignores the power and privilege aspects of different groups, positions anything other than straight, white, cisgender, etc. as different from the “norm” and promotes binary and non-intersectional thinking. Models of identity development that promote a monolithic view of “here’s how all Asian-Americans are,” “here’s how every coming out story goes” can hurt rather than help clients that hold those identities by giving clinicians false confidence that every client of that identity will have the same problems and respond to the same clinical approaches.

I vehemently agree with Gorski and Goodman. Instead of a colonized multicultural counseling directly our attention downward to disenfranchised people, they urge counselors to rather look “up the power hierarchy, where inequalities are embedded in systems and structures that privilege the few at the expense of the many” (2015, p. 7). What a revolutionary thought! This is the solution to the problems caused by shallow cultural competence: decolonization.

Sadusky and Yarhouse (2020) propose another solution: a framework of cultural humility. Such a framework is honest about the limits of how much we can know about any person and promotes nuance, curiosity and sensitivity; it “forces us into the tension of the unknown” (Sadusky & Yarhouse, 2020, p. 109). The prevalent emphasis in the field on cultural competence causes assumptions and overgeneralizations if not handled with, well, humility. Cultural humility is not an excuse for lack of knowledge and active attitude to learning, though. In the words of Laird (1999, as cited in Mallory et al., 2017), clinicians should take a position of “informed not-knowing” (p. 31). A cultural humility lens nurtures an ability to hold multiple perspectives on the complexity of each person.
In this paper, I will review the history and present of transgender people’s involvement with the health and mental health establishment, particularly highlighting the fraught dynamic of mental healthcare providers as gatekeepers standing between trans people and desired medical services, forcing trans people to perform a certain standard of transness. I will highlight the particular mental health vulnerabilities in this population. I will make suggestions for trans-affirmative and effective best practices for clinicians. The reminder of this literature review will be concerned with narrative therapy, expressive arts therapy, and combining the two to best serve the needs of TGNC clients. Finally, in the discussion, I will offer my recommendations for clinical practice and further research based on what I enumerated in the Literature Review.

**Literature Review**

**TGNC People**

It is the best of times and the worst of times for TGNC people. On the one hand, they are experiencing unprecedented levels of visibility and thus, a certain amount of normalization and acceptance: TV shows like Pose and Transparent; Merriam-Webster’s dictionary selecting singular “they” as the 2019 word of the year; high-profile celebrities like Caitlyn Jenner and Elliott Page transitioning. Yet, it is also the worst of times: high-profile celebrities like J.K. Rowling are stoking transphobia (Horbury & Yao, 2020), and with 44 murders, 2020 was the deadliest year on record for transgender people in the United States (Human Rights Coalition, 2020). It is within this climate that mental health practitioners must sensitively and culturally competently treat TGNC people.

Unfortunately, the LGBTQ community is not immune from the dynamic present in all marginalized communities wherein the most privileged members of the community become the face of the community / the loudest voices. Much like the feminism of the suffragettes excluded
women of color in order to further white women’s advancement, the gay rights movement has largely focused on rights for white gay men such as the right to get married, ignoring the fact that trans people’s rights to housing, employment and safety are in danger, and also that we owe the entire modern pride movement to trans women of color (Whitman & Boyd, 2020).

Despite the public perception that transgender identities are “trendy” or modern, transgender identities have existed as long as there have been gender roles. In fact, gender nonconforming people predate the gender binary, which is, itself, a violent tool of colonization and white supremacy (Shirazi, 2011, as cited in Goodman & Gorski, 2015). Therefore, again, I argue that a decolonial/anticolonial lens is essential in treating trans clients effectively. Item B.11 of the ALGBTIC Competences (2009) states that clinicians treating trans clients must “educate themselves and others about the damaging impact of colonization and patriarchy on the traditions, rituals and rites of passage specific to transgender people across culture over time, e.g., Hijras of India, Mahu of Hawaii, Kathoey of Thailand, Two-Spirit of Native American/First Nations people” (p. 6).

History and Present of Pathologization of TGNC People

Gender non-conformity was not considered a medical condition until the early 1900s, when the psycho-medical categories of gender identity disorder and gender dysphoria were created in Western Europe (MacKinnon, 2018). Since then, people of queer identities have faced pathologization at best and active harm at worst from the medical establishment; for example, homosexuality was classified first as a “sociopathic personality disturbance”, then a “sexual deviation” until it was finally removed from the DSM-II in 1973 (MacKinnon, 2018). However, transphobia has proved itself the most tenacious form of discrimination against queer people: though society’s picture of baseline normal or healthy has expanded to include gay people, and
though huge strides have been made toward trans acceptance, the past and present of the relationship between TGNC people and the medical establishment remains troubled and fractured.

Until 2013, the state of being transgender was classified as “Gender Identity Disorder” in the Diagnostic and Statistical Manual of Mental Disorder 4, and now remains there in the DSM-5, with the slightly less stigmatizing name of gender dysphoria. In another mildly positive development, it also was moved from “Sexual Dysfunctions and Paraphilic Disorders” to its own section. Conversion therapy (the process of trying to change an individual’s sexual orientation or gender identity), which is scientifically proven to be ineffective and incredibly harmful (Hendricks & Testa, 2012), is still legal in 29 US states.

**The Problem with Gatekeeping**

Transgender people involved in the process of medically or surgically transitioning may have a troubled relationship with therapists due to the role of mental health clinicians as gatekeepers to desired treatments (Holt et. al, 2020). In order to pursue medical and surgical transition, transgender people have to get a letter from a therapist saying that they’re ready for transition. This puts them in the difficult position of proving that they’re “trans enough” or the “right kind” of trans person. Their medical providers “guard and sometimes obstruct access to transition-related care” (MacKinnon, 2018, p. 78). Therefore, this subset of TGNC people may associate therapy with gatekeeping and performing what the therapist wants to see and hear, rather than share genuinely about their life (Holt et. al, 2020).

“Trans enough” or “the right kind of trans” is also known as transnormativity, wherein some trans narratives are considered more authentic or legitimate than others. Typically these narratives include being trapped in the wrong body, feeling trans from an early age, and adhering
to strict gender roles after transition. Transition is a one-time process; gender affirming hormone therapy (GAHT) and/or gender confirmation surgery (GCS) is seen as the “cure” and the patient and thereafter considered normal and healthy. However, there is no one trans narrative, and HRT and GRS are not the answer for many TGNC people, particularly nonbinary people.

Focusing on transition is reductive, essentialist, and linear in a way that does not reflect reality for most trans people. It is also, in the case of medical transition, classist: the various surgeries trans people pursue are costly and require a great deal of time off work, meaning they are not economically feasible for many people (Brewster, Motulsky & Glaeser, 2019).

The movement from a disease-based model to an identity-based or strengths-based model of transgender clinical care is a hugely positive step but the work is far from over.

**Mental Health Needs of TGNC People**

TGNC people face elevated rates of depressive symptoms, suicidality, interpersonal trauma exposure, substance use disorders, anxiety, and general distress (Valentine & Shipherd, 2018). The unique challenges TGNC people face vary by developmental stage. Young TGNC people are completing the developmental task of identity consolidation. They may contend with estrangement from family and an attendant heightened vulnerability to homelessness; however, foster care, shelters and transitional housing may also be sites of transphobia and discrimination (Yu, 2010, as cited in McCann & Sharek, 2015). TGNC people are also the population most severely affected by HIV/AIDS (McCann & Sharek, 2015).

Suicide is a huge issue. According to Haas et al., (2014) suicide attempt rates may be as high as 41% among trans people. In a study by Grossman and D’Augelli (2007, as cited in Rivera & Morris, 2020) nearly 50% of trans youth had seriously considered suicide and 25% had
attempted it. In one sample in a study by Bailey et al. (2014, as cited in Bartholomew et al., 2019) suicidal ideation had a lifetime prevalence of 84%.

Despite being a small percent of the population at large (an estimated 1-8% in the US), transgender people are significantly overrepresented in mental health settings (Coppola, 2017). As many as 75% may seek therapy (Grant et al., 2011, as cited in Bartholomew et al., 2019), largely because of therapists’ position as gatekeepers of transition-related medical care.

Trans clients may experience gender dysphoria or the feeling of discomfort of how society views their body. However, not all trans people experience dysphoria and it is not a requirement to be “really” trans.


**The Coming out Process**

The coming out process has changed significantly with time and is different for every person. Cass (1979) and others have proposed stage models for gay people’s coming out experience which have been extrapolated to trans people. However, the literature has since shifted to the consensus that coming out is a nonlinear and potentially lifelong process, embracing an interactionist rather than a stage model (Pelton-Sweet & Sherry, 2008). Gorski and Goodman (2015) also caution that any sort of identity development framework can be more dangerous than it is helpful if clinicians extrapolate from it that all clients of that identity are the same.

Clinicians also do clients a disservice if they regard being “out” as the goal and any degree of closeted-ness as a bad thing. Consideration of outness as a measure of mental health
may actually worsen the mental health of closeted people (Talburt, 2004, as cited in Pelton-Sweet & Sherry, 2008). Choosing when, whether, and how to come out is an intensely personal decision mediated by many factors such as safety, access to basic needs, employment, and so forth (Brewster et al., 2019).

**Barriers to Care for TGNC People**

Snow et al. (2019) identified three broad barriers to TGNC access to mental health services: fear of being pathologized, fear of incompetent clinicians, and affordability. As established earlier, the fears of pathologization are well-founded.

The ethical and accreditation standards of the APA, ACA and others “mandate that all therapists who work with LGBT clients be adequately prepared for the needs of this population,” (Pelton-Sweet & Sherry, 2008, p. 172) yet almost no clinicians receive any training on trans issues whatsoever (McCann & Sharek, 2015; Nylund, 2017).

**Theoretical lenses for clinical practice with transgender clients**

**Humanistic / Client-centered therapy**

Beaumont (2015) argues that clinicians should treat their clients with unconditional acceptance. This is very in line with the “unconditional positive regard” at the heart of client-centered therapy, a school of thought founded by Carl Rogers. Rogers’ daughter, Natalie Rogers, is one of the founders of expressive arts therapy and very much espouses the client-centered approach as well. She also believes that each person has the capacity for self-direction and has an impulse toward personal growth and full potential (Malchiodi, 2011).

**Queer and Feminist Theories**

The work of Judith Butler presents the idea that gender is not a fixed state but rather a continuum with endless variation, and not natural/biological but rather performative (Butler,
“constructed, multiple and fluid” (Nylund, 2017, p. 162). In her words, “Gender has no essence, rather it is reiterated in everyday practices” (2004, as cited in Benson, 2013). It would be challenging to counsel trans clients without this lens, because, by definition, one would be pathologizing them, and, thus, subtly or overtly alienating or harming them. Like narrative therapy, queer theory is predicated upon post-structuralist ideas. Trans people illustrate the failure of the gender binary to contain the vastness of human experience, another reason this is a relevant lens.

Feminist and post-feminist theory emphasizes what kinds of questions are being asked and who is asking them over answers. The question “who is the patient and where is the illness?” (Talwar, 2010, as cited in Hetherington, 2020) exemplifies this viewpoint’s commitment to critiquing systems of power.

Recommendations for Clinicians

Despite these myriad issues, trans people are seeking therapy in greater numbers than ever before, which is great news (McCann & Sharek, 2015). What can clinicians do to ensure that they are delivering high-quality care?

Guiding Texts

Two documents may provide a starting point: the American Counseling Association’s (2009) Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Competencies for Counseling Transgender Clients, and the mental health care section of the World Professional Association for Transgender Health (WPATH)’s (2011) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People Version 7 (SOC 7). The ALGBTIC competencies rest on a “wellness, resilience and strength-based approach...and a multicultural, social justice, feminist, and privilege, power and
oppression-informed theoretical orientation” (2009, p. 1). It stresses the responsibility of clinicians to assume an advocate and change agent role on behalf of trans clients in the field (as did the SOC 7), and compensate for the lack of research on treating trans people by evaluating and re-evaluating their own work with trans clients. The SOC 7 stresses the necessity of clinicians to self-educate and to have information available for trans clients. It emphasizes that, in spite of the gatekeeper role of the counselor, decisions regarding hormones and surgery should be “first and foremost a client’s decisions” (WPATH, 2011, p. 25). The SOC section on mental health concluded with a call for clinicians to improve access to competent care for trans clients by pressuring health insurance companies to provide more coverage and offer more services at a distance through telehealth. The SOC are good but unfortunately reconfirm clinicians’ role as gatekeepers.

These are my recommendations, including and building on these documents:

Trans-affirmative Care

ALGBTIC Competencies (2009): competent counselors will “understand that attempts by the counselor to alter or change gender identities and/or the sexual orientation of transgender clients across the lifespan may be detrimental, life-threatening, and are not empirically supported” (p. 6). Unfortunately, clinicians still do this, with incredibly harmful consequences: “A participant in [a study] disclosed that a therapist called her a ‘freak of nature’ and ‘sexually immature’ and she left the session thinking ‘I am the lowest of the low’” (McCann, 2015, p. 78). I don’t know what code of ethics that therapist adhered to, but I feel confident that this is a violation of any reputable ethical code.

Self-awareness
Counselors should strive for “awareness of their own assumptions, values, and biases” and “their own gender identity and gender privilege” (Chavez-Korell & Johnson, 2010, p. 204). They should reflect on their own social location and the privilege they experience as a cisgender person (Nylund, 2017). They should be mindful not to apply any knowledge they may already have about trans people to their clients, since transgender people are not a monolith and every person’s story is different. Counselors should utilize supervision and consultation to make sure they are minimizing biases (ALGBTIC, 2009, p. 11).

**Self-education and Preparation**

Clinicians must go out of their way to take the initiative to educate themselves, and make it an ongoing process. As with any other marginalized group, the burden of education should not be placed on the marginalized person. In any context, but especially in this situation where the client is a client there to receive a service, they should not be performing emotional labor. Clinicians should understand the distinction between sexual orientation and gender identity. Clinicians should use the person’s correct pronouns, have an understanding of trans-specific mental health issues, and display welcoming, nonjudgmental attitudes (McCann & Sharek, 2015).

**Attention to Language**

“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, as cited in Schnebelt, 2015, p. 49). As I established in the introduction, making the effort to use correct terminology and pronouns is a sign of respect. If unsure, clinicians should take it upon themselves to educate themselves, and above all, ask clients what language they are comfortable with and defer to the principle of self-determination.
Attention to Environment

Material things that make for inclusive environments include: “TGNC-affirming signage in prominent areas, gender-neutral bathrooms, provider and staff training in culturally competent TGNC care, Forms and documents that are gender and trans inclusive, provider advocacy on behalf of patient, appropriate staff response when enacted stigma is experienced, direct discussion of issues related to race and gender with TGNC persons of color, and gender sensitivity in rooming/cohorting decisions” (White & Fontenot, 2019).

Cultural Considerations

Clinicians should approach clinical practice from the lenses described in the introduction of cultural humility and decolonized practice. Clinicians should conceptualize clients’ distress at societal forces like transphobia “not as pathological, but a response to being immersed in toxic social hierarchies” (Chavez-Korell & Johnson, 2010, p. 210). Documents like the SOC 7 are useful but according to its authors, “WPATH recognizes that the SOC have grown out of a Western tradition and may need to be adapted depending on the cultural context.” (WPATH, 2011, p. 32).

Avoid “Broken Arm Syndrome”

“Broken Arm Syndrome” refers to the tendency of medical personnel to attribute anything that is wrong with a trans person, even something so obviously unrelated as a broken arm, to the fact that they are trans. At the same time as being well-informed, clinicians should be open-minded and not assume that every issue a trans client brings to therapy must somehow relate to being trans (ALGBTIC, 2009). Transgender people are complex human beings and being transgender is only one facet of their identity. Chavez-Korell & Johnson also caution counselors “about being overzealous transgender allies and encourage counselors to be mindful
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of fetishization of the trans community” (2010, p. 206). Competent counselors will “respect and attend to the entire individual - not just their gender identity-related issues” (ALGBTIC, 2009, p. 7).

A common clinician mistake is focusing too much or too little on clients’ identity. In a qualitative study of 45 trans mental healthcare clients by Mizock and Lundquist (2016), multiple study participants “expressed irritation over their therapists’ inflated focus on gender” (p. 151). Conversely, it harms the therapeutic alliance when the clinician ignores or denies the client’s gender identity altogether (Hunt, 2014).

**Understand Intersectionality**

Like all people, transgender clients exist at the intersection of many identities, which interact in complex ways. Hays’ (2001, as cited in Whitman & Boyd, 2020, p. 101) ADDRESSING framework can provide a touchpoint for just how multidimensional people are. ADDRESSING stands for age, dis/ability, religion, ethnicity, social class, sexual orientation, indigenous background, national origin, and gender identity. Item B.7 of the ALGBTIC competencies (2009), for example, states, “understand how the specific intersection of racism, sexism, heterosexism and transphobia influences the lives of transgender people of color (p. 6). “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, as cited in Schnebelt, 2015, p. 47). Clients with other marginalized identities experience transphobia differently. “TGNC persons of color experience more enacted stigma and found it difficult to receive care that acknowledged all aspects of their multiple minority status” (White & Fontenot, 2019, p. 208)

**Customize Care**
Resist the inclination to apply a “one size fits all” approach or assume that all TGNC clients are the same; these are reasons trans study participants have left therapy (Mizock & Lundquist, 2016). It’s important to meet clients where they’re at (Holt et al., 2020).

Clinicians should not say things like “I don’t see color” about race or “you’re just the same as a cis person” to TGNC clients. This erases and invalidates their lived experience (Holt et al., 2020). Clinicians should be flexible and allow your therapeutic approach to shrink and expand in proportion with what the client indicates is important to them.

**Narrative Therapy**

Narrative therapy in its current iteration was founded in 1990 by Michael White and David Epston (White & Epston, 1990, as cited in Erbes et al, 2014). It is a school of therapy which emphasizes the primary role of storytelling and narrative in human experience. Clients are challenged to “reauthor” their lives by exploring alternative viewpoints that open up new possibilities. Narrative therapy is characterized by empowerment of the individual and subversion of the dominant paradigm. By externalizing the problem, examining their history, and constructing new, more nuanced and empowering narratives, clients can change the parts of their lives that are within their control, and change their relationships with the parts of their lives that are out of control.

Chavez-Korell & Johnson (2010) noted that a narrative therapy lens “acknowledges the impact of cultural and sociopolitical realities...there are no absolute truths; instead, realities are socially constructed and maintained through personal narratives” (2010, p. 203). In the words of Nylund (2017), “Most therapy models privatize problems and de-emphasize the role of social structures, unfittingly attributing sociopolitical problems to the individual.” (p. 163). Trans people face significant stress, discrimination and oppression due to sociopolitical realities, and
construct their identity in opposition to the dominant paradigm; therefore, narrative therapy is uniquely well-suited to them. Nylund (2017) was involved in creating a subset of NT called Queer Informed Narrative Therapy that capitalizes on the power and privilege implications of NT that Chavez-Korrell & Johnson mentioned.

The key tenet of narrative therapy is “the person is not the problem, the problem is the problem” (Nylund, 2017, p. 162). Through externalization, the client can relate to the problem in a new way; space is opened up to generate alternative stories and the problem is unstuck from their identity.

A clinician utilizing narrative therapy uses questions to help the client understand and separate from a limiting narrative. The questions also help the client “express in tangible form a ‘unique outcome’- exceptional events, actions, or thoughts that contradict the problem-saturated story where the problem did not win out” (Malchiodi, 2011, p. 158). Unique outcomes are also called “sparkling events”. Through the finding of unique outcomes, deconstructing limiting beliefs related to the problem-saturated narrative becomes possible.

**Post-structuralism**

Narrative therapy draws heavily from the work of Michel Foucault and the philosophy of post-structuralism, developed in France in the 1950s. In contrast with structuralism, which came before it, post-structuralism rejects binaries and posits that truth or reality cannot be extricated from culture and is therefore subject to biases and misinterpretations- narrative therapy couldn’t exist without the understanding that clients can change their lives by interrogating their narrative biases. Foucault believed reality was subjective and did not find the concept of absolute truth conducive to growth (Dennis, 2020). Foucault was critical of the ways society and medicine stigmatize and dehumanize people when they label them, making poststructuralism well-suited to
working with TGNC clients. The word “structuralism” within post-structuralism even calls to mind the NT intervention of deconstruction. “By integrating a poststructural theoretical position in his practice of therapy, Michael White proposed that the complexity of life—how lives are lived, and how we conceptualize identity—is mediated through the expression of the stories we tell” (Madigan, 2019, as cited in Dennis, 2020, p. 13).

**Expressive Arts Therapy**

Expressive arts therapy was founded by Shaun McNiff, Paolo Knill and others in the 1970s (McNiff, 2009). It is a school of therapy guided by the idea that properly supported self-expression through the arts can promote growth and healing (Pelton-Sweet & Sherry, 2008). Through visual art, music, dance, and/or drama, patients gain a container for challenging emotions, and may be able to integrate difficult experiences. “Expressive therapy has been defined as using the arts and their products to foster awareness, encourage emotional growth, and enhance relationships with others through access to imagination; including arts for therapy, arts for psychotherapy, and the use of arts for traditional healing; and emphasizing the interrelatedness of the arts in therapy” (McNiff, 2009, as cited in Malchiodi, 2011, p. 185).

Expressive arts therapy differs from the individual expressive therapies, also known as the creative therapies, in that, rather than focusing on a specific modality, as is the case with art therapy, drama therapy, dance movement therapy, and music therapy, ExTH draws on all the modalities, emphasizing creative process over result or technical skill, therefore being accessible to a larger cross-section of clients (Knill, Levine, & Levine, 2005). In addition, ExTH differs from the umbrella “creative arts therapies” in that ExTH emphasizes what is known as the “intermodal transfer,” or the deepening in meaning or therapeutic potential when a client
switches from one creative modality to another within a single session. However, in practice the two terms are used interchangeably.

Shaun McNiff (1981, as cited in Gupta, 2020) said that the arts can “remake and transform both internal and external realities. Art empowers us to participate...throughout time, art has shown that it can change, renew, and revalue the existing order. If art cannot physically eliminate the struggle of our lives, it can give significance and new meaning and a sense of active participation in the life process” (p. vi, p. 594).

Expressive arts therapy draws on Jung’s theory of active imagination: the idea that valuable insight is present in the client’s unconscious mind and can be brought into consciousness with the arts: “The expressive arts therapies offer a road to the unconscious process that allows for finding meaning in the present. Utilizing these tools helps to foster personal growth and flexibility as we grow, make mistakes, and assert ourselves again and again” (Babysky-Grayson, 2013, p. 65).

The “intermodal transfer” is the idea that switching between modalities leads to greater insight or therapeutic benefit: “the purpose of facilitating transition [from one modality to another] is to encourage spontaneous expression, stimulate creativity, and enhance the experience of feelings, allowing for deeper understanding” (Malchiodi, 2011, p. 191).

Expressive arts therapy is advantageously flexible to individual client needs. In contrast of focusing on a specific art modality, “the therapy is enhanced in clinical depth and facilitates expression in a manner most appropriate to the particular client” (Malchiodi, 2011, p. 186).

Advantages Over Talk Therapy

Talk therapy is not an inherently welcoming or accessible format for many clients. Talking about one’s traumas and problems can be challenging and triggering with anyone, let
alone a stranger. But ExTH has been shown to succeed where words fail. Additionally, “the expressive art therapies have a way of circumventing and bypassing logic, intellectualizations and judgments” (Malchiodi,, 2005, as cited in Babyatsky-Grayson, 2013, p. 73).

Expressive arts therapy, with its impressive breadth of modalities, can meet each client according to their own personal passions and areas of comfort. For example, at my graduate internship I routinely have clients vehemently refuse when I offer art therapy, yet they light up when I mention music therapy, or vice versa. We then are able to advance farther in the work than we would be able to. In addition to being good for the efficacy of the work, offering choice is also anti-colonial practice, according to Heath (2018), who always asks clients “what is the medium or mediums you would most prefer to heal in?” (p. 51).

**Combining ExTH and NT**

Because visual art, drama, dance, and music are powerful forms of storytelling, expressive arts therapy can enhance narrative therapy for clients less interested in talk therapy or narrative writing.

Cobb and Negash (2010) combined NT and AT with the intervention of altered book making, noting that it is uniquely in line with the narrative therapy intervention of reauthoring: “The exercise of reauthoring a book that already exists symbolizes the parallel possibilities that clients have to reauthor their own lives” (p. 54). They also noted that NT and AT share some theoretical beliefs; both place the therapist and client on equal footing; and as mentioned earlier, art is a natural choice for externalization. They then defined altered book making: “as the book undergoes metamorphosis, the artist’s adventures, experiences, and feelings are storied” (p. 59).
They then laid out a case for how altered book making specifically can be used for the NT interventions of defining the problem, externalizing the problem, identifying unique outcomes and creating new meaning.

“The visual arts make the unconscious conscious. Creating an image brings tangible form to psychological realities...allowing us to become aware of and confront those realities” (Gupta, 2020, p. 597). Because the arts provide a container for challenging emotions, they dovetail perfectly with the essential NT process of externalization. “Art is used to externalize and formalize a story, fear, or experience and it takes a weight off to put the image outside of oneself” (Brooks, 2006, as cited in Babyatsky-Grayson, 2013). Specifically, the ExTH framework of decentering, or focusing, rather than on the presenting problem, on, through the arts, entering an alternative, imaginary world, and generating new possibilities, (Knill et al., 2005) is directly analogous to the NT process of externalization and then searching for unique outcomes in order to construct an “alternative narrative” (Nylund & Temple, 2017). “In taking a narrative approach to art therapy, the art expression also becomes a form of externalization with added benefits to the therapeutic process...it can provide an opportunity to make meaning and to rework images into new stories” (Malchiodi, 2011, p. 156).

A subset of ExTH, bibliotherapy / poetry therapy, relates to NT in a very obvious, literal way. Bibliotherapy consists of the therapeutic reading of selected texts, after which the client goes through four stages: recognition, examination, juxtaposition, and finally self-application, in which the work is integrated into the person’s inner self. (Babyatsky-Grayson, 2013). In poetry therapy, poems are read and “the focus is on the person, not the poem. Clients are not asked the true meaning of a poem, but rather the personal meaning and its various applications to their lives” (Lerner, 1987, as cited in Babyatsky-Grayson, 2013, p. 64). An obvious combination of
poetry therapy and NT is the common intervention of having a person retell the story of their life in poetic form so they may view it from a different perspective and gain new insight (Babyatsky-Grayson, 2013).

Caldwell (2005) argued that ExTH and NT interventions can be combined by clinicians assisting older adults with the life review process. She also writes, “Narrative and expressive arts techniques allow us a myriad of ways to tap into [this] ongoing creative meaning-making process in all our lives” (p. 173). While older adults and TGNC people are greatly different, though intersecting, populations, they share the quality of being harmfully and unnecessarily pathologized by the medical establishment; therefore, some of Caldwell’s findings may hold true for TGNC people, as well. Also, trans older adults, as Kondas (2020) enumerated, face a host of unique challenges, including being barred from some forms of transition for medical issues, increased dependence on transphobic family members and caregivers, and being forced into gendered housing in institutional settings such as nursing homes. Kondas argues that trans elders may be well-served by a values and goals brainstorming activity informed by Acceptance and Commitment Therapy (ACT).

Fraser & Waldman (2004, as cited in Pelton-Sweet & Sherry, 2008) said art therapy with lesbian and gay clients “made visible the invisible, hidden, and secret, to bear witness to pain and to celebrate courage” (p. 89). providing reinforcement for the externalization aspect of both art therapy and narrative therapy’s relevance to LGBTQ clients (this was with lesbian and gay clients but could be extrapolated to trans clients.)

All of the art therapies share a belief that “the creative imagination can find its way through our most perplexing and complex problems and conflicts” (McNiff, 2005, as cited in
Babyatsky-Grayson, 2013, p. 70). This emphasis on imagination and self-determination is what unites ExTH and NT.

In music therapy, “clients can use music to represent their past, present and futures and to tell their own personal stories using either the music or the lyrics” (Babyatsky-Grayson, 2013, p. 74). The same could be said for any of the therapeutic arts modalities: “Art has a narrative component as well and provides a record of where a person comes from, where they are in the moment and where they are going in the future” (Brooks, 2006, as cited in Babyatsky-Grayson, 2013, p. 118).

Narradrama is a fusion of NT and drama therapy originated by Pamela Dunne that incorporates the interventions of outsider witnesses, double listening, and reauthoring. (Dennis, 2020). Dunne’s eight-part embodied approach to Narradrama closely mirrors traditional narrative therapy but brought to life through drama.

Dance movement therapy (DMT) has been used with trans clients: “its use of activating and engaging the body allows for a deeper understanding of body image issues that transgender individuals often face due to feeling alienated from the body of a gender they don’t identify as” (Hanan, 2010, as cited in Lisman, 2018, p. 9).

The North American Drama Therapy Association (NADTA) website (2019, as cited in Dennis, 2020, p. 22) says “[Drama therapy] gives LGBTQQIAP2S clients a play-space and laboratory where they can find a sense of self that feels more aligned and integrated with their identity.”

**ExTH, NT, and the Unique Needs of TGNC People**

According to Shipherd et al. (2010), objection to common therapeutic practices is a significant barrier to TGNC mental health care. In a study of 130 TGNC individuals, 22 percent
reported not wanting to talk about their personal life and 22 percent reported not wanting to speak in groups. Therefore, nonnormative forms of therapy such as ExTH and NT may be more acceptable to them. After experiencing therapy as a site of gatekeeping wherein the therapist is the “expert” who judges whether they are “trans enough,” ExTH and NT, which both position the client as the expert on their own life, could be a refreshing change. In narrative therapy, the clinician and client are collaborators and “we [clinicians] join our clients on a search for meaning, purpose, and identity” (Madigan, 2011, as cited in Sadusky & Yarhouse, 2020).

Chavez-Korell and Johnson (2010) recommend an “integrative affirmative counseling” method with trans clients that incorporates narrative therapy, multicultural counseling competencies, and the ACA’s Competencies for Counseling with Transgender Clients. “In using a narrative approach,” they write, “transgender clients tell their truths (i.e., their narratives), share their experiences, and reauthor new narratives thus creating new realities and (re)claiming their personal strength and resilience” (2010, p. 204).

TGNC people’s lives are often shaped by the stories others have about them: from family members saying they’re just confused, to celebrities saying they’re sick and fomenting hysteria about bathroom laws, to our entire society set up to prescribe a certain cisnormative script for people’s lives, they experience tangible harm from dominant narratives. While narrative therapy interventions cannot change those external narratives, they can change their inner stories.

Trans people are an incredibly heterogeneous population. As Sadusky and Yarhouse (2020) point out, “If you have met one transgender person, you have met one transgender person” (p. 108). NT and ExTH are particularly customizable to the individual client.

Group expressive arts therapy with other sexual and gender minorities (SGM) can help TGNC people because social rejection / isolation is a common and major mechanism of minority
stress. I can confirm this as a TGNC consumer of mental healthcare. I was involved in a partial hospitalization program specifically for LGBTQ people in 2016, and it definitely helped me in ways neither individual therapy nor group therapy with the general population would have.

**Minority Stress Model**

Meyer’s influential minority stress model, originally developed applied to lesbian, gay and bisexual people in 1995, was applied to trans people by Hendricks and Testa (2012). This model removes the burden of mental illness etiology from sexual and gender minorities (SGM) and places it onto the society that rejects, pathologizes and traumatizes them. This stress from society then causes elevated rates of mental illness and substance abuse. This happens through three processes: 1) discrimination in an individual’s life that causes stress; 2) the expectation and vigilance that the person then develops; and 3) the internalization of negative attitudes and prejudices (Hendricks & Testa, 2012). This internalization is corroborated by Nylund (2017): “Many of the problems that transgender clients experience are conceptualized not as manifestations of intrapsychic processes, but as the effects of transphobia” (p. 163). It is this inner stress due to transphobia that I argue could be dramatically transformed by narrative therapy and expressive arts interventions. Even the word “internalization” calls to my mind the essential NT process of externalization.

Meyer (2003, as cited in Hendricks & Testa, 2012) also noted that rather than just psychopathology, minority stress also leads to resilience and often coalescing around a minority identity. I argue that this is an additional area to explore with TGNC clients through NT and ExTH.

**Specific Interventions for TGNC Clients**
In this section I will review some expressive arts and narrative interventions that have been done or proposed with trans clients. Intervention research focuses on questions of gender identity and coming out almost to the exclusion of any other thing, as if TGNC people are one-dimensional. However, Whitman & Boyd (2020) do an excellent job of proposing treatment for the whole person in their book, “Homework Assignments and Handouts for LGBTQ+ Clients: A Mental Health and Counseling Handbook” which, despite being a resource for clinical practice and not a work of research, contains much fertile ground for further study.

Makin (2000, cited in Pelton-Sweet & Sherry, 2008) had queer clients make two self-portraits to represent one’s inner and outer worlds using a variety of media as a springboard for sharing.

Maher (2011, cited in Beaumont, 2015) used “The Bridge Drawing” with a group of transgender women. They were asked to draw a bridge with themselves somewhere in the image. Maher found that this activity provided an opening for the women to share how they were feeling about the transition process.

Beaumont (2015) noted the aforementioned tendency of trans people to struggle with shame and self-judgment when arguing that gender-variant individuals may benefit from Compassion-Oriented Art Therapy (COAT). COAT interventions merge guided imagery with artmaking in order to build distress tolerance, self-soothing and self-compassion skills. One COAT intervention is for participants to create images of “a safe place, their self-critic, an ideal compassionate person, the experience of compassion flowing out to others, the experience of receiving compassion, and a dialogue between their compassionate self and their self-critic.

Rivera & Morris (2020) developed a “creative, interactive lesson in identity and resilience” for traumatized TGNC youth. Participants would trace their silhouette, reflect on
some questions about their identity, collage magazine clippings that represent positivity, strength, and survivorship within their silhouette, and reflect and share afterward their emotional reactions to the project and how their identity has changed over time (p. 350).

Georgiou (2020) offered another variation on the self-portrait “a picture of what it feels like to be you” with a client, “Michael,” but also placed the client in family and society context by also adding a family portrait and a collage depicting “himself, his life, his support system, and anything else he wanted to add”. (p. 395).

Babatisky-Grayson (2013) describes the “Soundtrack of your life” intervention: “Clients are asked to list transitions in their lives that might correspond to particular songs of either that time or songs that have helped to carry them through ...difficulty or change. This could also be called their personal story, narrative or life theme” (p. 79).

Clients can read Portia Nelson’s 1993 poem “Autobiography in Five Short Chapters” about encountering the same problems and challenging oneself to make new decisions and then can be invited to write their own autobiography in five short chapters. As an optional art therapy addition, they can create a cover for their book (Babatisky-Grayson, 2013).

Makin (2000, cited in Pelton-Sweet & Sherry, 2008) had clients make puppets and have the puppets speak on their behalf: this is externalization through both art therapy and narrative therapy.

Pelton-Sweet & Sherry (2008) argued that “by nurturing [LGBTQ clients’ imagination, clients in the midst of clarifying their sexual and gender identities may be able to protect their physical and emotional health while learning more about, and ultimately becoming, their authentic selves” (p. 173). Narrative therapy is all about building imagination and generating new possibilities.
“Art therapy has been used with clients of all sexual orientations and gender identities to treat those mental health issues that are common for members of the LGBT community such as panic, hopelessness, and low self-esteem.” (Pelton-Sweet & Sherry, 2008, p. 173).

Discussion

In this paper, I reviewed the past, present, and what I argue is the best possible future for clinical practice with TGNC clients. In the introduction, I began with an overview of terms and the importance of correct language and pronouns with this population. I then gave an overview of the broad approaches to deviance from the norm in the field of mental healthcare: starting with approaching trans people with a pathologizing and diseased-based model; continuing on to a culturally competent or multicultural model, which was an improvement but did not ultimately challenge the larger colonial framework that led to the pathologization in the first place; and ended with the radical and humanity-affirming paradigms of decolonization and cultural humility.

At the outset of the literature review, I gave more details on the pathologizing history and present of trans healthcare, including, for example, a disproportionate focus on medical transition that is reductive and essentialist, and a troubled gatekeeper relationship between trans clients and the medical establishment. I noted that trans people are particularly vulnerable to suicidality and to feelings of shame and worthlessness due to minority stress (Meyer’s 2003 framework positing that trans distress comes not from being trans but from the transphobia of others). I offered humanistic, queer theory, and feminist/post-feminist theory lenses, and again reiterated the importance of decolonizing practice.

Then, recommendations for clinical practice included: providing trans-affirmative care (conversion therapy is scientifically proven to be ineffective and harmful), self-awareness
(engage in self-reflection about one’s own relationship to gender identity), self-education and preparation, attention to language (always deferring to the principal of client self-determination), attention to environment, embracing a cultural humility framework (as described in the introduction), avoiding “Broken Arm Syndrome” (or magnifying the person’s gender identity in a way that makes it hard to treat them as a whole, unique person), understanding intersectionality (the way multiple marginalized identities changes people’s experience of the world), and customizing care (avoid a one-size-fits-all approach and conform to each client’s unique needs).

The remainder of the literature review was concerned with narrative therapy and its roots in post-structuralism; expressive arts therapy and its core ideas of client agency, Jungian active imagination, and the intermodal transfer; and combining NT and ExTH to meet trans clients’ needs. The biggest area of overlap in NT and ExTH is the intervention of externalization. By externalizing a problem in NT or placing feelings into a sculpture or art piece in ExTH, the client can gain the distance to realize “I am not the problem, the problem is the problem”. Since, according to Meyer’s minority stress model, transphobia can lead people to internalizing those ideas, externalization is powerful for gaining enough distance to be able to do deep therapeutic work. Also, after having many other people’s stories about them forced onto them, NT empowers trans people to create their own narrative.

I was struck, in my research, by how well decolonization, narrative therapy, and trans consumers of mental healthcare’s needs all fit together. Colonized counseling can fail clients is by positioning disenfranchised individuals purely as victims and objects of oppression, and positioning the clinician as the active agent empower-er. Freire (2000) writes, “True liberatory practices reject humanitarianism and approaches that view someone experiencing oppression as a
passive object” (p. 6); instead they embrace what he called *humanization*, which focuses on one’s own power and agency in the personal and collective struggle for freedom.

This could not be more in sync with narrative therapy! Which is so focused around one’s own power and agency to tell one’s own story, and which inherently challenges exploitative systems. According to White and Epston, the founders of NT, “power is built through the establishment of ‘truth’ and normalized by large groups of people” (1990, as cited in Mallory et al., 2017, p. 32).

My biggest conclusion from my research is that counselors cannot be apolitical in 2021. By our very allegiance to a shallow “cultural competence” we are politically saying we are ok with the colonized, Eurocentric, binary way things are. This shallow cultural competence needs to be replaced by a deep understanding of power, privilege and oppression, and a sense of humility. We cannot in good conscience treat TGNC clients (or anyone for that matter) without being grounded in this understanding. Otherwise we risk doing harm to an already vulnerable population.

My recommendations for the conducting of original research and clinical practice is that we are not trans-affirmative enough. As far as original research, in a study conducted by Piccirillo (2013, as cited in Schnebelt, 2015), a study ostensibly to benefit trans people, the author failed to refer to the subjects by their correct genders consistently. As far as clinical practice, we have well established the shortcomings that are present. Nylund (2017) interviewed trans clients, and they said the solution to better care is a combination of formal education and direct experience with transgender clients.
If we can embody the principles of decolonization and cultural humility, we can support
the growth and transformation of a vibrant, beautiful, irreplaceable subset of humanity. And, I
argue, narrative therapy and expressive arts therapy are two of the best ways to accomplish this.
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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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