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Hypocrisy in Higher Education: Racism and Transphobia as Barriers and Harm in Mental Health

Capstone Thesis

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Abstract

Mental health involves acts of naming and noticing, thus the hypocrisy of harm within mental health programs is explored and discussed through interpersonal and structural means. In a space that is meant for safety and care, inaccessibility, pejorative terminology, pathologizing identity, and exclusionary tactics are riddled throughout the layers of the mental health field. From campus, to literature, to different forms of therapy racism and transphobia work against non-dominant groups through interlocking forms of oppression. The centering of Western, White ideology is harmful to students in these programs, as well as the clients of BIPOC, QTBIPOC, and trans* communities. Mental health professionals are unequipped to work with these demographics, as there is much less research and clinical practices to support them. By not attending to these issues, higher education and its research is complicate in cyclical racial and transphobic harm. Without acknowledging said issues and working towards more expansive forms of care, mental health professionals will continue to harm their clients.

Keywords: racism, transphobia, higher education, practices, curriculum

Hypocrisy in Higher Education: Racism and Transphobia as Barriers and Harm in Mental Health

Before getting into harm within higher education, I will name my own privileges, identities, and relation to this topic. Though I may have personal experiences connected to racism and transphobia within higher education, there are many aspects I can only empathize with, ‘understand’ from a distance, and educate myself on. By no means am I an expert on the vast lived experiences, nor varying systemic means of oppression. I come to this topic with my identities and experiences, as well as the things that I have witnessed within my own program.

I am a trans non-binary, mixed person that holds different levels of privileges and marginalization. I am a second generation, as my mother is an Arab-Malay immigrant from Singapore. If following my patriarchal lineage, we are third generation French-Canadian. I have witnessed, experienced, and felt a sense of loss due to assimilation, the idea of “otherness,” and a lack of “true belonging.” This multifaceted identity has been invisible to my peers and past therapists. Whether on campus, in the U.S. or Singapore, or at internship sites, I am seen as questionable and/or as other. Certain aspects of my identity are visible, while others may be hidden or unknown until further spoken of.

Despite the macro system I am in, my family system provides privileges such as of generational wealth, white & white passing privilege, access to higher education, and upper-middle class status. Some of my other privileges are being able-bodied, not being visibly trans (within the U.S.) and being a native-English speaker. These privileges allow me a sense of safety, assurance of care, fulfilment of base needs, and accessibility to many systems and places. As a mixed-white queer, I am afforded access to communal spaces on campus more readily than others.

Becoming a therapist was not something I originally thought would be a part of my life. Over the years, the privileges and means of marginalization became more apparent to me. My first therapeutic experience made me feel as if I could not divulge my full self and left parts of me unseen, which would continue for over a decade. Through time I continued to see the lack of like-counselors for many people and pushed me towards a therapy program.

Communities have been supporting, helping, and healing one another throughout time. Personal and historical movement within our communities of care have propelled many people into the field of mental health psychology and counseling. It has been within the last couple centuries that communities have medicalized emotional healing into complex systems (Foucault, 1978; Foucault, 1994). Thus, the field of mental health is subject to the same oppressive powers that exist in our communities and cultures (Goodman & Morris, 2022). Here, racism and transphobia have interlocking systems of oppression that continue within the field (Ghabrial & Anderson, 2020; Kaiser, 2017; Talwar, 2010). The mental health profession asks for the requirement of higher education to engage in this work, which may already create a barrier for who may practice mental health counseling.

Higher education is an opportunity for individuals and communities to gain skills, acquire more knowledge, and thrive in their chosen careers. Mental health programming provides education and mentoring on the application of theories and interpersonal communication. The counselors and therapists who teach within these programs, as well as their students, adhere to beneficence and nonmaleficence (APA, 2017), benefiting their clients and communities and causing no harm. These foundational principles seem lost on its educators and practitioners, as the system itself reifies systemic oppression and harm throughout its programming and use.

Mental health fields buttress racism and transphobia through systemic, interpersonal, and educational means of power (Kaiser, 2017; Museus et al., 2015; Siegel, 2018).

It is within positions of power, as professionals, administrators, faculty, and students, that people engage in hypocritical behavior. The idea that one within the mental health field will always do what is best for a client and cause no harm to anyone within its process is a falsehood that the mental health field stands on. Professionals can never ensure total safety, and it is unfair to the people that seek support to believe that they can. If the goal is to reduce harm amongst relationships, both with clients and colleagues, people within the field must move toward a more empathetic and understanding world of mental health support.

The structural racism within United States healthcare is “central to these barriers facing racial and ethnic minorities,” (Moore et al., 2021, p. 2). The recreation of oppressive harm alongside these barriers creates a staggering wall for entry into mental health counseling. Higher education reifies structural racism through its retention issues with Black, Indigenous, People of Color (BIPOC) students, faculty, and schools, lack of role models/faculty/mentorship of same-race staff, negative interpersonal relationships on campus, gaps within literature, erasure, and stereotyping information (Johnson et al., 2021; Proctor et al., 2018; Proctor & Owens, 2018; Singh, 2020). The nuances of racism vary through cultural and geographical differences, and the labeling of BIPOC can diminish the very different forms of oppression and prejudice these groups face. Here, anti-blackness and colorism is as an insidious means to further discriminate against and harm those who are Black and/or have dark complexions. In my own experience within a clinical mental health program, the nuances of racism and intersection of oppressive forces are rarely breeched, if mentioned at all.

We must note that BIPOC is not an agreed upon term by people that are included within this acronym. This term, to some, minimizes the vast differences between these communities, the global presence of anti-blackness, and varying experiences of prejudice and power within these groups. Terms such as global majority (Lim, 2020, n.p.) are also used to cover the wide variety of non-white racial groups, and there are arguments for why this grouping does not cover nuances of race as well. Knowing these nuances and discussions, BIPOC is used within this paper to simplify terminology while acknowledging the issues with the term. Queer, trans, Black, Indigenous, and people of color (QTBIPOC) is another term that will be used to name the intersection of the trans* and BIPOC communities.

Psychology and counseling professions asks members to create safe relationships amongst their clients. Higher education is to prepare professionals for the intricacies of these relationships, yet many facets of one's identity or lived experience do not end up in literature and practices. These gaps in knowledge that lead to harm remind people within the mental health field that its members must be critical towards research, as well as reflective in their capabilities and power within the profession. Singh (2020) reminded our field that, "without critical theories such as Critical Race Theory, we are left with a history that has largely been defined by White men- and then later White women," (p. 1114). A hegemonic group and approach such as this lacks the ability to understand, explore, and appreciate the intersection of multiple marginalized identities.

Dual alienation, or "the idea that individuals who belong to more than one marginalized group are doubly marginalized," (Veltman & Rose, 2019, para. 3) leads mental health professionals to consider another harmed population within therapy: the trans* community of color. These issues are often separated within literature, and though that separation has its place

amongst lived experiences, the lack of attention to its overlap is disconcerting. Talwar (2010) noted,

Art therapy scholarship has explored issues of difference from the perspective of race, ethnicity, gender and sexuality, but it has done so mainly by viewing each as an isolated dimension of culture rather than an intersecting principles that shape experiences. (p. 11)

The interlocking systems of oppression need to be acknowledged within the field, so professionals can better work with its members.

Trans with an asterisk* is an umbrella term within the transgender community to include more expansive lived experiences, labels, and people of gender variance. Trans* includes nonbinary, agender, genderqueer, two-spirit, gender non-conforming, etc. Though this term may not be used within all literature, it is a means to encompass the personal, cultural, and expressive differences amongst the trans community. Queer is another term that is used to include members within the trans* community, though it also includes other identities of sexual orientation. Within this paper, queer is an umbrella term used for people within the 2sLGBTQIA+ community. This range includes, but is not limited to, lesbian, gay, pansexual, agender, gender variant, two-spirit, and transgender people.

Members within the trans*/queer community are at higher mental health risks and more readily seek out therapy, yet mental health professionals are inadequately trained on affirming or advocating for this demographic (Bettergarcia et al., 2021, p. 365). Access to mental health care, in the United States, can already be a challenge. The queer community must navigate therapist's personal transphobia or microaggressions and gaps in knowledge or relatability, all while dealing with the medicalization of trans* identity (Siegel, 2018, p. 3). An intersectional frame which

names and explores the multiplicities of oppressive systems are integral for the growth in the field of mental health.

Mental health programs and higher education recreate forms of power and oppression through outing, misgendering, deadnaming (both in-person and digitally), lack of a supportive community, exclusions of gender inclusive facilities, supportive policies and procedures, medicalization, and generalizing the trans* experience (Flint et al., 2021; Nicolazzo 2021; Siegel, 2018). Outing, misgendering, and deadnaming can be both macro and microaggressions, as outing someone may put these individuals in danger alongside the psychological and personal effects of not being seen or respected as oneself. The overall lack of attention to trans* needs leave its members to be vulnerable, misunderstood, tokenized, and/or mistreated. The care that this profession asks of itself is failing this demographic's needs.

Some scholars and professionals may cite growth and forward movement in understanding these forms of discrimination and subjugation. However, there is still much work to be done to create a safer space for people of color, trans* people, and trans* people of color. The mental health field still lives within the greater systems of racism and transphobia, which have their own myriad of literature, actions, and systemic barriers that enforce cishetpatriarchal ideology and centers settler-colonial culture/norms. "From the performance of white time structures, white policies and procedures, in the worship of the written word that pushes out BIPOC people from the profession, the valuing of quantity over quality, the perfectionism, the power-hoarding, the right to white comfort," (Singh, 2020, p. 1118), are but some of the means in which dominate culture influences the mental health field.

This paper creates an intersectional lens using qualitative, quantitative, and arts-based research on BIPOC, QTBIPOC, and trans* communities. Arts-based research adds another

dimension and perspective to personal experience, exploration, and mental health counseling practices. The literature will delve into cultural influences in and outside of education which further discriminate and erase concerns and experiences within these marginalized groups. There is a clear need for de-centralizing Whiteness and centering lived experiences of BIPOC and trans* members (Meyers, 2020, n.p.). When working within mental health, and mental health education, professionals are dismissing and discrediting people when they do not tend to the many cultural differences, means of being, and sense of belonging in the world.

Rather than focus on the intersectional identities of race and gender variance as separate entities, this paper will better illuminate, critique, and dismantle the interconnected systems of oppression. From The Diagnostic and Statistical Manual of Mental Disorders (DSM), which once categorized transgenderism as a mental health disorder (American Psychiatric Association, 2017), to stereotyping people of color in educational textbooks, to constantly citing White, Western ideology as the basis of mental health and psychology, professionals within the field must advocate for those who are marginalized and for intersectional approaches.

When there is a disregard to intersectionality within education and practice, the practice is both hypocritical and complacent. It continues the disservice to the people seeking care and harms students within its educational system. The overt and covert forms of racism and transphobia are hardening barriers to expand this field into a holistic, inclusive one. A couple courses or conversations on different identities is not enough to be culturally competent. Consequently, it is a harm to our clients and the marginalized communities that the system of counseling does not tend to the gaps within its practice and literature. Trolander (1997, n.p.) spoke to the self-advocacy 'minority' groups engage in to further the field's understanding of said groups. Thirty years later, mental health professionals still struggle with inclusive practices

and theory within their field, as the attention to these groups are rarely centered within education. Singh (2020, n.p.) and Nicolazzo (2021, n.p.) name the continued oppressive tendencies within education and practice around the BIPOC and trans* communities.

Contextualizing Campus and Harmful Practice

The research on racism and transphobia within higher education spans many aspects of student life and types of programs within the mental health field. The case studies and experiential based research creates individualistic knowledge reflecting real-life situations. Lived experiences are shaped by the specific spatial-temporal world and its culture(s) in which the individual is in. The contextual history and relationships are equally important in understanding the personal, social, and institutional influences on a person or client.

Racism and transphobia are global issues creating violence and harm towards BIPOC, QTBIPOC, and trans* people. The mental health field, which asks for further education, recreates these forms of harm through its inaccessibility, distrust, disconnection, and negative views and experiences. The past few years in the United States have proven these interlocking systems of oppression to be a point of contention and violence. Banning Critical Race Theory (CRT) in schools and banning healthcare for trans* youth, creates an ideological, systemic, and relational space of harm. When professionals do not give attention and effort against the social oppression of these marginalized groups, it gives the impression that the needs of these peoples are not a priority or do not matter.

The disconnection from these oppressed groups created through structural and interpersonal levels makes approaching the mental health system difficult. These barriers are seen in these oppressed communities through systemic discrimination, inaccessibility to services, inability to find like-providers, cultural prejudice, harm from mental health professionals (Moore

et al., 2021, p. 10). As the field is majority cis and white, an examination of power dynamics created through the professionalization of healing and care is necessary and without it, cycles of harm will continue.

Healing and support have been part of peoples' communities throughout human history, yet so many practices disregard Indigenous and cultural forms of care (Singh, 2020, p. 1115). Psychology was founded on "traditional" theory utilizing patriarchal, Western ideology. The average household may immediately go to Freud and oedipal complexes when thinking of therapy and counseling. Overall, many White men are centered in therapeutic thought (Hamrick & Byma, 2017; Singh, 2020; Talwar, 2017). The systematized form of interpersonal support and healing within mental health is grounded in said psychology as well as empirical and evidence-base practices (Hamrick & Byma, 2017; APA, 2005).

Psychological associations create guidelines, processes, and procedures that people within the profession abide by. These systems hold much power and influence towards research, educational practices, and accessibility to resources. Art therapists look towards the American Art Therapy Association (AATA) and its structural and institutional power. The system puts Whiteness to an advantage, its research often leaves gaps in research among 'minority' clients, and art therapist members of color name their erasure and marginalization within the AATA (Talwar, 2010, n.p.). People in positions of power within the AATA overtly covertly influence its community and means of practice. Talwar (2017) noted that multiple therapeutic scholars, "offer an overview of the theory of whiteness and how whiteness has dominated art therapy education curricula, negatively affecting and limiting productive dialogue about race and structural oppression in the field," (p. 103).

More recently, as stated by Kaiser (2017), the AATA received much feedback and frustration with its choice to work with and relate to Karen Pence's art therapy work. Therapists cannot, and should not be expected to, separate their views and alignment with government administration that, "stands for and attempts to maintain denial of health care for many groups, denial of reproductive rights for women, denial of rights for LGBTQIA individuals, and is anti-immigration," (p. 154). As therapists who are asked to be committed to social justice, this alignment goes against ethical, therapeutic values and creates further violence towards oppressed groups.

Macro and micro issues such as these make the AATA an unsafe space for BIPOC, QTBIPOC, and people within the trans* community. The AATA, and other psychology-based associations, provide workshops and educational spaces as we are required to take courses to keep licensure. A system based in white, Western ideology reifies said notions and practices through its educational and communal requirements. Whiteness becomes invasive, creating overt and covert ways of controlling access and practice to the field (Helms, 2017, n.p.).

Value systems and approaches become skewed with the erasure of these oppressed groups and the centering of individualism, focus on personal improvement, and need for independence. To disregard the harmful systems that non-dominant groups experience as major effects on their mental health is wildly nonsensical. Professionals are asked to advocate for their clients, and this must include inclusive ideology, education, and practices.

The field of mental health has moved through modern thought to expand its educational resources and practices to include multicultural, feminist, intersectional, and post-modernist theory, racist and transphobic ideology, and practices exist on multiple, influential levels. To combat conventional theory, anti-colonial, queer, liberation, CRT, decolonization, becoming, and

the aforementioned theory, research, and practices create space for marginalized groups and their needs (Flint et. al., 2021; Lepere, 2019; Singh, 2020; Zappa, 2017). Though this space and academic thought exists, it is in much less of a capacity in comparison to more traditional, Western methods and education.

Examining the multifaceted levels of White, Western focus in mental health, the microclimates, such as campus life and education, are exclusive and harmful for BIPOC, QTBIPOC, and the trans* community. There are multiple aspects that affect the comfortability of campus life. Policies, personal stress, access to same-race faculty and staff, harassment, and microaggressions make higher educational communities stressful and unsafe (Proctor et al., 2018; Siegel, 2018; Singh, 2020;). Feeling a sense of community and safety are integral for success within academia. Being understood, seen, and having accessibility to positive supports and supportive systems are large parts of this safety and building community.

The literature tends to the long histories of inequity, Whiteness, and exclusions, which directly effects the ability for BIPOC, QTBIPOC, and trans* people to find space on campus. Proctor et al.'s (2018) qualitative study covers the struggle of retention and persistence of Black students in psychology programs, as they often are unable to be supported in a positive way on campus. These supports include, but are not limited to,

Faculty clearly communicating expectations, being accessible during office hours to support students, responding quickly to emails to clarify student concerns and questions, lending personal testing materials to help meet their course requirements, and helping students find answers to questions that faculty themselves may have been unsure of. (p.

516)

Professional demeanor is important for many of these desires to be met. When faculty show their biases, prejudice, or aggression towards their oppressed students, these supports become inaccessible or actively harmful. Murphy-Shigematsu (2010) named the hurtful actions of educators and colleagues who both stereotyped and denied students and therapists of color of their lived experiences, making it more difficult to navigate the field (n.p.).

Mental health educators and professionals cannot expect students to bear this burden or be the pioneers in its change. In a quantitative study referring to sexual minority group or color, Ghabrial and Anderson (2021) reminded us, “increased poor mental and physical health due to experiences of acute and chronic stress caused by discrimination,” (p. 38). Discrimination has no place within higher education. The lack of attention, on an individual and systemic level, to the affects of discrimination and oppression is unethical in a field of care and acceptance.

Oftentimes, diversity, equity, and inclusion positions, groups, and structures on campus are performative. Siegel, (2018) reported,” at the university level, name-change and nondiscrimination policies present different possibilities and risks of disclosure; even if someone does not use a policy, its presence can serve a symbolic purpose,” (p. 4). Students are led to believe that these spaces are safe, only to find out later that they would experience prejudice and discrimination. Some members are ‘lucky’ to be aware of what they are getting into as Singh (2020) “had to tell them [trans & non-binary BIPOC] the same thing I had to tell White trans[*] and non-binary students previously. Our programs are not safe. Our training is not sufficient. You will experience harm,” (p. 1119). Oftentimes the means in which BIPOC, QTBIPOC trans* people experience harm are lost upon cis, White and non-black peers, admin, and educators. Members within the trans* community “rarely receive the support that they need, reporting high levels of harassment, as well as more negative perceptions of overall campus climate (...) trans*

educators are less comfortable with their campus, classroom, and department climates than cis educators,” (Siegel, 2018, p. 3). The emergence of trans* inclusive workshops, often done by the one trans* person within faculty and adding pronouns to one’s email does little to actively support its community members. These practices are a band aid on the wound of academic transphobia.

Within art therapy, this can be seen through the common practice of the genogram. Zappa (2017) illuminated this topic explaining, “trans[*] and gender-independent people are forced to ‘out’ themselves as nonnormative and explain their identity to the dominant groups, they are being forced to deal with the biases of those who participate in their everyday oppression,” (p. 133). Educational practices like this normalize oppressive tactics and interactions by not approaching these topics with care. Educators themselves are often unaware, both causing the harm and asking the other to name and correct said harm.

Education cannot expect BIPOC, QTBIPOC, and trans* community members to just deal with added stress of the campus and its curricula in an environment that already asks for so much time, effort, and money. Nonetheless, this is the unspoken expectation. The normalization of medical oppression towards BIPOC, QTBIPOC, and trans* members is within educational literature. The dominant U.S. culture creates dominant narratives by centering itself and its values. At colleges within the U.S., “student activists in medicine and public health have begun to engage their educational institutions in examining both the problem of racial essentialism in teaching and the pervasive health inequities that continue to plague U.S. healthcare,” (Braun & Saunders, 2017, as cited in Kaiser, 2017). Not only does it have such bias and inequity, psychology and counseling education co-opts thought and rituals from these oppressed groups

while reiterating misinformation, medicalizing, and erasing them and their history (Johnson et al., 2021; Napoli, 2019; Siegel, 2018).

Hoshino and Browsey Junge (2006) gave space for art therapists of color issues and inequities within the field. They were succinct and named the “medical profession, as unaware of cultural perspective and tendency to pathologize without recognizing culture,” (p. 140). Cultures that are not White and Western are thrown under the umbrella of ‘multiculturalism.’ How can a multitude of cultures be paired off from and boiled down to such a term? How does a majority white field teach multiculturalism? BIPOC, QTBIPOC, and trans* educators and professionals are often forced educators. Talwar (2017) named Gipson’s experience which,

question[ed] the ethics of a romanticized notion of multiculturalism influence[ed] by neoliberalism in art therapy. Taking a self-reflexive stance as a black woman teaching in a predominantly white institution, she explore[d] the emotional fatigue of ‘naming difference’ and dealing with conversations about ‘white privilege.’ (p. 103)

The educational burden should not weigh on the oppressed. This lack of education sets up future clients to also become forced educators. People within the trans community often educate professionals on affirming, transgender based care (Siegel, 2017, p. 3). As dominant cultures reign, there is not only a lack of appreciation for the vastness and differences of racial, ethnic, and gender variant groups, and they also expect “the other” to do much emotional and educational labor for them.

When White counselors and educators stay uneducated, unaware, and within the Western paradigm, they lack the capacity to see the gaps within mental health practices. Singh’s (2020) qualitative research pointed out the fear and disillusioned white counselor, “there is a literal retreat in racial identity development where white folx *resist* the work with everything in them”

and the lack of critical self-awareness, “[white counselors] don’t apply this racial identity development to what happens within counseling psychology (Helms, 1993) when our, for instance, BIPOC students are calling white faculty, supervisors, and trainers on their internalized and/or anti-BIPOC racism.” (p.117). Here, education not only asks less of its students, but also denies the assumed stereotypes within its literature and BIPOC lived experience.

The literature shows the various means in which BIPOC, QTBIPOC, and people of the trans* community experience harm within mental health. This harm will further extend to the community, which has to receive services from underequipped and biased therapists and/or be unable to find a same-race counselor/one with similar lived experiences. With a biased foundation, mental health professionals may find it more difficult to create strong, safe therapeutic relationships with our clients.

Higher Education Literature and Research

Whiteness is abundant and greatly influential in mental health literature (Mayor, 2012, n.p.). As a majority White field, it should be obvious that the White, Western perspective is centered in its research and theories, making it difficult for ‘others’ to enter this space. Helms (2017), named the separation created from “White heterosexual males of privileged classes (WHMP) [who] formulates and maintains the rules for determining who has access to the booty of Whiteness and at what level (...) Whiteness rules simply because one exists in environments where Whiteness dominates,” (p.718). People in counseling must acknowledge psychology, academia, and its research as fields dominated by Whiteness.

Traditional literature and research on race and gender-variance issues and practices are lacking, relaying misinformation, and use harmful terminology (Johnson et al., 2021; Singh, 2020; Zappa, 2017). Western science often disregards or belittle ‘other’ cultural thought and

practice. This denigration is seen in Western science's approach to the Indigenous community.

Napoli (2019) relayed the dominant culture approach to

Indigenous beliefs, stories, and practices as metaphor or myth (...) to situation any Native belief, practice, or personal experience as metaphor risks changing the true nature of the experience, as well as subjugating, distancing, and detaching the original meaning, relationship, and world view, yet doing so is a common practice in both psychology and expressive therapies. (Bishop, 2008 as cited in Napoli, 2019, p. 177)

By separating cultural meaning from its source, one strips these practices and beliefs of their validity and purpose. Much like the possessive nature of abuse, dominant culture separates one from their resources and connections to alter their sense of reality and capabilities.

When psychology, counseling, and arts-based research separates the individuals from their lived truths, clinicians are unable to learn how to adequately approach their potential clients. Research is supposed to give professionals insightful knowledge of groups, approaches, histories, and ideology, yet so much research is lacking. It is lacking in amount as well as non-biased and non-violent content. Harmful aspects of this research include but is not limited to; ignoring the T within LGBT research, pathologizing identity, use of slurs, generalizing culture and its peoples, heteronormative assumptions towards queer experiences, lack of understanding between sex and gender, and name calling (Beauregard et al., 2017; Bettergarcia et al., 2021; Zappa, 2017).

This predominantly White field sets the stage for the experiences of these oppressed groups, as they are involved in this research. In a phenomenological study, Johnson et. al., (2021), relayed art therapist student of color experiences of, "their cultures were not represented adequately, declaring the material was outdated, played into stereotypes, or omitted essential

cultural tenets,” (p. 52). This misinformation taught within programs is rarely addressed nor replaced with more adequate research.

When mental health professionals do not tend to the role of oppression in our research, they do not tend to major influences and struggles amongst their clients. Talwar (2010) reminded professionals of the subjectivity within the field and its effects, “

art therapists need to examine the role of oppression, the impact of popular culture and visual media in controlling how minority populations have been viewed. This means that we must question theoretical frameworks as well as therapeutic practices that control and fix racial and sexual identities in ways that are negative, degrading, and demoralizing. (p. 13)

Disregarding these influences and racial histories denies or diminishes the harm of White supremacy. This profession cannot forget the historical violence of slavery, internment camps, and displacement, as this violence extends generations later and lives within this current culture.

Research must empower therapists and their clients to better assess, reflect, and move forward. Unfortunately, much research is stuck in the past, often recreating harmful practices and tendencies. For example, Zappa (2017) named the consistency in, “literature and some people within the mental health community use terms such as transexual, transgenderist & hermaphrodite, which can be considered offensive,” (p. 132). Offensive terminology has no place in therapy, yet many clinicians are not up to date on queer and cultural language. It is commonplace that our scientific research separates its subjects into male and female. Oftentimes it relays male-tendencies, female-symptoms or other forms of separation by the sexes. Usually, this separation is to refer to the gendered roles and differences of one’s life, yet our research

often conflates sex and gender (Johnson, 2012 as cited in Zappa, 2017). Through this correlation, academia and its practitioners reify the gender-binary within its institution and literature.

Denying one's validity, existence, and preferences is the furthest one could be from empowerment. Terminology is not the only way in which psychology has harmed as, "discrimination can be seen in the fact that non heterosexuals [and trans* people] have historically been diagnosed as mentally ill and in need of 'fixing,'" (Hadley, 2013, p. 378). The idea of trans* people needing to be "fixed" is still used by non-affirming friends, family, and colleagues of trans* people. Garb (2021) reminded the field of biases, "Black patients are over diagnosed with schizophrenia and underdiagnosed with affective disorders," (p.6). Assumptions of Black expressions and denial of oppression as a form of trauma, inhibits appropriate care. The safer spaces of therapy cannot be a part of this problem.

The medicalization of the trans* community has created barriers for their affirmative care. In an ethnographic study that reviewed qualitative and quantitative data Siegel (2018) explained,

The medicalization of trans identities has several consequences. Most notably, psychiatric diagnoses regulate access to gender affirmation/transition-related care, such that someone needs to receive a diagnosis of gender dysphoria, for example, to qualify for top surgery (...) because the medical model of trans identity necessitates body dysphoria, individual and communities might also internalize this characteristic as the basic of social identity. (p. 3)

Amongst cisgendered educators and clinicians, this process may seem important to 'ensure a trans* person is making the right decision for themselves.' Professionals cannot forget the harm they have caused through their judgmental, violent literature. The mental health system must

acknowledge its ability to take away autonomy from this community. Zappa (2017) reminded professionals of the historical language and research of trans* people within art therapy; starting with transsexualism, gender identity disorder, and therapists' discomfort working with trans* clients (p. 130).

Even the idea of multiculturalism has its issues. Yes, it is important to have a broad view of peoples, cultures, rituals, and influences of one's contextual world. Nonetheless, the idea of multiculturalism centers Whiteness and Western experiences and livelihoods (Moodley, 2007 as cited in Talwar, 2010). In course curricula and research, multiculturalism covers "the other." Talwar (2010) proposed, "Art therapy educators, researchers, and therapists must move beyond the notions of marginalized and fixed ethnic and racial "Black/White" paradigms of practice and include White people as an essential part of multiculturalism," (p. 13). Placing all other groups, outside of White people, into their own category is blatantly harmful, yet seemingly normalized within higher education, its research, and literature.

Multiculturalism is used in a way where it is both broad in scope and homogenizing in content. It can often feel like a checked box when covering curricula content. It's been thirty-one years since Pederson (1991) cited Ponterotto (1988) in the criticisms of multicultural research, they named

First, there is no conceptual theoretical framework. Second, there is an overemphasis on simplistic counselor-client process variables while disregarding important psychosocial variables. Third, there is overreliance on experimental analogue research outside the 'real world' setting. Fourth, there is a disregard for intracultural within-group differences. Fifth, there is overdependence on student samples of convenience. Sixth, there is continued reliance on culturally encapsulated measures. Seventh, there is a failure to

adequately describe the sample according to cultural backgrounds. Eighth, there is a failure to describe the limits of *generalizability*. Ninth, there is a lack of minority cultural input. Tenth, there is a failure of responsibility by researchers toward minority subject pools. (p. 11)

The fact that these ten criticisms still ring true is both embarrassing and shows the lack of change within the profession.

It is not just the ways in which the mental health field writes and refers to others that is harmful in its literature, but the denial of other voices and perspectives. Erasure comes from the lack of representation to these groups, the denial of their personal perspectives, and the omission of harm from White, Western members within the field. Helms (2017) noted, “White people find themselves in the quandary of teaching, researching, and practicing in domains about which they know little (e.g. how racial oppression feels), while virtually ignoring domains in which they are experts (e.g. their feelings about benefitting from racial oppression and their roles in maintaining it),” (p. 723). White scholars often ignore the intersectional systems of oppression created and reinforced within its literature and practices.

Research that tends to the intersection of race and gender variance is not nearly as abundant as White, heterosexual research and practices. Moore et al. (2021) named the need to integrate qualitative and quantitative data for identity development with minority youth (p. 3). The entire phenomenological study by Hoshino and Borowsky Junge (2006) was to give space to the voices of art therapists of color, as there is an obvious gap within our literature. Branco and Jones’ (2021) grounded theory research filled a need of practices for dealing with microaggressions, as this has rarely been talked about let alone taught within programs.

Race and Gender variance in Art Therapy

With art therapy being based in psychology, it not only has these aforementioned issues and barriers, but also adds layers of appropriation and erasure. Art therapists of color, from Johnson et al.'s (2021) multiple case study, named art therapy education was lacking in its emphasis of art therapists of color as well as having little information on the therapists of color that within its history (p. 51). Not only are these gaps an issue, but there are problems with what the current literature says about these oppressed groups. Karcher and Caldwell (2017) stated, "the limited representations of queer and disabled bodies through performance, literature, and drama as metaphors and with aspects of voyeurism that reinforce the notion that these bodies are abnormal and should be rejected and repressed, exploited, excluded and violently obliterated," (p. 479). The way researchers and professionals portray the 'other' heavily influences perception and interaction with said peoples. As dominant narratives stray, art therapy tends to do the same. Talwar (2010) relayed,

Art therapists have emphasized clients' visual expressions rather than the role of the greater visual culture in shaping clients' perspectives and creating internalized oppression (...). How has art therapy reinforced ideas of normalcy by privileging images of heterosexually, for example, or promoting images as a homogenizing force of identity?

What are the racial, gender, and class norms that art therapy has privileged? (p. 13)

When researchers, educators, and counseling professionals center White thought and practice within art therapy, they actively center dominant forms of visual expression and practices. When professionals are focused on White norms of being, it is possible for them to center identity as part of a client's issue or subject to be focused on within the therapeutic space. The placement of a client's identity as inherently "other" is both demeaning and can negatively affect treatment.

Adequate research allows mental health professionals to work effectively with communities, yet BIPOC, QTBIPOC, and trans* people do not have said research. Zappa's (2017) historical review of trans* research tended to, "the limited scope of literature on trans and gender-independent people in art therapies raises questions about the ability of art therapists to work effectively with this group and do so in an ethical manner," (p. 132). It is not just here where interpersonal understandings and relationships of the trans* community fall short. Art therapists of color were often, "misunderstood, underestimated, and unseen or overlooked by White professionals and classmates," (Johnson et al., 2021, p. 50). When BIPOC, QTBIPOC, and trans* people are barely researched, supported, and treated with respect, is it really surprising that this field is so cis and white? For a field that prides itself on safety, higher education is quite unsafe for these individuals.

Art therapy is also known to be appropriative. The use of the mandala has been stripped from its culture and simplified for the sake of mindfulness. At an art therapy conference, Lepere (2019) relayed discussion on said appropriation, "the engagement on the mandala and the cultural appropriation allowed the plenary to think about how the story of Indigenous knowledge in modern education has remained dominant in untrue assumptions and references," (p.297). It is not just the appropriation, but art therapy's relation to nondominant groups. Napoli (2019) spoke to the disrespect,

Mainstream consumption of Indigenous spirituality and healing practices have not been grounded in a respectful relationship with Native leaders. Instead, the many rich and varied Native spiritual and healing traditions have been flattened under the concept of shaman and treated as frozen in the past, universal archetype, and/or metaphor. (p. 178)

Through the appropriation of knowledge and disregard of respectful relationships to Indigenous culture, researchers, educators, and counselors alike engage in practices of erasure and colonial amnesia (Napoli, 2019; Lepere, 2019).

White and cis professionals must tend to their relationships outside dominant culture and the nuances of our practice to better approach artistic and spiritual rituals of other cultures. It must be noted that non-black and non-indigenous professionals must also tend to other cultural nuances and values. For professional growth “as creative arts therapists we need to encourage *response-ability* in our practice- that is the *ability to respond* amidst suffering and against oppression,” (Hadley, 2013, p. 377).

Current Educational Methods

In spite of lack luster literature, there are some theories and practices that can better support BIPOC, QTBIPOC, and trans* peoples. Post-modern theory allows for subjectivity and contextual understanding, as there is movement away from the idea of objective truth. There is research that covers a more inclusive therapy practice, said articles utilizes feminist, intersectional, anti-colonial, liberation, and queer ideology and frameworks to better understand and approach it’s prospective clients.

The fixed truth disallows the varying perspectives and lived experiences of those outside of dominant narratives. Nicolazzo (2021) named their frustration with traditional ideology in practice and education,

That the notion of fixity is a problem of how theories are used rather than how they were conceptualized and developed, I assert that the theories themselves, as well as the environment in which these theories are created/used, remain heavily steeped in modernist, positivist, and conservatist assumptions of truth, knowledge, reality, and

organization. In this sense, far from placing any “blame” for a lack of fluidity on either educators or theorists, I believe both parties share responsibility in de/re/constructing theories and epistemologies that recognizes identities as fluid and malleable. (p. 512)

Intersectional, feminist theories take social structures, such as race and gender, and its context to better understand one’s perspective and/or lived experiences. This post-modern ideology has led to more critical theories that are better able to dissect systems and epistemologies of specific populations. Nicolazzo (2021) spoke to theories like TribalCrit and Critical Trans Politics which are, “elucidating how White supremacy, colonization, racism, and sexism operate to erase-figuratively and literally- people and experiences from our shared past/present/future,” (p. 513). Post-modern critical theories allow specific groups to critique dominant narratives and their harmful tactics and assumptions related to said groups.

The trans* community uses different queer, liberation, and other post-modern theory to expand upon and correct dominant narratives and their assumptions and means of erasure. Beyond meeting curriculum needs, graduate program course content is often up to the individual, as such, personal research is often required to further one’s understanding and application of these critical forms of thought. This often leaves more ‘niche’ theories and practices to be left to the wayside. For example, Flint et al. (2021) explained that becoming is a theoretical concept that moves therapeutic practice and means of understanding gender identity away from either/or and towards *and*. “With becoming, we orient to gender *ontologically* and *epistemologically* as more than the binary of woman/man (...) Moving beyond binaries, becoming is in-between, not as between two points, but an in-between of intensities that are always on the move,” (p. 3). Per my experience within graduate counseling program, this baseline understanding of viewing

trans* people is often lost nor readily explored within a class setting. Oftentimes, in-depth understanding of non-dominant groups are left to those within the group to share and educate.

Despite the limited education and theoretical foundation towards the trans* community, Karcher and Caldwell (2014) were able to use the process of becoming with their clients. Caldwell used Dance Movement Therapy (DMT) with a transgender client to explore somatic effects of oppression. Through their therapeutic work, their client was able to come out to friends and family, explore tension related to the transition process, and creatively show their transformative experience in a public setting/amongst peers. Therapist and client shared this experience and findings at multiple conferences, further empowering the client in their work and amongst community. Karcher and Caldwell (2014) summed it up perfectly, “When given the opportunity to influence the method of dissemination of research findings, members of marginalized communities can experience a sense of agency and healing that comes from the ability to learn from the data and to articulate their experience through their own worlds, movement, or images,” (p. 482).

In spite of the centering of cisgenderism and White Western ideology, there are theories and practices which better support BIPOC, QTBIPOC, and trans* peoples. Seeing the need to focus on sexual minority people of color, Ghabrial and Anderson (2021) researched and developed a Queer People of Color Affirmation Scale (QPIAS). Through qualitative research with 703 QTBIPOC people, “QPIAS predicted resilience and empowerment above and beyond existing single-axis measures of sexual and ethnoracial identity information,” (p. 49). The QPIAS as an assessment tool informs strength-based care (p. 49), which will better support this oppressed group’s growth and resilience.

As mental health professionals continue to take in other perspectives, voices, and approaches, they search to understand other roots of counseling and healing. For BIPOC, QTBIPOC, and trans* people, liberations and anti-colonial perspectives may better understand their histories and support their specific needs. Singh (2020) reminded White and non-black professionals of the importance of liberation psychology, “Our job in building a counseling psychology of liberation is to believe the lived experiences of Black counseling psychologists, and to follow their leadership without over-burdening Black people within and outside of our profession with education us about our internalized whiteness,” (p. 1116). Singh (2020) also named important race related power dynamics that are rarely spoken of in mental health education. The impact of oppressive trauma can be lost on those within privileged, dominant groups. “That means *we are all carrying* racial trauma into counseling psychology spaces- whether we are white (internalized white superiority) or BIPOC (internalized anti-Blackness) [we hold] 14 generations of racial trauma,” (p.1118). To not tend to this dynamic and embodied harm is irresponsible within counseling.

It is acknowledged that this paragraph has no place in this paper, as anecdotal and personal asides do not have space in academic writing. It is included to name the exclusionary barrier of lived experience within academia, as this specific content is more difficult to find within peer-reviewed articles. Nonetheless, the personal anecdote relates to points named by Murphy-Shigematsu (2010), “Supervisors’ abilities and inabilities to understand the identities of our supervisees greatly affect the content and quality of supervision,” (p. 18) Within my program, there has been the question of, what does one do when a client actively disrespects and/or harms you in an oppressive manner? What do I do, as a mixed, trans nonbinary person when my being is not acknowledged nor respected? What do BIPOC counselors do when

someone is actively racist and/or xenophobic towards them? Per some professionals one is to seek supervision. Even if the harm consistently continues, some have said is wrong for one to refer out. This becomes a “me problem.” This response can be seen as a *microinsult* or *microinvalidation*, as these messages from educators can make one feel unimportant and excluded (Sue et al., 2007, p. 274). Professionals need practices for both client and clinician to approach said trauma, differences, and microaggressions.

Only through research and contemporary literature has there been alternative options. Branco and Jones (2021) spoke to microaggressions within session, and how they inevitably impact client-counselor relationships (p. 281). They utilized work from prior therapists to develop microinterventions into microcounseling interventions (p. 284). This skill is something that should be taught within all programs. These interventions include, “(1) ‘Make the invisible visible,’ (2) ‘Disable the microaggression,’ and (3) ‘Educate the offender,’” (Sue et al., 2019, as cited in Branco & Jones, 2021). Each strategy must take the level of client-clinician relationship and possible impact with the client, while still allowing space for alleviating harm and unburden the clinician (Branco & Jones, 2021, p. 289). The skill of broaching, or “facilitating continuous open intercultural dialogue concerning similar and different social identities, the impact of the identities, and the sociopolitical and intersectional nature of social identities between client and the counselor,” (Branco & Jones, 2021, p. 293), is another useful skill that should be normalized within programming. If professionals are asked to be multicultural and involve themselves within social justice, this should be a common, more comfortable practice that all counselors are taught and engage in.

There is and has been an obvious need for multicultural growth, understanding, and identity education (Pederson, 1991; Trolander, 1997). In a time where there is much racial,

gendered, and sociopolitical strife, those within the mental health field must better attend to the nuances and intricacies of BIPOC, QTBIPOC, and trans* peoples. Expanding one's theoretical background, research, literature, and skills are necessary steps to create safer spaces for the peoples and positive mental health professionals to support them.

Discussion

Review of this topic shows that there is a real lack of understanding in psychology, education, and therapeutic practice about BIPOC, QTBIPOC, and trans* people. These groups are often spoken of as if they were homogenous or grouped in a way that diminishes their differences and existence. For example, the T is often barely recognized or lost within LGBTQIA+ literature, simplified cultural relationship dynamics, or being compared to White people and Western culture (Hoshino & Borowsky Junge, 2011; Pederson, 1991; Zappa, 2017).

Literature has shown that the White gaze inserts and perpetuates its biases onto "the other." Thus, this gaze is reiterated time and time again through program curricula. Personal remarks and assumptions, use of harmful terminology, and reinforcements of stereotypes make students within the mental health field have a skewed idea of who BIPOC, QTBIPOC, and trans* people are and how to effectively treat them. Oftentimes, there aren't many, or any, skills nor practices for these groups, or for the therapists that are apart of them (Bettergarcia et al., 2021; Branco & Jones, 2021). Inaccurate research reifies systemic oppression and is further reinforced through the high value of academic achievement.

Misguided information is not just harmful, it is actively violent. These groups already hold generational trauma, and this information which is lacking understanding and empathy furthers the trauma. The literature has shown pathologizing identity, generalized behavior, and racial discrimination act as forms of microabuses (Kaiser, 2017; Mayor, 2012; Singh, 2020,

Zappa, 2017). This misinformation seeps into the structure of our health system, as it creates disparities, harmful clinicians, inability to find like providers, and an overall stressful system for these groups (Beauregard et al., 2017; Bettergarcia et al., 2021; Talwar, 2017).

Structural racism and transphobia in mental health education is hypocritical at its best and deadly at its worst. Oppression on campus can create an exclusionary atmosphere, relational antagonism, normalize microaggressions, sense of erasure, harm around disclosure, and forced obligation to educate others because one's identity (Branco & Jones, 2021; Mayor, 2012; Siegel, 2018; Zappa, 2017). These interlocking systems of oppression make the educational space and profession difficult for BIPOC, QTBIPOC, and members of the trans* community to navigate and work within.

The inaccurate, harmful information, coupled with the ignorant, tense atmosphere can often lead to interpersonal harm within the educational sphere. The client-therapist relationship, as well as the therapist-supervisor and student-educator roles, can be riddled with hurtful microinvalidations and microaggressions, which is not only burdensome but often lead to a lack of trust (Branco & Jones, 2018; Murphy-Shigematsu, 2010; Siegel, 2018). This lack of trust can build overtime, not only with an individual, but within an institution and amongst organizations.

Research shows practices within mental health are often grounded in Western ideology, ignoring the importance of personal and cultural differences in its approaches to clients. Marginalized groups receive harm within all steps of the therapeutic process, from education that erases their existence, educators who perpetuate White ideals, literature that stereotypes them, peers who tokenize, and supervisors who assume and project dominant narratives onto their lives and within their treatment plans.

Per resources, the issues of racism and transphobia have been problematic within the field for decades. It is clear that there are gaps and misconceptions within literature and lack of lived experience amongst educators and practicing professionals. Some may say that it is at least better than it was. To this thought one should be ashamed, as individuals and the system denies the trauma of past and present, and disregards the groups of people who suffer from this structural and interpersonal oppression. The need for structural and personal change is long past due.

As this field is unfortunately behind in its educational and professional support for BIPOC, QTBIPOC, and trans* communities, it leaves these members to be particularly vulnerable. Even in the timespan of writing this paper the U.S. has seen racism within the Supreme Court nomination process and passing of transphobic legislature in multiple states (ACLU, 2022; Epstein, 2022). Professionals cannot ignore the impact that this, and similar forms of structural oppression, has on its communities. Unfortunately, the likelihood of practitioners to adequately empathize with and support these members is low.

How do professionals expect to create safer spaces and ethically work with clients without deep introspection of their power, privileges, and oppression? When there are little to no like-self counselors, members of these communities often have to explain their experiences in hopes of getting some semblance of understanding. Clients are asked to navigate inaccessible mental health systems and microaggressions within their sessions.

Literature related to race and trans* peoples has been able to add to research, create new practices, and critique our current system. Nonetheless, said research and skills cannot and will not cover all of the nuances of BIPOC, QTBIPOC, and trans* people. There is no monolith, and it will always be important to tend to the needs and context of the individual. Regardless,

expanding upon literature and its content is important. There must be as much research related to BIPOC, QTBIPOC, and trans* people as there is for other demographics.

The literature can and does outline steps to move towards expansive, inclusive care. It names ways in which White professionals can unlearn problematic stances and biases as well as learning new perspectives and ways to support others. Still, it is unable to lay out a universal process of what this looks like. Each individual must reflect on their context, intersectional identities, and relation and power within their world. There is no standard to what accountability looks like around this process.

For starters, higher education has the obligation to review and critique their current curricula and examine its complacency in racist and transphobic content and behavior. If this is done through the, often tokenized, members of their DEI committees they must be compensated thoroughly for their work, as this process can be triggering, violent, and laborious some for these individuals. It is possible to use outside sources that utilize CRT and lived experiences to critique institutional content and practices.

Curricula needs to include current literature with a breadth of lived experience. Education must have multiple historical perspectives, as it is unethical to ignore Indigenous histories and effects of settler colonialism. Programs need to include the influence of BIPOC, QTBIPOC, and trans* professionals, histories, practices, and healers. These changes include decentering Whiteness and Western theory, and center practices and theories of liberation, Indigenous histories, and influences of oppression on mental health.

The profession must accept that peer-reviewed articles are not the end-all of appropriate literature and understand the exclusions and barriers within academic research. Rather, educators can utilize content from people who have lived experiences of varying and intersectional

identities, which may include essays, oral histories, and or creative means of personal expression. It is necessary for educators of dominant groups to question their ability to teach certain courses and topics, handing over said positions to professionals of those communities.

Change goes beyond the systemic level. Professionals of dominant narratives must engage in the process of unpacking their Whiteness, biases, and harmful behavior. This can be done through affinity spaces, re-education, personal therapy, self-reflection, and accountability processes. Aspects of this process includes unlearning racist and problematic history, accepting individuals as experts of their own history and identity, disengaging with the White, Cis-heteropatriarchal gaze, and moving beyond multiculturalism towards and intersectional framework of racial and cultural relativism. It is important for dominant professionals to look into their privileges and be willing give up their positions to non-dominant individuals.

Professionals must be equipped to work with conflict resolution and showing up without defenses when working with clients of different identities. Knowing one's biases is a prerequisite for this work, and it is the professional's responsibility to reduce harm and move towards healing. This includes the current system and engaging in social justice and advocacy work. Healing can look like breaking generational cycles and trauma, engaging in the lifelong practice of anti-racist work, and making space for liberation. Within the field, the research, means of education, and relationship between professionals and clients will not be able to change without the personal and communal work. Members of the field should always be curious and questioning. As mental health care requires constant education, said education must be able to provide spaces for inclusive literature, safer and expansive practices, and support BIPOC, QTBIPOC, and trans* growth within the field.

References

- American Civil Liberties Union. (2022, April 8). *Legislation affecting LGBTQ rights across the country*. ACLU. <https://www.aclu.org/legislation-affecting-lgbtq-rights-across-country>
- American Psychological Association. (2005). *Policy statement on evidence-based practice in psychology* (updated April 2021). <https://www.apa.org/practice/guidelines/evidence-based-statement>
- American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). <https://www.apa.org/ethics/code/>
- American Psychiatric Association. (2017). *Gender Dysphoria Diagnosis*. American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>
- Beauregard, M., Stone, R., Trytan, N., Sajnani, N., (2017). Systemic barriers in mental health care for LGBTQI and gender nonconforming drama therapists and clients. *Drama Therapy Review* 3(2), 285-312. DOI: 10.1386/dtr.3.2.285_1
- Bettergarcia, J., Matsuno, E., Conover, K. J., (2021). Training mental health providers in queer-affirming-care; A systematic review. *Psychology of Sexual Orientation and Gender Diversity* 8(3), 365-377. DOI:101037/sgd0000514
- Epstein, K., (2022, March 24). *The discriminatory history of the Senate confirmation process that started when a Jewish person was first nominated for the Supreme Court in 1916*. Insider. <https://www.businessinsider.com/racist-history-of-senate-scotus-confirmation-hearings-ketanji-brown-jackson-2022-3>

- Flint, M. A., Kilgo, C. A., Emslie, K., & Bennett, L. A (2021). The nexus of trans collegians' pronouns and name practices navigating campus space(s): Beyond the binary. *Journal of Diversity in Higher education*. DOI:10.1036/dhe0000349
- Foucault, M. (1978). *The History of Sexuality: Volume 1: An Introduction*. Pantheon Books.
- Foucault, M. (2000). *Power*. (J. D. Faubion, Ed.). The New Press.
- Garb, H. N. (2021). Race bias and gender bias in the diagnosis of psychological disorders. *Clinican Psychology Review*, 9, 1-9. DOI: 10.1016/j.cpr.2021.102087
- Garces, L. M. (2012). Racial diversity, legitimacy, and citizenry: the impact of affirmative action bans on graduate school enrollment. *The Review of Higher Education*, 36(1), 93-132.
- Ghabrial, M. A., Anderson, J. P., (2021). Development and initial validation of the queer people of color identity affirmation scale. *Journal of Counseling Psychology*, 68(1), 38-53. DOI: 10.1037/cou0000443
- Goodman, J. D., & Morris, A. (2022, March 1). *Texas Investigates Parents Over Care for Transgender Youth, Suit Says*. The New York Times.
<https://www.nytimes.com/2022/03/01/us/texas-child-abuse-trans-youth.html>
- Hadley, S., (2013). Dominant narratives: Complicity and the need for vigilance in the expressive arts therapies. *The Arts in Psychotherapy*, 40, 373-381. DOI: 10.106/j.ai.2013.05.007
- Hamrick, C., & Byma, C. (2017). Know history, know self; Art therapists' responsibility to dismantle white supremacy. *Art Therapy*, 34(3), 106 -111. DOI: 10.1080/07421656.2017.1353332
- Helms, J. E., (2017). The challenge of making whiteness visible: Reactions to four whiteness articles. *The Counseling Psychologist*, 45(5), 717-726. DOI: 10.1177/0011000017718943

- Hoshino, J., Borowsky Junge, M., (2006). Themes and reflections on the stores of art therapists of color. *Art Therapy: Journal of the American Art Therapy Association*, 23(3), 139-143. DOI: 10.1080/07421656.2006.10129623
- Johnson, T., Deaver, S. P., Doby-Copeland, C., (2021). Art therapy students of color: the experience of seven graduate students. *Art Therapy*, 38(1). 50-56.
- Kaiser, D. H., (2017), What do structural racism and oppression have to do with scholarship, research, and practice in art therapy? *Art Therapy*, 34(4), 154-156. DOI: 10.1080/07421656.2017.1420124
- Karcher, O.P., & Caldwell, C., (2014). Turning data into dance: Performing and presenting research on oppression and the body. *The Arts in Psychotherapy* 41(5), 478-483. <http://www.sciencedirect.com.ezproxyles.flo.org/science/article/pii/S0197455614000963>
- Lim, D. (2020, May 10). *I'm Embracing the Term 'People of the Global Majority.'* Medium. <https://regenerative.medium.com/im-embracing-the-term-people-of-the-global-majority-abd1c1251241>
- Lepere, R., (2019). Conference Review: Critical pedagogies in arts therapies 2019: Curating dignity and other points of view. *Drama Therapy Review* 5(2), 293-299. DOI: 10.1386/dtr_00008_5
- Mayor, C., (2012). Playing with race: A theoretical framework and approach for creative arts therapists. *The Arts in Psychotherapy*, 39, 214-219. DOI: 10.106/j.aip.2011.12.008
- Meyeres, L. (2021, May 26). *Listening to voices of color in the LGBTQ+ community.* Counseling Today. <https://ct.counseling.org/2021/05/listening-to-voices-of-color-in-the-lgbtq-community/>

- Moore, K., Camacho, D., Spencer-Suarez, K., (2021). A mixed-methods study of social identities in mental care among LGBTQ young adults of color. *American Journal of Orthopsychiatry*. DOI: 10.1037/ort0000570
- Murphy-Shigematsu, S., (2010). Microaggression by Supervisors of Color. *Training and Education in Professional Psychology*, 4(1), 16-18. DOI: 10.1037/a0017472
- Museus, S. D., Ledesma, M. C., Parker, T. L. (2015). Racism and Racial Equity in Higher Education. *ASHE Higher Education Report*, 42(1), 49-71.
<http://doi.org/10.1002/aehe.20067>
- Napoli, M., (2019). Ethical contemporary art therapy: Honoring American Indian perspective. *Art Therapy* 36(4), 175-182. <https://doi-org.ezporxyles.flow.org/10.1080/07421656.2019.1648916>
- Nicolazzo, Z., (2021). Imagining a trans* epistemology: What liberation thinks like in postsecondary education. *Urban Education*, 56(3), 511-536.
DOI:10.1177/004208917697203
- Pederson, P. B., (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling & Development* 70, 6-12.
- Proctor, S. L., Nasir, A., Wilson, T., Li, K., Castrillon, P. (2018). Retention and persistence of African-American students in school psychology programs. *Psychology Schs* 55, 506-524.
- Proctor, S. L., Owens, C. (2018). School psychology graduate education retention research characteristics: Implications for diversity initiatives in the profession. *Psychology Schs* 56, 1037-1052. DOI:10.1002/pits.22228

Siegel, D. P. (2018). Transgender experiences and transphobia in higher education. *Sociology Compass*, 13(10). DOI:10.1111/soc.4.12734

Singh, A., (2020). Building a counseling psychology of liberation: The path behind us, under us, and before us. *The Counseling Psychologist*, 48(8), 1109-1130.

DOI:10.1177/0011000020959007

Sue, D. W., Capodilupo, M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., Equilin, M. (2007). Racial microaggression in everyday life: Implications for clinical practice. *American Psychologist*, 62(4), 271-286. DOI: 10.1037/0003-0066X.62.4.271

Talwar, S. (2010). An intersectional framework for race, class, gender, and sexuality in art therapy, *Art Therapy*, 27(1), 11-17. DOI:10.1080/07421656.2010.10129567

Talwar, S. (2017) Ethics, law and cultural competence in art therapy. *Art Therapy* 34(3), 102-105, DOI: 10.1080/07421656.2017.1358026

Veltman, A., Rose, L., (2019). LGBTQ mental health: What every clinician needs to know. *Psychiatric Times* 36(12), 21.

Zappa, A., (2017). Beyond erasure: The ethics of art therapy research with trans and gender-independent people. *Journal of the American Art Therapy Association*

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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. Thesis

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