

Serving Queer People Through Art Therapy: Opening a Dialogue for Inclusivity

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ABSTRACT

Serving Queer People Through Art Therapy: Opening a Dialogue for Inclusivity

Jordanna Vamos

Using a historical-documentary approach, this paper will investigate literature within the fields of art therapy and queer related studies in order to draw attention to the particular mental health needs of members of the queer community and the ways in which art therapy is particularly suited to address these needs. This review of literature has demonstrated the need for specialized mental health care that is able to accommodate and support clients who identify as queer. The internalization of homophobia/transphobia as well as engendered social roles has meant that those who do not identify or order themselves in these normative ways may experience struggles in developing a positive sense of self; these individuals may therefore benefit from forms of therapy geared towards not only support but validating and appreciating their differences. The objective of this paper is to highlight for art therapists the ways in which art therapy has the potential to fill this void for clients who identify as Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Questioning, and Two-Spirited (LGBTQQ2S), and to challenge art therapists to continue to look for ways to expand the field as well as their own practices to better include appropriate services for members of the queer community.

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SERVING QUEER PEOPLE THROUGH ART THERAPY: OPENING A DIALOGUE FOR INCLUSIVITY

Introduction

For the purposes of this publication, the term *queer* will be used as an umbrella-term to encompass the expansive spectrums of sex, sexuality and gender that are beyond the confines of heteronormativity. Though not mutually exclusive, under this queer umbrella the following ways of identifying will be included: lesbian, gay, bisexual, transgender, transsexual, queer, questioning, as well as two-spirited (LGBTQQ2S).

The queer community in Canada, at present, is in the earliest stages of developing adequate specialized healthcare. However, the current queer population is still at extreme risk. Queer individuals struggling to understand their identities within predominantly heteronormative and engendered cultural norms, often internalize homo/transphobia as a result of stereotypes and negative social attitudes (Addison, 2003). There is a slowly growing body of research and much speculation as to how a sense of sexual/gender identity confusion and/or internalized homo/transphobia negatively affects the lives of queer people. This is a historical-documentary research project within the field of art therapy, psychology, and queer theory. The intention is to reflect upon and question the ways in which the field of art therapy can better be applied to clients who are queer by incorporating queer theory and acknowledging queer issues. The importance of this research lies in the notion that psychodynamic art therapy has the potential to expand in order to better meet the needs of the queer community.

Research Rationale

A founding pillar of art therapy is that it provides alternatives to traditional forms of talk therapy. Therefore, art therapy naturally lends itself to those who do not fit into a traditional box. The queer community is in need of alternatives to mainstream forms of mental healthcare because of the specificity of the needs and challenges it is facing. As such, there is a great opportunity for the art therapy profession to identify applications and interventions that appropriately meet the needs of the under-served queer community.

Primary Research Question

How can widening the art therapy canon to include queer theory not only help to expand art therapy theory, but suggest more inclusive and specialized services to members of the queer community?

Subsidiary Research Question

- 1) What aspects of the traditional art therapy cannon are already successful in meeting the specific needs of a client who identifies as queer?
- 2) What aspect of the traditional art therapy cannon can be identified and developed in response to being less successful at meeting the needs of the client who identifies as queer?

Methodology

This paper will take a historical-documentary research perspective and will therefore not include participants, but rather, focus on literature about members of the LGBTTTQQ2S community as well as literature about art therapy.

This research project will be conducted using a historical-documentary methodology in order to address the historical and current sociocultural factors that have accumulated to inform both where the field of art therapy currently sits in its theoretical

orientation and in its clinical practice. It will also examine the historical and current sociocultural factors that have amassed in highlighting the particular challenges and unique experiences lived by members of the queer community. The orientation of this research will be grounded in queer theory, because to date, research in art therapy has had little exposure to this school of thought. The data accumulated will then be synthesized and explored in order to further expand the inclusivity of the art therapy modality so that it can better address queer issues and the needs of members of the queer community.

Data Collection

The data collection for this research project will focus heavily on a search for literature relevant to my research question and subsidiary questions. This will be largely made up of various forms of publications; books, articles, theses and dissertations from recent graduate work in relevant fields. I will be employing various academic search engines to help gather my data.

Data Analysis

The data analysis will comprise coding the various publications relevant to my research question. I will be extracting common threads, categories, and pertinent themes from these publications.

Operational Definitions

- Coming-out of the closet: Acknowledgment of thoughts and feelings (pertaining to one's sexuality), deciding when, and whom to tell, through decision based on desire to validate one's own lifestyle and to establish authentic interpersonal relationships while balancing potential cost of such disclosures (Omoto & Kurtzman, 2006).

Note: variations of this term include; coming-out, out, out-ed, and antonyms can be considered as “in the closet” as well as “closet-ed”, referring to individuals who have not disclosed their queer statuses.

- Gender: A dimension of human identity in which traits of masculinity and femininity are assigned to individuals on the basis of their biological sex (Pack-Brown & Williams, 2003).
- (*Alternately*) Presenting with masculine or feminine qualities, largely dependent on cultural associations ascribed societal roles and stereotypical mannerisms (Piccirillo, 1996).
- Gender identity: One’s inner, subjective sense of being male or female, a complex core self-perception (Piccirillo, 1996).
- Hanky code: A designation of a person’s sexual preferences, signaled by the colour of the handkerchief and the pocket in which it is worn (Dalzell & Victor, 2006).
- Heterocentric: The assumption and centrality of heterosexuality (Fraser & Waldman, 2003).
- Heteronormativity: The taken-for-granted assumption of heterosexuality as the normal and natural way of being (Kitzinger, 2005).
- Heterosexism: An ideological assumption that denies, denigrates, and stigmatizes any non-heterosexual form of behaviour, identity, relationship or community (Igartua, Gill, & Montoro, 2003).

- Homophobia: Fear of same-sex relationships or of queer individuals, including “homoprejudice” which refers to negative judgments and stereotyping of queer individuals (Fraser & Waldman, 2003).
- Internalized homophobia: Negative feelings that the queer person harbors about their queer status (Igartua et al., 2003).
- Sex: Being male or female as defined by biology, genetics and the anatomy, specifically the genitalia (Piccirillo, 1996).
- Sexual Orientation: Whether one is attracted to male or female partners, both, or neither (Piccirillo, 1996).
- Social construction: Socially sanctioned agreements about the meaning and significance of human traits, notably race, gender, and sexual orientation (Pack-Brown & Williams, 2003).
- Worldview: culturally based and learned presumptions and assumptions that exemplify how a person perceives the world around them and how the world perceives its relationship to the person (Pack-Brown & Williams, 2003).

Risk Factors Associated With Queer Status

Sociocultural factors

Youth are expected, by peer group enforcement, to behave and enact a gender in accordance to their birth sex (Pascoe, 2007). Pascoe further asserts that; “People hold other people accountable for ‘doing gender’ correctly” (p. 13). Within the culture of North American high schools, the word *fag* is inherent to jokes between male students (Pascoe, 2007). Pascoe speaks about the use of the word *fag* in this setting, by likening it to a game of hot potato. With regards to this term, she states: “... an identity no boy

wanted but that most boys could escape, usually by engaging in some sort of discursive contest to turn another boy into a fag. In this way the fag became a hot potato that no boy wanted to be left holding. One of the best ways to move out of the fag position was to thrust another boy into that position (p. 61).”

An example of how culturally accepted engendered jokes can be damaging in reinforcing non-inclusive gender roles can be seen in Bruce Feirstein’s (1982) book, *Real Men Don’t Eat Quiche: A guide book to all that is truly masculine*. This book has several chapters, including chapter ten, entitled: “Three things you won’t find in a real man’s pocket.” The three items listed include: “1. Lip Balm. 2. Breath Freshener. 3. Opera tickets.” The introduction of this book is comprised of an interview with a truck driver who states:

We’ve become a nation of wimps. Pansies. Quiche eaters. Alan Alda types—who cook and clean and relate to their wives. Phil Donahue clones—who are *warm* and *sensitive* and *vulnerable*. It’s not enough anymore that we earn a living and protect women and children from plagues, famine, and encyclopedia salesmen. But now we’re also supposed to be *supportive*. And *understanding*. And *sincere*... Are American men doomed to abandon the principles of Strength, Dignity, and Sylvester Stallone forever? (p. 10-11).

With regards to social apathy towards homophobia, Sarah Schulman (2009), author, journalist, playwright and activist, addresses the need for a societal re-writing of the understanding of homophobia and likens it to feminist struggle of re-conceptualizing the notion of rape in the 1970s and 1980s. She states:

Rape is now officially wrong. The practice of rape is more pathologized and

victims of rape are less stigmatized. There is a legal consensus that rape is wrong. Women are not blamed for being raped with the regularity that we once were. In other words, there is a broad cultural agreement that rape is wrong, and this agreement was achieved by a social movement rooted in human experience. This can be an instructive model for the transformation of social codes around familial homophobia. (p.7)

Familial homophobia

The role of the family in influencing the sense of self for the queer client cannot be overlooked. Schulman (2009) speaks of the importance of one basic truth: gay people do not cause, or deserve homophobia, and that it is a pathological byproduct of the dominant heterosexual climate (Schulman, 2009). Along these lines, Igartua and Des Rosiers (2004) point out that most queer clients end up, on some level, parentified; teaching, explaining, supporting and reassuring their parents about what it means to be queer both socially and personally. These authors also list two experiences that are familiar to most members of the queer community: First, "...coming out, a process of self-interrogation in opposition to social expectations that has no parallel in heterosexual life. The second common experience is that we have each, at some time in our lives, been treated shoddily by our families simply, but specifically, because of our homosexuality (p. 1)." Schulman (2009) discusses the notion of 'shunning' as "an active form of harassment" as it is quite easy to do and has therefore, become quite commonplace within the dominant culture (p. 10). This is especially harmful within the family unit as it reinforces an exclusion of the public sphere into the private sphere, a space normally allotted for support in processing harmful outside messages about the

self. For homophobia to come within the confines of the family further negatively reinforces and isolates the family member who happens to be queer.

The isolating struggle of the queer person can be understood through Schulman's (2009) description and comparisons:

Most social movements have been constructed by people who were related: civil rights and labor movements involve multi-generations of rebellion by the same families. Even feminism has tried to be a movement of mothers and daughters.

But the gay and lesbian movement, like the disability movement, is made up of people who stand apart from the fate of their family members, and whose most intense oppression experiences may be at the hand of those same relatives...

Unfortunately, without third-party intervention, we each often still are brainwashed into conceptualizing of familial homophobia as our own individual problem. We see it within the specificities of our own families, and we often have to enter those families alone and deal with this problem alone. We can commiserate with others later, but the battle is ours alone. This false privatization of familial homophobia has kept us from acknowledging that it is not a personal problem, but rather a cultural crisis. (p. 38)

Internalized homophobia

Because the process of self-identifying as somewhere within the queer spectrum is an internal process, it generally happens in isolation in a heteronormative sociocultural climate. Therefore, it is important to address internalized homophobia, as this phenomenon seems to be a driving force in the internal struggles of those who are considering ending their life because of their queer status (Clermont & Sioui-Durand,

1997; Igartua et al., 2003; Omoto & Kurtzman, 2006). Internalized homophobia is, for many, so powerful that even without the risk of being “out-ed” or having to come-out, the feelings of shame are experienced with such strength, that shame itself is the actual cause of distress (Igartua et al., 2003). The secrecy that is driven by shame is especially isolating in this circumstance, as an individual going through difficult times usually turns to their close relations for support. The shame involved in internalized homophobia however, does not allow the individual to feel free to seek out that support, out of fear of rejection. Igartua et al. (2003) also assert that internalized homophobia is, in fact, predictive of psychological distress. Clermont & Sioui-Durand (1997) support this affirmation in that they state that the fear of social rejection is of greater concern to the individual who identifies as queer, than their actual queer status.

Garofolo et al. (1999) point to some of the reasons that have been included in prior studies as to why so many queer youth are considering suicide as a viable option. These reasons develop out of a sense of feeling ‘divergent’ or ‘abnormal’ and they are primarily related to: the stress leading up to coming-out, the stress caused by coming-out, and feeling rejected as a result (Garofolo et al.). Igartua et al. (2003) further support this finding by suggesting that the disclosure of queer status in the primary community, such as family and friends, is the period of greatest risk for suicidal ideation as well as suicide attempts. Igartua et al. also determined that the mid-twenties of a queer individual’s lifespan is the age range of greatest suicidal risk. Some other risk factors that can impact the mental health of a newly-identifying queer individual include stigmatization, stereotyping, and prejudice that queer people face due to societal heteronormative standards (Clermont & Sioui-Durand, 1997).

Mental health factors

Youth of the queer community are at a particularly high risk for many mental health disorders (Igartua et al., 2003; Omoto & Kurtzman, 2006; Stone Fish & Harvey, 2005). Some of the psychiatric disorders that have high incidence in the queer community include: major depression, generalized anxiety disorder, conduct disorder, substance abuse, suicidal ideation, and suicide attempts (Fergusson et al., 1999). It is difficult to assess whether or not there is comprehensive quantitative data in regards to the queer population, suicidal ideation, and suicide attempts, as all of these elements are still veiled behind high levels of social stigma, fear, and shame (Garofolo et al., 1999). Igartua et al. (2003) studied a sample of individuals from the lesbian, gay, and bisexual (LGB) community in Montreal, Quebec, and reported some staggering statistics. Of the participants, 65% had experienced suicidal ideation and 14% of them had, in fact, carried out suicide attempts. A 1999 study in the U.S. pointed to the fact that the queer participants were 2.28 times more likely than their straight peers to have attempted suicide in the preceding year alone (Garofolo et al., 1999). Clermont & Sioui-Durand (1997) pointed to the fact that as of 1997, all North American studies done on queer individuals and suicide attempts revealed a very high incidence of suicide. Twelve of these studies reported rates between and 20% and 50%.

While the severity and finality of suicide make its prevention of paramount importance, this is not the only maladaptive crisis that is common in the queer community. Stone Fish & Harvey (2005) refer to Jacobs' 2004 U.S. national survey that highlighted the fact that almost half of the homeless youth in the U.S. fall somewhere under the queer umbrella. For queer youth, the risk of parental rejection and resulting

homelessness is an enormously powerful closeting agent (Clermont & Sioui-Durand, 1997).

There are also other mental health and sociological risks associated with queer individuals. Queer individuals are more likely to seek out mental health treatment than their straight peers (Pelton-Sweet & Sherry, 2008). They are nearly five times more likely to be treated for a panic disorder, three times more likely to be treated for depression, and lesbian and bisexual woman are nearly four times more likely to be treated for anxiety or for drug dependency than their straight counterparts. Pelton-Sweet & Sherry (2008) also found that queer individuals suffer high rates of other stress related diseases such as diabetes, heart disease, asthma, and have a quicker rate of advancement of infectious disease.

Coming-out

The coming-out process has been repeatedly shown to be the source of highest distress for members of the queer community (Igartua et al., 2003; Pelton-Sweet & Sherry, 2008). In the year 2000, there were still 38 American States where one could be fired for being gay, and there was yet to be any federal hate crime legislation that would specifically address sexual orientation (Addison, 2003). The U.S. National Education Association found in 2005 that 84% of queer youth suffered from verbal harassment at school, 39% were physically harassed at school, 64% indicated that they did not feel safe in their school environment, and an alarming 33% of them decided dropping out of school was a better option than continuing school and enduring harassment (Pelton-Sweet & Sherry). Schulman (2009) defines the coming-out process as being rooted in “the capacity for feeling strong enough to overwhelm social expectation” as being at the basis

of a “homosexual identity.” (p. 34). Schulman also speaks of the detrimental and deep-seated effect that the queer person experiences from desperately trying to avoid being falsely accused and shunned within the sphere of everyday living (2009).

Reparative Therapies

Also known as conversion, ex-gay, or reorientation therapies, reparative therapies are types of psychotherapy with the treatment goals of obliterating a queer person’s same-sex feelings and their wish for intimate same-sex relationships (Grace, 2005). This form of therapy has been known to include: behavioural therapy, electric shock therapy, hormone therapy, drug therapy, religious and homophobic counseling and propaganda, subliminal therapies with the aim of instilling ‘feminine’ or ‘masculine’ behaviour, and ‘covert desensitization’ therapies that teach a young person to associate homosexual feelings with disgusting images (Grace, 2005).” Cramer, Golom, LoPresto & Kirkley (2008) also include masturbatory reconditioning, aversion therapy, social skills retraining, cognitive restructuring, hypnosis, lobotomies, castration, ovary removal as well as abstinence training, as techniques that are also used. If the reparative therapy is coming from a clergy member, it may include threats of eternal damnation, prayer and the trust in god to change their orientation, as well as making the client accountable for their ability to change their sexual behaviours (Cramer et al, 2008).

These theories are based in the perception that homosexuality is a mental disorder, a notion that was not eradicated from major Western psychological associations until the 1990s (Grace, 2005). This recent publicly voiced denouncement of reparative therapies by the major North-American associations is underscored by their position that reparative therapies have not been adequately researched— there is a lack of empirical

evidence, and the statistics that are available are not reliable. The American Psychological Association (APA) now encourages their therapists to conduct affirmative therapy and due to the lack of empirical evidence to the contrary, do not condone these reparative therapies (Cramer et al., 2008).

Reparative therapists reason that sexual orientation is a choice that the queer person makes consciously and that this choice is pathological and morally suspect. In some instances the queer client is told they are sinning (Cramer et al., 2008). One of the major faults in this form of psychotherapy is the lack of distinction between what constitutes sexual behaviours from sexual orientation (Grace, 2005). The failure to make this distinction, in reality, encourages the client to suppress sexual behaviours thereby creating the false assumption that they have changed their sexual orientation. In actuality, all that has changed is their focus on, and increased execution of, heterosexual behaviours. Some of the other issues that arise from reparative therapies include feelings of guilt, paranoia, nervous breakdowns, genital mutilation, post-traumatic stress disorder as well as suicidal thoughts and even suicide (Grace, 2005). Cramer et al. (2008) also state that whether or not the therapy is successful in changing the client's orientation, it has been documented that clients having received reparative therapies report decreased sexual arousal, which has been attributed to aversion conditioning (2008). These same authors also describe a study of male clients who suffer from other negative effects of reparative therapies such as severe anxiety around men whom they deem attractive, suicide attempts, severe depression, increased aggression, as well as generally feeling dissatisfied with their relationships. It is believed that while a client may momentarily feel better after reparative therapy, the long-term effects are negative.

The importance of denouncing reparative therapies cannot be overstated, especially in the role of therapist. It is crucial to be vocal about the damage that is done by reparative therapies. In doing so, the therapist protects queer youth who are particularly vulnerable (Grace, 2005). Queer youth have a great deal to cope with and process as they try to understand their orientations, their identities, manage family pressures around heteronormativities, contend with a lack of dialogue around queerness in the classroom, as well as community morals, values and expectations (Grace). These factors, combined with the overwhelming fear around being abandoned, ostracized, harassed and discriminated against by family, peers, and community may result in queer youth feeling a strong desire to be ‘cured’ making them particularly vulnerable to reparative therapies (Grace, 2005).

Queering Psychological Theory

Queer theory and its relationship to the field of psychology

According to The Canadian Art Therapy Association (CATA): “Art therapy combines the creative process and psychotherapy, facilitating self-exploration and understanding. Using imagery, colour, and shape as part of this creative therapeutic process, thoughts and feelings may be expressed that would otherwise be difficult to articulate (McIlroy, 2010).” Judith Rubin, an art therapist and author who has written what are arguably some of the most seminal texts in the field of art therapy, suggested in her 1984 *The art of art therapy*, that not only is it important for art therapists to not try to fit art therapy into therapeutic molds in which they do not actually fit very well, but that the time has come for art therapists to “develop meaningful theoretical constructs from the matrix of art therapy itself (p. 190).” It is this sentiment that this research is built on.

Rubin stated: “As we continue, in this new millennium, to struggle towards greater clarity and more coherent theory in the field of art therapy, it is essential that we not abandon the parallel psychotherapy. It is equally important to continue the debate, and to go on with the attempt to apply ways of thinking about people and change to art therapy... (Rubin, 2001; p.3).” It is this openness towards change, adaptation and metamorphosis that creates encouragement that art therapy is willing to try on ideologies such as queer theory and feminist thought.

Because of the binary nature of psychological theory which tends to polarize people, their emotions and their behaviour, it is important to consider theoretical frameworks that challenge this worldview, one of them being queer theory. According to Moon (2008), queer theory steps away from the compartmentalization of people and of thoughts, and it challenges the idea that identity is fixed. The fact that current psychological theory is based in a heteronormative understanding of emotional conduct implies that there is a specific way that the body and the individual are to be ordered within society and that to deviate from that hegemony will render an individual amongst the marginalized (Moon, 2008). Though the belief that emotions are innate is standard within the discipline of psychology, queer theory attempts to highlight the fact that each society engenders emotions which renders them socially constructed and therefore, learned rather than being intrinsic and specific to either a male or female birth body (Moon, 2008). By viewing emotion from a queer theory stance, the idea that someone expresses feelings generally ascribed to the opposite sex renders itself irrelevant, and what becomes important is the individual’s experience of those emotions, which for this researcher, is worthy of more attention (Moon, 2008).

That the founding fathers of psychology were privileged, nineteenth century, white men means that the engendering of psychology served those men well in proving their assumptions about not only gender, but about sex, race, class and culture (Burt, 1996). This means that those few privileged definers are the same individuals who would most benefit from perpetuating assumptions about gender as stiffly fixed rather than fluid, putting into question the actual relevance of prevailing, yet biased, notions of gender (Burt, 1996).

The subversive nature of identifying as “transgender” can often put an individual at risk as it can make those who rely on cues from the dominant culture extremely uncomfortable (Piccirillo, 1996). By incorporating a system of classification that is person centered in its orientation, each individual is free to be their own unique construction of ways of being, thinking and feeling (Piccirillo, 1996).

Greene (2004) speaks of the importance of acknowledging diversity and multiculturalism around notions of ethnicity, race, gender, sexual orientation, age and disability, as social constructs. Greene goes on to state:

In western culture, these aspects of human diversity are deemed of great importance by social scientists and they are often viewed as both explaining and justifying the positions people hold in the social hierarchy. In the context of psychotherapy, their salience must be determined by how much of a difference these differences actually make in people’s lives, at a given time, how they are understood and what they come to mean to the client. This naturally leads to questions about how these relative statuses in and of themselves contribute to the client’s position in the social hierarchy and what the client must do to negotiate

the social barriers associated with disadvantaged status. Given the relational nature of social status, it also raises questions about the effects of the theoretician or clinician's position in that hierarchy.

How does the theoreticians' subjective social positioning, their awareness of it or lack thereof effect their conceptualization of the psyche and how it works? Furthermore, how does it affect their view or awareness of the social hierarchy and their understanding of their place in it? Beyond these issues, we must ask what is reenacted in the therapy process itself when the clinician is a member of or strongly identifies with a privileged and dominant group and the patient is/does not. I contend that there is the potential for the normative social power relationship to be reenacted. (p. 59)

Within the field of psychology, a psychodynamic orientation is a broad term used to conceptualize therapy that is rooted in, and shares many basic hypotheses with psychoanalysis (Kaner & Prelinger, 2005). While it is important to highlight these pitfalls of psychodynamic theory applications to members of the queer community, it is also important to acknowledge some of the misconceptions of psychodynamic psychology as they contribute to the notion that psychodynamic psychology can be a modality that can be applied to members of the queer community. Greene (2004) speaks about the common oversight that psychodynamic therapy does not refer to one theory but rather refers to an entire constellation of theories that stem from Freudian psychoanalysis of neurosis. Of particular relevance in this "father theory" would be the idea that both feelings and thoughts that may cause distress for the individual's ego will be defended against by being relegated to the unconscious. Also of relevance is the psychodynamic

assumption that if the client becomes aware of their unconscious behaviours, thoughts and feelings, that they can adapt and change.

Incorporation of feminist theory

Davis Halifax (2003) speaks of feminist psychotherapy as allowing for the exploration of power within the relationship. This author states that:

Both participants are imbued with expertise, so that from the very beginning the client is an active participant. Feminist psychotherapy clearly follows the client's expressed needs and goals, and therapy is evaluated in a collaborative and ongoing process. Feminist psychotherapy is non-pathologizing and recognizes strengths and competencies. A feminist and rational model of therapy is able to value what each participant brings to the relationship. At its best, it is capable of containing and tolerating the confusion that may arise with the admission of difference entering a supportive, collaborative, empowered, therapeutic relationship will carry that experience with them into the outside world. The relationship of self-to-self and self-to-other will undoubtedly be affected. Yet we must still acknowledge all that exists in our culture that works against our newly acquired knowledge of self and of our capacity to do and act. (p. 35)

It is important for the psychodynamic therapist working with queer clients to acknowledge that there are two important components that need to be addressed (Greene, 2004). There needs to be a marriage of intra-psychic mechanisms as well as an acknowledgment of the client's understanding of their position within their social world, and the dominant views of their position in their social world based on their queer status.

It is worthy of noting that while most art therapists are women, art therapy literature has consistently maintained a level of ignorance with regards to feminist approaches to mental health (Burt, 1996). The author goes on to assert that art therapy is hindered by that lack of awareness of the sociopolitical structures in play that continue to be oppressive to women (Burt, 1996). Based on literature reviewed, Burt feels that it is more important to develop the field of art therapy out of the experiences and contributions of the professionals doing the work, rather than looking to other areas of mental health and trying to relate these other fields to the unique potentialities of the creative arts modalities. Because of the inherent gender bias of psychological theory, art therapists, who happen to be mainly women, are doing a disservice to the advancement of the field by not considering a feminist perspective to the research potentialities of the field (Burt, 1996).

Art Therapy

Application

This section will focus on the work that is currently being put forth by practicing art therapists who are working with clients who are members of the queer community. This chapter is meant to give ideas to the reader about specific materials and directives that may be a good fit when working with this population, but to also inspire the reader to develop techniques based on their own practices that may be a good fit as directives for working with clients from the queer community.

Creative expression and sexual identity as well as expressiveness and physical and emotional health are being increasingly quantified (Pelton-Sweet & Sherry, 2008). Findings indicate that art therapy during the coming-out process has been shown to

increase the participant's wellbeing (Pelton-Sweet & Sherry, 2008). It is often the case that the coming-out process is the most important factor that queer individuals explore through creative expression (Pelton-Sweet & Sherry, 2008). Pelton-Sweet & Sherry go on to point out that the safe space provided through art therapy is an excellent asset as it allows for the client to try on new ways of being, and practice being authentic in relation to their queer identities (2008).

Psychoanalytic discourse surrounding the topic of queer status has been centered mainly on asking 'why' questions in regards to the client's queer status instead of how that queer individual is experiencing and living their sexual and/or gender identities (Fraser & Waldman, 2003). Art therapy has a unique advantage compared to traditional therapies as it has a great potential to be regarded as subversive due to its position in the psychological community as an "alternative" therapy (Fraser & Waldman, 2003).

Jones (2003) emphasizes that art therapy has a "deviant potential for ambiguity," able to incorporate the "less-than-straight line" in ways that the spoken word rarely can. Despite the possibility for subversiveness, art therapy theory appears unaware of sociopolitical structures that are gender biased (Jones, 2003). Not only is art therapy not living up to its potential as being a leader in new ways of addressing mental health, but art therapy is actually behind the other psychologically based fields in this respect (Jones, 2003).

Clientele who are in need of the potentialities of subversive therapy options would gain from the field of art therapy, which naturally lends itself to helping those who don't fit conventional norms. Susan Saltzburg (2007) gives a first hand account of how narrative therapy has the potentiality for facilitating a youth's coming-out process. "As

the lives of these young people unfolded before me, I watched as they tentatively stepped into or around their LGB identities looking for ways to bring others into the circle of knowing.” (p. 58)

The Role of the Art Therapist

Responsibilities

Grace (2005) eloquently speaks to the role of the art therapist. The author states: Mental-health professionals ought to focus on ‘the etiology of the discomfort’ that brings a homosexual to seek therapy. Richard C. Friedman maintains that therapists need to understand both the historical and sociocultural underpinnings of homophobia. As well, he asserts they need to understand the psychodynamics of internalized homophobia, which is a negative self-concept about being/acting homosexual that develops due to sociocultural exposure to heterosexism and anti-gay behavior. (p. 147)

Before working with clients who either identify as queer or who are questioning their gender identities, it is imperative to consider the socio-historical attitudes towards the queer community (Clermont & Sioui-Durand, 1997). The typical binary understanding of gender devalues the human potentiality for fluidity of experience and expression and the ever-changing nature of gender from situation to situation (Barnstein, 1998). This view also discards the fact that gender is socioculturally constructed. Pelton-Sweet & Sherry (2008) provide a preliminary list of ways that mental health providers can act as allies to queer individuals.

This list includes: providing support and groups, facilitating family support, advocacy work, health and social service availability, health education, role modeling and

mentorship, as well as career guidance. It is also important that the therapist be competent in and knowledgeable of queer issues and attitudes towards queer statuses (Pelton-Sweet & Sherry, 2008). This involves understanding sexual identity development, heterosexism, heteronormativity, homophobia, and being respectful of the diversity of human nature (Pelton-Sweet & Sherry, 2008). The therapist should also be aware of the cultural background of the client and the relevance of that background to the client (Sherebrin, 1996). Religion and moral codes can immensely affect the ways that individuals feel allowed to conduct themselves, and if their inner desires are in conflict with the sociocultural standard of their community, then there is a potentiality for distress (Sherebrin). Additionally, the art therapist should be aware of symbols within the queer community that may hold specific meanings such as queer destinations, cultural icons and also language specific to the population (Addison, 2003).

Knowing the sociocultural background of the client who is queer, would allow the therapist to inform her/himself on, and be sensitive to both the internal and external conflicts that the client might be facing (Sherebrin, 1996). For instance, whereby Torah law prohibits damage to reproductive organs, a person who is transsexual who grew up in a religious Jewish home, may be conflicted between their desire to alter their bodies and the possible repercussions from their desire to alter their bodies and therefore breaking a moral law that they were taught (Sherebrin, 1996). This may leave this individual feeling shame, guilt, and/or self-hatred (Sherebrin, 1996).

It is important to note, that even within the queer community there are specific engendered roles that are played out, and these roles are as socially constructed as the heteronormative roles of 'man' and 'woman' (Brody, 1996). For example, some lesbians

play out the binary social roles of ‘butch’ and ‘femme’ (Brody, 1996). These kinds of roles are supported by specific codes within the queer community that are often used to distinguish someone’s gender, such as hairstyle, clothing, jewelry, body language and the “hanky code” (Brody, 1996). For instance, for a client to refer to someone as a ‘beard’ or a ‘bear’, or for them to use the term ‘bare-backing’, may not resonate with every therapist, whereas a therapist informed on language used within the queer community may understand the implied meanings of these terms.

When a therapist practices unconditional positive regard and is successful in reassuring their client that they and their queer status are accepted, the therapeutic relationship can serve as a “corrective emotional experience” from what may have played out within the familial relationship (Igartua & Des Rosiers, 2004).

It is important for the therapist to make sure that their message of acceptance does not only happen during therapy, but before and afterward as well. This includes offering signals of inclusion, such as having queer literature laying around, using strictly inclusive language, and avoiding any assumptions of either sexual or gender identity (Addison, 1996). The therapist should be certain to address and confront any homophobic comments or jokes made by anyone, including fellow therapists, in front of clients to reinforce to the client not only that they are allies, but that such speech is unacceptable (Addison, 1996).

There is a need for the therapist to also reinforce that by virtue of the client’s queer status, they are not mentally ill, and that the therapist adamantly denounce therapies such as conversion therapy that aims to “reverse” their queer identities so that they better fit into heteronormative standards (Pelton-Sweet & Sherry, 2008). The

therapist must be competent in and knowledgeable of queer issues and attitudes towards queer statuses (Pelton-Sweet & Sherry, 2008). This involves understanding sexual identity development, heterosexism, heteronormativity, homophobia, and to be respectful of the diversity of human nature (Pelton-Sweet & Sherry, 2008). It is critical that the therapist respect where the client is in their coming-out process. To push a client who is not yet ready to come out, creates a risk to their emotional stability (Pelton-Sweet & Sherry, 2008).

A therapist must always remember that just as there is no one way to be straight in the world, there is also no one way to be queer, and that what may be relevant for one queer client, may hold little relevance for another (Fraser & Waldman, 2003). The creative arts therapist working with clients who are queer must take into consideration that while the client is queer, this may have little to do with why they are seeking therapy (Fraser & Waldman, 2003). Therefore, it is important for therapists to be aware of their own projections on the subject so as to not assume that the client is in any form of distress about their queer status (Fraser & Waldman, 2003). Along these lines, it is important to always keep in mind that there is far more to a person's identity than their sexuality and/or gender alone (Fraser & Waldman, 2003).

For the client contending with societal and internal homophobia, perceiving their therapist as queer may cause them to devalue their therapist and their relationship with them and they may even perceive their therapist as trying to "convert" them or as attracted to them (Igartua and Des Rosier, 2004). In spite of the fact that in the current cultural climate public figures are revered when they come out, pushing a client towards coming out prematurely can be detrimental to their well-being. While coming out is an

important step both personally and politically, this step is part of a long and arduous process and one that is rarely worked through without much ambivalence. It is important to acknowledge and to communicate to the queer client just how difficult it is to come-out. Also of importance is to consider the risk factors for the client coming-out, as there are situations when this is not advisable. These authors list some ways of decreasing the client's anxiety when working with clients struggling with the coming-out process. This list includes: the normalization of non-heterosexual feelings, understanding the distinction between attractions and identity, the avoidance of labeling as well as exploring and entertaining various fantasies, be they heterosexual and/or gender-normative, or not.

With this understanding, the therapist should keep in mind that in settings where they are not expecting to be dealing with issues of sexual and/or gender identity, that the therapeutic space may be used to explore these concepts (Fraser & Waldman, 2003). For instance, there is a cultural tendency to desexualize older adults or people who are differently-abled, and thus a therapist working within elder care or group home settings may find her/himself an unexpected ally to clients exploring these topics (Fraser & Waldman, 2003). Troiden, a well-known sexual identity stage theorist, supports this claim by agreeing that an individual's sexuality is constantly emerging, in flux, and flexible in nature (Troiden, 1988).

However, a fundamental premise of medical ideology pathologizing sexual and gender differences posits that people who identify as queer are putting their personal desires, such as non-reproductive sexual expressions, over the physiological and "innate"

functions of sexual intercourse for the purpose of perpetuating the human species (Clermont & Sioui-Durand, 1997).

Perhaps the biggest hurdle in dismantling the stereotypes and marginalization of the queer community is that, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised, (DSM-IVR), those who identify as transgender or transsexual are considered mentally ill. Among the DSM-IVR checklist of criteria for having “gender identity disorder” are: play, peer relations, speech characteristics as well as statements about sexual anatomy that typically belong to members of the opposite sex (Zucker & Bradley, 1995). Such a binary understanding of gender devalues the human potentiality for fluidity of experience and the ever-changing nature of gender from situation to situation (Barnstein, 1998). This view also discards the fact that gender is socio-culturally constructed.

Cramer et al. (2008) encourages the therapist working with the queer client to practice affirmative therapy as this supports the APA’s ethical guideline to avoid unfair discrimination, avoid harm, and avoid false or deceptive statements. These authors state that affirmative therapy: “avoids discrimination by embracing the LGB individual’s identity, sexual attraction, and behaviour. Avoids harm by validation of the client’s feelings, exploring and emphasizing the value of the individual. Avoids deception by acknowledging lack of data while still treating the client in an ethically appropriate manner (p. 12).” For a concise overview of how conversion therapy and affirmative therapy models meet, or do not meet, APA guidelines for working with queer clients, please see Appendix.

Techniques

Pelton-Sweet & Sherry (2008) discuss art therapy as particularly suited for exploring themes such as identity, and suggest collage, group murals as well as sculpture, as suitable ways for dealing with experiences of bigotry, hatred, homophobia, internalized homophobia, concepts of family, guilt, shame, fear, anger and sexual identity. The authors speak in detail about an activity he titled: 'Inside Me, Outside Me,' in which the client is asked to make two separate self-portraits, one of the publicly presented self and one of the private internal self. Pelton-Sweet & Sherry point out that early on in the coming-out process, these two portraits may look dramatically different. Self-portraits in art therapy, they explain, "allow[s] the client to externalize feelings and qualities of self too delicate to expose verbally." They go on to suggest working with boxes, masks, as well as puppet making and play.

Lewis et al. (2005) highlight how expressive writing has been an effective technique for coping with the stresses around being open with one's lesbian identity. They note how humans have a seemingly innate desire to express their thoughts and feelings to others, and that expressing emotion has both psychological as well as physiological benefits.

In this researcher's capacity as a student art therapist working with youth, some of whom were dealing with issues pertaining to their sexuality, the use of writing appeared to help these young people work through some of the ambivalence and incongruence in values and desires that they held, in contrast to those of their family and culture. For instance, working with the term 'should' and creating two 'should' lists helped these young people sort out what 'should' statements were introspectively defined, and which "should" statements came from outside forces. Examples might include: "I should accept

that I am queer” versus “I should be straight,” or “I should have the right to love whom I choose even if they are of the same sex as me” versus “I should be happy with what I get in life and fix myself up in a way that people of the opposite sex will think I am attractive.” Anecdotally speaking, such exercises seemed useful when clients would vacillate between ‘shoulds’ that appeared to come from their desire to be self-actualizing versus the ‘shoulds’ that emanated from outside forces. In creating these two lists, clients were able to examine the difference in the messages they received and work through some of the confusion around that experience.

Issues of transference and countertransference

There are several configurations of transference and countertransference that can play out and need to be taken into consideration when one or both parties of the therapeutic relationship identify as queer. Igartua and Des Rosiers (2004) provide some of the foundational work regarding what aspects of transference and countertransference need to be acknowledged and considered within a queered therapeutic relationship.

The layers of transference between a queer client towards a queer therapist may actually be more complicated than one might originally assume. Not only are there aspects of parental transference as well as erotic transference common to a dyad of any client and therapist, there are the added complications of disclosure and perceived queer status (Igartua & Des Rosiers, 2004). This section will address these complex issues.

In some cases, both the therapist and the client identify somewhere under the umbrella of queer. In these situations, it is important to acknowledge what their shared life experiences may be, and how they each have or have not resolved their coming-out with their parents (Igartua and Des Rosiers, 2004). What influence will the roles of the

parentified queer child play into the transference/countertransference relationship between client and therapist? Will this configuration allow for a “corrective emotional experience?”

While parental projections often guide transferential dynamics, this aspect becomes further complicated when there are also levels of erotic transference present (Igartua and Des Rosiers, 2004). One of these aspects does not preclude the other and may be therefore be difficult to address as issues related to mother/daughter sexuality were generally omitted from Freudian understandings of development. The authors allude to the importance and relevance of the mother/daughter Oedipal complex in the child that grows up to become lesbian. Because this notion is rarely addressed or even considered, Igartua and Des Rosiers feel that this has resulted in therapists’ being inadequate at recognizing and addressing this important aspect of erotic transference amongst women. Referred to as “the negative oedipal,” this concept is typical of the non-inclusivity of the experiences of queers (p. 128).

In the configuration where the therapist is perceived to be queer by their queer client, especially for the client who is in the early stages of their queer identification, it must be taken into account that the client may over-identify with their therapist. This can be very helpful to the client as it may allow for important role-modeling (Igartua and Des Rosiers, 2004). On the other hand it is important that this idealized identification be addressed, as it may make it difficult for the client to see the difference between their own experiences and those of their therapist. Igartua and Des Rosiers distinguish a healthy, short-term idealization, from one that is rooted in deeper-seated desires to fuse with the object, because the object is seen as omnipotent. This latter type of idealization

may result in the client having trouble accepting their short-comings. Counter to the feeling of fusion with the idealized object, this may bring up negative feelings towards themselves, and envy and disenchantment with the therapist. This idealization can become even more complex when the client has erotic feelings towards their therapist. In their over-identification they may see the object as synonymous with the self and therefore, as someone who can mirror her perfectly, able to satisfy her sexual needs and desires. Igartua and Des Rosiers state: "In some cases, however, a therapist perceived as lesbian may simply be too threatening and these patients may only be able to explore their sexuality with someone they perceive as heterosexual." (p. 131)

Another consideration is the client who perceives their therapist to be heterosexual. The primary concern here is that the client may perceive the therapist as representative of the heterosexist society and may, therefore, project larger concepts of heterosexism unfairly to the queer-positive therapist (Igartua and Des Rosiers, 2004). When the client feels threatened in these ways by their therapist, they may actively engage in distancing themselves from their therapists, telling themselves that the therapist's worldview must be different than theirs, and that they cannot possibly understand what it is that they are going through. If this defensive stance on the part of the client is reacted to negatively by the therapist, then this can further the distance between them. There can be several reasons that a client may react this way to their therapist. It is possible that their reaction is a result of being deeply affected by familial and societal homophobia. It is also possible however, that this reactivity may be the result of an exaggerated pride around their queer status, something that is associated to an aspect typical of the middle stage of coming-out, whereby the individual will devalue

many aspects of heterosexual identification and lifestyle (Igartua and Des Rosiers, 2004). A client at this stage may contend that they are more suited for a queer therapist as they do not want to have to educate their therapist with regards to queerness. While this is understandable, the authors encourage the therapist to remain steadfast in a line of questioning that provokes the client to reflect upon their personal interpretations of their experiences. If there are signs of erotic transference, Igartua and Des Rosiers encourage the therapist not to work with this transference as though it is a defense, but rather to use it as an opportunity to validate and help the client integrate their sexual orientation.

It is equally important to consider countertransference around queer issues as this encompasses not only the therapist's sexual orientation, but also how much and when they will disclose to their clients about their queer status (Igartua and Des Rosiers, 2004). The queer therapist should strive to be aware of their potential to over-identify with their queer client as doing so may not allow them to see their client's individual identity and experiences as different than their own. This could influence the course of action taken by the client and/or encouraged by the therapist based on the therapist's own experiences. These authors also encourage a queer therapist to consider, and reconsider, whose needs would be fulfilled by disclosing their queer status to their client. Igartua and Des Rosiers further point out that a queer therapist may be more aware of their erotic countertransference than their heterosexual counterpart (2004).

For the heterosexual therapist working with queer clientele, it is important to first acknowledge any stereotyped beliefs and feelings that they may have towards queer people (Igartua and Des Rosiers, 2004). Of equal importance would be for the accepting heterosexual therapist not to deny the difference of experiences between heterosexual and

queer people. In addition, the heterosexual therapist should not be too quick to ally with the queer client who is defensive against the heterocentric sociocultural climate. Instead, it could be more useful for the therapist to help guide the client's exploration through how they may have contributed to the very experiences that they are describing.

Something else that these authors feel is crucial for the heterosexual therapist to consider would be any homoerotic feelings or fantasies that they may have been suppressing.

Such unacknowledged feelings have the potential to elicit anxiety and defenses in the therapist and their "third ear" may not be attuned to listening for flirtation in their own voice and therapeutic stance. One last factor that Igartua and Des Rosiers deem key for the heterosexual therapist to consider would be any feelings of jealousy towards their queer client. For example, are they envious of the client having a known community to belong to, of having the freedom to lean towards androgyny that the heterosexual person may not feel safe to do, or of the sense of rebellion implicit in identifying as queer?

These authors believe that for any therapist working with the queer community, it is important to treat the queer client in the same way they would any cross-cultural client (2004).

Conclusion

The queer communities in Quebec/Canada today are facing a deficit in specified health care. The shortage of health care providers and relative lack of research being done to address these issues leaves this population at risk. Queer individuals struggling to understand their identities in a predominantly heteronormative and gender specific culture internalize homophobia as a result of stereotypes and negative attitudes towards them (Hogan, 2003). Possibly the result of stigma, or fear of stigma, queer people may

be less inclined to seek out treatment in times of great distress, which may be the time they need the most support. This resistance to identify their queer status to others may also contribute to little research and much speculation as to how a sense of gender identity confusion and/or internalized homophobia negatively affects the lives of queer people. Those employed in helping professions may also know little about how to best support queer individuals in developing a positive sense of self. One study shows that internalized homophobia can be correlated with increased levels of depression, anxiety, and suicidal impulses (Igartua et al, 2003). The sample of LGB adults showed that 65% experienced suicidal ideation and 14% attempted suicide. Moreover, the moment of disclosure of one's sexual or gender identity has been shown to lead to distress, suicidal ideation and even suicide attempts in a large number of queer individuals (Fergusson et al., 1999; Garofolo et al., 1999, Igartua et al., 2003).

It is for these reasons that it is imperative that creative arts therapists take a serious look at how our uniquely situated modality can help to fill the void in specialized services geared towards queer people. In order to begin this process of expansion in the field of art therapy, it is important to look at what past and current research have illuminated on the subject. It is for this reason that the direction of this particular research paper was to take an historical-documentary approach in order to start synthesizing the various ideas and positions and present them in an overview format facilitating future research.

It is clear that there is foundational work being done within field of psychology to identify and address some of the issues facing queer people. The literature points markedly to the fact that the event of and time leading up to coming-out of the closet,

poses a particular threat to the emotional well-being of queer people (Igartua et al., 2003; Pelton-Sweet & Sherry, 2008).

Also contributing to the difficulties facing queer clients are sociocultural factors. These factors include peer group enforcement (Pascoe, 2007), engendered jokes, as well as social apathy towards homophobia (Schulman, 2009). These influences do a disservice in that they reinforce non-inclusivity by not only pitting people against each other but by reinforcing false assumptions and making light of quite serious issues.

Familial homophobia poses a particular threat to the wellbeing of queer clients. It encompasses messages of in-acceptance and shunning towards the queer family member and also includes the parentification of the queer family member (Igartua and Des Rosiers, 2004; Schulman, 2009). This encompasses being in the role of teaching, and explaining as well as providing support and reassurance to their parents, a role reversal that leaves the now isolated queer family member without the typical experience of an individual in the role of the child being able to turn to their parents to meet those very needs (Schulman, 2009).

Internalized homophobia is also a factor that is worthy of attention when working with clients who are queer. It evokes strong feelings of shame, secrecy, and isolation and therefore is quite powerful at creating a distressing experience of self for the individual who is queer. In fact, it can be so powerful that simply the fear of others finding out their queer identities can in and of itself be a source of significant stress for the individual (Igartua et al., 2003). Internalized homophobia does not develop in a vacuum, however, it is informed by the interactions that the individual who is queer experiences such as

stigmatization, stereotyping, and prejudice that they are exposed to within the rigid confines of the dominant culture (Clermont & Sioui-Durand, 1997).

Perhaps because of the culmination of all these factors, both internal and external, individuals who are queer are shown to have higher levels of both mental health and physiological health issues (Igartua, Gill & Montoro, 2003; Omoto & Kurtzman, 2006; Pelton-Sweet & Sherry, 2008; Stone Fish & Harvey, 2003). These issues include: major depression, generalized anxiety disorder, panic disorder, conduct disorder, substance abuse, suicidal ideation and suicide attempts, as well as diabetes, heart disease, asthma, as well as quicker advancement of infectious disease (Fergusson et al., 1999; Pelton-Sweet & Sherry, 2008).

For the art therapist to better serve their clients who are queer they must first and foremost create a safe space for the client to freely and authentically express themselves, as well as practice new behaviours and ways of being (Pelton-Sweet & Sherry, 2008). The focus of therapy addressing the client's queer status should not revolve around asking 'why' questions but rather should focus on the experiences lived and felt in relation to the client's queer status (Fraser & Waldman, 2003?).

In order to be proper allies to clients who identify as queer, it is important for the therapist to provide support, groups, facilitate family support, advocacy, role modeling, mentorship, career guidance, health education, as well as health and social service resources (Pelton-Sweet & Sherry, 2008). The therapist should also be well versed in queer issues, including attitudes towards queer statuses as well as the cultural background of the client, and the relevance of that background to the client (Pelton-Sweet & Sherry, 2008; Sherebrin, 1996). The therapeutic relationship has the potentiality for corrective

emotional experiences when the therapist practices unconditional positive regard and successfully reassures their client that they are accepted by the therapist not only within the therapeutic space but the time around the therapy sessions as well (Addison, 1996).

Of particular importance, the therapist needs to be clear in their denouncement of reparative therapies and that by virtue of the client's queer status, they are not mentally ill (Pelton-Sweet & Sherry, 2008). The therapist must also consider that despite the similarities of identification of sexual and/or gender identity of various queer clients, this does not mean that their experiences are interchangeable. Furthermore, their reasons for seeking out therapy may be vastly different and may have nothing to do with their queer identity at all (Addison, 2003). Also worthy of specific attention would be the transference and countertransference relationships between the client and the therapist (Igartua & Des Rosiers, 2004). Cramer et al. (2008) also encourage the therapist to consult the American Psychological Association's ethical guidelines when working with a client who is queer and to refer the client to a different therapist if the therapist feels ill equipped to practice the affirmative therapy needed by the struggling client who is queer.

Limitations and Suggestions for Further Research

By virtue of its length, this research paper is quite limited in the depth to which it can address these issues. My goal was to provide the reader a broader understanding of the issues that are affecting marginalized queer people and the scope to which, at least at present, we as creative art therapists are limited in our ability adequately support our queer clients. This choice was made in part to start the momentum of art therapists looking more towards adapting their practices to be more inclusive of queer issues and also to hopefully inspire future, and more in depth research in this area.

In writing on this topic, I recognize that while I chose, for the purpose of this paper, to use queer as an umbrella term, this is something that some readers may take offence to. For some, the term queer is derogatory. Others may argue that differences between sexuality and gender are wide enough apart that the issues do not necessarily coincide and therefore should not be lumped together. Still for others, personal membership in, or identification with one community does not automatically create membership in another. While I understand how some may feel frustrated by my use of 'queer' as a label, this decision was not made lightly. It was the result of my consideration of this topic as a whole, and an attempt to illuminate some of the ways in which the field of art therapy might begin to adapt in order to better serve queer individuals. This research was an attempt to open a dialogue within the art therapy community with respect to its foundation and to, perhaps, challenge current and future art therapists to think beyond psychodynamic theory. As art therapists, we have an opportunity to take advantage of both our newness as a field and our non-traditional methods as a point of entry into expanding and developing theory that is more inclusive.

Lastly I chose to take the position that queer people, particularly queer youth, are 'at-risk'. It is important to point out however that I am not implying that by virtue of sexual or gender identity that queer Canadians are at risk, but rather that the effects of negative attitudes and stereotyping exacerbate all that queer Canadians have to contend with when trying to create a positive sense of self. It is therefore important to acknowledge that this acquisition of positive sense of self does not come easily for most, but instead comes with some levels of distress, confusion, alienation, and pain. It is these experiences that pose a risk to queer people. I believe art therapy may be particularly

suiting to help comfort, support, and synthesize thoughts and emotions in order to help queer people create a positive sense of self.

Closing Remarks

One of the major difficulties I encountered when beginning this research was personal. I was cautioned to take care in how I might challenge the field I am preparing to enter. I perceived this advice to mean that I might be over-stepping my bounds as a new therapist, to say that we are not meeting our potential in counseling our queer clients. I see it as a disservice to our field to not point out a way that we can grow and evolve and better serve a marginalized community. Secondly, I feel that the purpose of graduate school is to start to develop an identity as a therapist, professional and academic, and part of that role is to help expand the field. Therefore I persevered because this research topic is important and deserving of acknowledgment as we have a long way to go in our evolution as such a young field and as a derivative of psychodynamic psychology.

The field of art therapy has a great potential to serve and benefit queer clients. Expanding its theoretical foundation, in my opinion, would strengthen the legitimacy of the field by becoming a beacon of inclusivity, and demonstrating its unique capacity to serve marginalized populations. Incorporating queer theory and feminist theory into our research and practice broadens our thinking and provides greater resources to those on the front-lines providing crucial services in ways that directly meet the very particular needs of queer clients.

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APPENDIX

Conversion Therapy and Affirmative Therapy in the Context of APA Ethical Guidelines for Working with LGB Clients

Note: Columns 2 and 3 assess whether the respective type of therapy adheres to the relevant ethical guideline. APA= American Psychological Association; LGB= Lesbian, gay, and bisexual.

APA Guidelines	Conversion Therapy	Affirmative Therapy
Attest that LGB orientation does not indicate pathology	No: Conveys pathology	Yes: Affirms healthy identity
Recognize own bias and seek consultation or referral when appropriate	No: Perpetuates therapist heteronormativity	Yes: Promotes therapist self-exploration
Understands the negative impact of social stigma on LGB clients	No: Reinforces stigma	Yes: Encourages coping with stigma
Understand how prejudice impacts an LGB clients' presentation therapy	No: Ignores role of prejudice	Yes: Addresses role of prejudice
Possesses knowledge and respect for LGB relationships	No: Shows disregard for relationships	Yes: Fosters enhancement of relationships
Understand issues faced by LGB parents	No: Fails to incorporate issues faced by parents	Yes: Includes active exploration of parent difficulties when appropriate
Recognize that families of LGB people include others outside of the biological family	No: Emphasizes the role of a homo-negative support system	Yes: Embraces multidimensional support system
Understand how LGB orientation affects interaction with family of origin	No: Reinforces heterosexist views of family	Yes: Seeks to understand the uniqueness of this family dynamic
Recognize how LGB orientation relates to, or conflicts with, other cultural identities (e.g., race)	No: Neglects contradicting cultural beliefs and values	Yes: Incorporates synthesis of multiple cultural identities and value systems
Recognize particular challenges faced by bisexual clients	No: Downplays idiosyncratic facets of nature of bisexuality	Yes: Highlights unique bisexual identity
Understand the unique risks of LGB youth	No: Overlooks potential harm to LGB youth	Yes: Assesses potential risk factor of minority sexuality identity
Parcel out generational differences in LGB people; pay attention to	No: Disregards diversity among LGB individuals	Yes: Seeks to understand disparities in generational

issues faced by LGB older adults		views of LGB identity
Attend to special challenges faced by LGB individuals with other disabilities	Not enough information to determine	Yes: Includes client view of disability treatment with LGB clients
Support the provision of education and training in LGB issues	No: Fails to address clinical advances in the area of treatment for LGB clients	Yes: Advances knowledge treatment with LGB clients
Bolster knowledge of LGB issues through education and training	No: Violates need to develop competence	Yes: Develops competence
Become familiar with resources for LGB clients	No: Limits options for LGB clients	Yes: Improves coping skills and resources for LGB clients

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