AN INSTRUMENTAL CASE STUDY ON THE RELATIONSHIP OF A

TRANSGENDER MALE IN RECOVERY FROM PSYCHOSIS WORKING WITH A

CISGENDER THERAPIST: A CROSS-CULTURAL PERSPECTIVE

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ABSTRACT

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This instrumental case study details the process of a cisgender drama therapist working with James, a transgender man in his early 20's. The cross-cultural approach to which the drama therapist adhered is examined via literature in drama therapy, creative arts therapies, and other psychotherapies, focusing on suggested best practices as well as current findings on transgender experiences in health-care settings. During the eight months that encompassed the therapy process James went through many changes, including preferred pronouns, a name change, relationships ending and beginning, and coming out to different people in his life, all of which were addressed within the sessions. The mutual respect and trust, which developed as a result of the cross-cultural foundational work, was key in addressing these important shifts in James' life. Narradrama was the primary form of drama therapy that was utilized although inspirations were taken from many sources, and the sessions became highly adaptable to James' needs on any given week. This paper aims to display the important role of cross-cultural humility within psychotherapy fields.

Keywords: Drama Therapy, Narradrama, Transgender, Cross Cultural, Cultural Humility

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"I believe in the power of people's stories, and in the power of language, metaphor, and collective narratives. I have come to believe that one of the keys to our larger political struggles lies in our ability to own and rewrite our personal stories"

- Sascha Altman DuBrul, *Maps to the other side: The adventures of a bipolar cartographer*

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Chapter 1: Introduction

My experience working as a drama therapy practicum student at a clinic for early psychosis intervention would prove to be challenging beyond my expectations, and yet simultaneously the greatest catalyst for growth that I have so far experienced in my career. A large part of this growth was due to James, a client who is a Caucasian transgender man in his early 20's who identifies as pansexual and polyamorous, and has previously received a diagnosis of psychosis NOS, currently living with a diagnosis of cyclothymic disorder. Through this journey I would realize not only how essential cultural awareness and humility are to a therapeutic relationship, myself not identifying as transgender, polyamorous, or pansexual, but also the true strength and versatility of drama therapy.

Entering into the therapeutic journey James displayed resistance in a variety of ways, although it initially appeared as a noted hesitation to jump into therapeutic work despite verbally stating that he did want to. This was at least partially due to the fact that previous therapy endeavors had not resulted in his desired outcomes, and he felt as though he was voluntarily subjecting himself to a medical system that sometimes made him feel marginalized and discriminated against due to both his mental illness and his transness. He was open that he wanted to try therapy again, still feeling motivated to achieve the therapeutic goals he had previously set, and yet harboring trepidation at the onset. This may have been due to the magnitude and impact that working on these goals would have on his life, change can be intimidating to many starting therapy, even if the benefits are clear in one's mind (Gelb, 2015). Another possibility for James' initial resistance could be the implications of working with a cisgender therapist, something that he stated had previously been a deterrent from therapy and a dynamic that will be further explored within this paper. Of course it may have been appropriate

for James to see a trans therapist, but as circumstances would dictate that was not an option at this clinic. As such the client was left with me, yet another cisgender mental health professional. Perhaps his hesitations were due to a combination of many factors, including some that remained undiscussed through the therapy sessions, but I do believe that focusing on developing my own cross-cultural counselling skills was of great benefit, helping to create a therapeutic space where openness, growth, and mutual respect was prioritized for both client and therapist. It was also a strength of the field of drama therapy that the therapeutic process could be tailored in multiple different ways to meet his specific needs. The co-creation of a suitable therapeutic environment between client and drama therapist was an important step in the therapeutic process, and was key in addressing the client's resistance.

This environment began to be shaped with the introduction of narradrama techniques, a method of drama therapy that is heavily influenced by narrative therapy (Dunne, 2007). In this method I, the drama therapist, was able to work with the client to concretely explore his history. James was resolute that he felt it necessary to do this before he could fully move forward with his future. This was also one of the goals that that he had tried to work through with different mental health professionals in the past, to little success. Narradrama allowed us to do this while still granting time and space to work on other therapeutic goals that arose such as mindfulness, interpersonal relationships, and defining boundaries and safe spaces both within and outside of therapy. Open and transparent communication in regards to the vast differences in our experiences due to our respective cis/ transness, as well as other cultural differences and similarities such as his being born in the city we were living in and I being a recent transplant, or both of us having strong opinions on intersectional feminism, among others, were important cross-cultural exchanges that assisted with growth and maintenance of the therapeutic

relationship. The atmosphere became one of openness and deep therapeutic work, which I will explore further in hopes of addressing my research question: How does a focus in cross-cultural counselling skills help a cisgender drama therapist work with a transgender individual in recovery for psychosis?

Definition of Terms

An important step of this work for me outside of the therapy sessions was to ensure that I was informed on up-to-date terminology in regards to how my client identified and the language that he used on a regular basis. Although much of it I was familiar with previous to our sessions I exerted efforts to ensure that, as terminology in regards to Lesbian, Gay, Bisexual, Transgender, Queer and Other (LGBTQ+) and other populations seems to be constantly evolving, I was maintaining my knowledge and education. I will now detail some of the key words/ phrases so that the reader may continue with a clarity of how these were defined and used in our sessions.

Gender Identity, according to Singh and dickey (2017), is how a person feels and sees themselves in regards to their gender. It is directly related to their sense of self and can change over time as one grows and gains life experience, among other factors. Cisgender is the term used to describe someone who feels that their gender aligns with the sex that they were assigned at birth (Markwick, p 331, 2016), and this is how I identify. A Gender Nonconforming (GNC) person is someone who does not seem to adhere to traditional societal definitions and expectations in regards to what is appropriate for their gender (Singh & dickey, 2017). Someone who is GNC may also use other labels to identify themselves, such as trans, gender expansive, or genderqueer, to name a select few. Transgender/ trans describes someone who does not feel that their gender is accurately represented by the sex that they were assigned at birth. This may mean

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that they identify themselves as a transman, which is how James' identifies, a transwoman, or by another label that better speaks to who they are.

When someone identifies as trans they may use different pronouns than what is expected, potentially using he when one may assume that they use she, or vice versa. They may also use a gender neutral pronoun such as they, xe, or ne. It has become common practice in some communities to ask what pronouns someone prefers prior to engaging in conversation, Markwick (2016) advises primary caregivers, "If you are not sure how someone identifies, then it is proper to ask in a respectful way and in a private place" (p 332). If this is not possible then using "they" or other gender neutral pronouns is also generally accepted until this action can be taken.

James also identifies as polyamorous and pansexual. Polyamory means that instead of practicing monogamy where one partakes in only one romantic relationship at a time, James is open to having multiple romantic relationships at one time (Merriam-Webster Dictionary, 2017). Pansexuality is the sexual attraction to people regardless of sex or gender identity.

Researcher Bias

Part of my work with this client was identifying my own biases when they appeared in our sessions, and working to ensure they did not influence my integrity, the quality of our work together, or the validity of this research. Although the client never asked how I identified, once stating that he did not want to intrude on boundaries that I was uncomfortable crossing with a client, I disclosed to him a couple pieces that I felt necessary. By practicing a certain amount of transparency I believe it allowed for more comfortable and open discussions when our experiences differed from one another. I let the client know that I identify as a cisgender woman, using the pronouns she/ her, while also comfortable with the pronoun they. I also disclosed that I was not originally from the area, meaning that I was not always as fully informed as he was on

the politics, cultural norms, or history that existed in this city or province. I also disclosed to the client that I have never personally experienced psychosis. The client was able to see, without me naming it, that I am White, fluent in English, able-bodied, and in my mid to late 20's.

Although this is a type of case study and one of my goals is to simply explain the therapy as it happened with as little researcher bias as possible, it is inevitable that my biases will to some extent influence my perception of what happened. Any of these named differences could produce a certain amount of unintentional bias on my part. Perhaps the most obvious researcher bias that may come into play is my own desire to promote drama therapy as a valuable tool, and psychotherapy in general as a necessary step for some people's healing process. Although my original hope was to display this research as neutrally as possible I now acknowledge that my perspective as a cisgender therapist will play an important part in how this study is told and how I addressed to cross-cultural topics which will be discussed.

Chapter 2: Review of the Literature

Culturally aware counselling is a concept that has been present for many years, and yet I still found it difficult to find adequate resources focusing specifically on LGBTQ+ populations. Here I will cover the main points that I found to be helpful within my process with James as I believe that many were written in order to address other forms of cultural differences can also be applied here. It is still worth noting that this is a piece of the counselling realm that requires more research and knowledge sharing among individuals who have gained this experience.

Cross-Cultural Counselling

Who we are, the culture that we identify ourselves with, and how that influences the way in which we, and others, see ourselves, is at the core of our identities and therefore naturally and consistently arises within therapeutic relationships. Although many of the studies done within the fields of cross-cultural counselling/ therapy focus on racial and ethnic cultural influences Hays (2016, p 7) notes that one must take into consideration a multitude of cultural influences on one's client's including age/ generation, developmental or other disability, religion/ spiritual orientation, ethnic and racial identity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. She also cites the American Psychological Association's (APA) guidance on best psychotherapy practices, which is, "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This suggests an open and inclusive approach to cross-cultural counselling skills, encouraging each therapist to essentially do the best with the tools they have. But how exactly does one do this? How can the therapist both respect the client and maintain the therapeutic goals, while still acknowledging

that there will always be cultural dynamics within the therapy space, and that the therapist is only human and therefore guaranteed to make mistakes?

Niño, Kissil, and Davey (2015) state:

(Therapists) need to learn how to connect across cultural differences to become culturally sensitive. Even though this has been recognized and accepted in extant literature … studies that specifically describe successful strategies therapists use to establish cross-cultural connections with clients continue to be sparse (p 123)

Due to this described lack within the field many therapists can find the idea of even just addressing the topics surrounding culture with clients daunting or intimidating (Cardemil & Battle, 2003; Burkard, Knox, Groen, Perez, & Hess, 2006). Despite this there are many within psychotherapy fields who do agree that it is the responsibility of the therapist to try to ensure a safe therapeutic space by creating an open and non-judgmental environment for cross-cultural discussions to occur, and one of the most important steps towards this goal is that they must be open to initiating these conversations because the clients may not (Ridley, & Mendoza, 1994; Blitz, 2006; Greene & Blitz, 2007; Mayor, 2012; Lee & Horvath, 2013). Williams (2016) even posits that both a readiness to participate in these conversations and constant self-examination of one's own biases and attitudes, "might be a rich opportunity to shift rigid social and societal narratives and deepen the therapeutic relationship" (p 14). Cardemil and Battle (2003) propose six suggestions to aid in the process of engaging openness in cross-cultural therapy which are:

1) Suspend preconceptions about clients' race/ethnicity and that of their family members, 2) Recognize that clients may be quite different from other members of their racial/ethnic group, 3) Consider how racial/ethnic differences between therapist and client might affect psychotherapy, 4) Acknowledge that power, privilege, and racism might affect interactions with

clients, 5) When in doubt about the importance of race and ethnicity in treatment, err on the side of discussion; be willing to take risks with clients, and 6) Keep learning (p 279)

Blitz (2006) agrees that the therapist is accountable to maintain their learning and education regarding cultural competencies, but then goes one step further by postulating that the therapist has a responsibility to educate their clients as well. She continues to explain that by utilizing psychodynamic tools therapists can expand their client's perceptions in order to promote antiracism and to work against other oppressive systems (p 261). Silverman, Smith, and Burns (2013) emphasize the importance of cross-cultural sensitivity education in a group setting, placing more responsibility on the therapist to create and maintain an environment which promotes inclusion of all cultures present and results in the therapist not being in an educator role, but facilitating open communication, learning, and connection among the group members themselves.

In order to create a space that feels safe enough to explore topics which can carry such weight therapist self-disclosure is sometimes utilized. Chang and Berk (2009) state that this can bridge distance created by power dynamics and cultural implications, and may even demonstrate common ground between the therapist and client, resulting in a strengthened relationship and promoting deeper work in the future. Burkard et al. (2006) had similar findings, reporting generally improved therapeutic relationships in cross-cultural counselling when therapist self-disclosure was employed (p 20). Watt-Jones (2010) is an advocate for location of self in therapy which is a more intense process that typical therapist self-disclosures where the therapist initiates an open conversation disclosing their own heritage, race, gender, sexual orientation, religion, or a multitude of other identifiers in order to collaboratively discuss how this may influence the therapeutic relationship/ process. By adhering to such an open attitude in regards to culture it can

show that the therapist is comfortable in discussing these topics, aware that they are important and essential in deep therapeutic work, and has now laid the foundation for them to be brought up again in the future by the therapist or client. Watt-Jones (2010), Chang and Berk (2009), and Burkard et al. (2006), all concede that further study is still needed in these areas and that there is, as with most therapeutic interventions, the possibility that it will not work as desired, and could require repair of the therapeutic relationship afterwards, or even result in termination on the part of the client.

The concept of cultural humility addresses that when mistakes happen or interventions do not produce a beneficial result it is the therapist's responsibility to address these situations with humility and openness (Shaw, 2017). Har-Gil (2010) notes that cultural competency, a model which has dipped in credibility over recent years, promotes the idea of a therapist gaining enough education and experience in regards to a certain culture to the point where the feel a certain mastery over it. Cultural competency, which has replaced the notion of cultural competency in many forums, allows the client to always be the expert in regards to their own culture, for even if the therapist knows a great deal about it everyone has their own unique relationship to their own culture (Isaacson, 2015). Respect, openness, transparency and remaining humble under all circumstances are the pillars of this model. This stance can be beneficial for many reasons, but perhaps the most important is that, "when clients viewed their counselors as high in cultural humility, those clients experienced much more improvement in counselling" (Shaw, 2017, p 44).

From just this first glimpse into cross-cultural psychotherapy there are obvious inconsistencies regarding the best practices for addressing cultural topics within therapy sessions. Based on this review of the literature it appears that the connecting factors between the literature are therapist education, humility, empathy, and openness, as well as the ability to create a safe

enough space to engage these issues. It appears that more research on these topics is required, hopefully resulting in further clarification. As Ridley and Mendoza (1994) state, "Because the literature on cultural sensitivity is at once massive, vague, and disorganized, professionals exposed to it for the first time react with confusion" (p 125). Through an ever-growing body of research and on-going hunger to provide the best possible care for the clients it is my hope for the psychotherapeutic community that it will one day find a confident and unified voice on the best-practices of cross-cultural counselling skills.

Trans Experiences Accessing Health Care

Although each individual will have a unique experience during their interactions with health care professionals examining the experiences of trans people in health care is a useful tool for understanding some of James' previously mentioned frustrations and trepidations. Wylie et al. (2016) note that although trans advocacy in health care in western cultures can trace back to the 1940's there are still many barriers that one can face when trying to obtain services, including fear of stigma and/or violence and less access to capable professionals (p 401). These among other obstacles can lead trans people to feel further disengaged from medical services and even more marginalized than is already common for members of a minority group (McCann and Sharek, 2016, p 280). For a group of people for whom disproportionate rates of anxiety, depression, substance abuse, and suicide are already prevalent (Gridley et. al, 2016), the lack of access to mental health services can have severe ramifications.

A study by McCann and Sharek (2016) that followed the experiences of seven transgender people looking to obtain therapeutic services states, "Participants wanted mental health professionals to be understanding, non-judgmental and to appreciate the person's unique experiences" (282). This is similar to the expectations set out by most people seeking counselling

services, and certainly at the core to most, if not all, therapeutic professions (American Psychological Association, 2016; North American Drama Therapy Association, 2003; UK Council for Psychotherapy, 2016). So why then, is it reported that the majority of transgender people report having negative experiences when they do try to utilize healthcare services (Transgender Equality Network Ireland, 2013), if their expectations and requests do not differ from the norm? The simple answer is that they more often than not feel disrespected and unheard by their health care professional, albeit often unintentional.

Two of the specific forms of disrespect, among many other, that have been reported are: not taking into account the importance of using preferred names, pronouns, and gender markers (Turban, Ferraiolo, Martin, & Olezeski, 2017) and accessing services that are uninformed and therefor thrust the transgender person into the role of educator (McCann & Sharek, 2016, p 284). Although acknowledging the importance of a word as small as "he" or "she" may seem inconsequential or trivial this is the wrong attitude to take. As the University of Wisconsin Lesbian, Gay, Bisexual, and Transgender Resource Centre (2017) states:

When someone is referred to with the wrong pronoun, it can make them feel disrespected, invalidated, dismissed, alienated, or dysphoric… It is a privilege to not have to worry about which pronoun someone is going to use for you based on how they perceive your gender. If you have this privilege, yet fail to respect someone else's gender identity, it is not only disrespectful and hurtful, but also oppressive (np)

As with much of the terminology previously addressed, putting in the effort to learn someone's preferred pronouns simply denotes the respect that people who are part not part of a sexual minority receive everyday.

To place the transgender service receiver in the role of educator is inappropriate for different reasons, but largely because that is not their job in this situation. If they are seeking the care of a professional then they are hoping to rely on the professional's expertise on the given subject, not be in the teacher position for the length of their appointment. Although I strongly believe, as reinforced by Marwick (2016) and as previously touched upon, trans education is lacking within health care professions, it is the responsibility of the professional and not of the client to rectify this. McCann and Sharek (2016) suggest that, "training programs should be guided by clearly defined competency frameworks and should include members of the transgender curriculum design, development, and delivery" (p 284). Until this change occurs and mental health professionals are exiting their professional programs better prepared I would also like to suggest that outside training programs or workshops are necessary. If this is not considered then the current risk of uneducated states which leads to unsafe, uninformed, and ultimately untrustworthy and therefore ineffectual therapeutic spaces will continue.

Psychosis

Psychosis in the Diagnostic and Statistical Manual of Mental Disorders, (5th ed.; DSM–5; American Psychiatric Association, 2013) is identified by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. Although James has been relatively stable, in the opinion of the drama therapist, since the beginning of their work together, having not experienced hallucinations or delusions within the past 9 months, these were symptoms to which he was previously familiar. James was diagnosed with psychosis NOS with cluster b traits in 2015, but currently holds a diagnosis of cyclothymic disorder (CD), a specific type of mood disorder where the person is, "chronically either elated or

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depressed, but for the first couple of years, they do not fulfill criteria for a manic, hypomanic, or major depressive episode" (Morrison, 2014, p 143).

Although James' relationship with psychosis and drama therapy as treatment for psychosis is not the crux of this paper I believe it important to briefly address as it informs the overall atmosphere of the clinic we were working in, the interventions that were used, and the themes that arose. There has been much debate on what is the most effective tool for treating psychosis, including medication, cognitive behavioral therapy, psychotherapy, and more (Butler, 2012; Carter, Read, Pyle, Law, & Morrison, 2017; Garrett, 2016; Keshavan, Lawler, Nasrallah, & Tandon, 2017; Lotterman, 2016). I will continue to overview how James and I utilized drama therapy specifically to help him navigate his complex relationship with psychosis, while also maintaining a cross cultural focus.

Drama Therapy and Narradrama

Drama therapy is an approach to psychotherapy which can utilize embodiment, theatre processes, play therapy techniques, talking interventions, other forms of creative arts (visual art, music, creative writing, dance/ movement, etc.) or a combination of all of these and more. "This approach can provide the context for participants to tell their stories, set goals and solve problems, express feelings, or achieve catharsis" (NADTA, 2017, np). It is a diverse field that different clinicians are able to interpret in vastly different ways, the same as many other forms of psychotherapy.

The majority of the work that I engaged with James was Narradramatic in nature. Narradrama is a type of drama therapy that partially stems from Narrative Therapy. They are both based in the idea that, as Dunne (2009) puts it:

The stories we tell ourselves about our own lives determine which events we consider important, our self-narrative determines how we interpret our experiences… as people become aware of different stories in their lives, they decide which stories to hold on to and build their lives on… what we emphasize or omit has real effects on the teller and often on the listener (p 172)

Dunne (2009) continues to note that the primary difference between Narradrama and Narrative Therapy is that Narrative Therapy is primarily talk therapy, while Narradrama incorporates creative arts and the cornerstones of drama therapy such as externalization, embodiment, role exploration, and interpersonal connection. The eight steps to the Narradrama process are, 1) Warming up to New Descriptions of Self Identity and Environment, 2) Externalizing the problem, 3) Possibility of Extension, 4) Externalizing choices, 5) Invite Personal Agency, 6) Alternative Stories and Unique Outcomes, 7) Restory life, and 8) Closure, Reflection, and Rituals (Dunne, 2009, p 183).

As Treatment for Psychosis. It is suggested that one of the strengths of utilizing Narrative Therapy with someone with a psychotic disorder, is that the diagnosis or the label is not able to truly encompass who the person is (Guilfoyle, 2014). This is similar to the argument Reisman (2016) makes towards utilizing drama therapy, stating that its' ability to reduce self-stigmatization and increase self-esteem by allowing the patients to play out strong, self-reliant, and empowered roles, as opposed to the "outcast" role where they tend to live is a strong catalyst for healing (p 93). Dunne's (2009) conceptualization of role exploration with Narradrama calls upon Landy (2008) and his *Taxonomy of Roles,* noting how his categorization of different roles can also be seen Narradramtically as problem-saturated roles, unique outcome roles, alternative roles, and preferred roles. Focusing on exactly what these roles mean to each individual

encourages the search for alternative solutions to old problems, new possibilities, and preferred paths for the future.

Dunne (2009) also posits that many people who search out therapy, regardless of diagnosis, do so because they feel trapped by the negative associations with their own identities and are unable to retain their sense of self. In Narradrama terms they are stuck in their problem saturated story. I would suggest that living with a narrative where your psychosis was a meaningless void in your life, stealing part of who you are, is a problem saturated story. By restorying it, finding the alternative narrative as one does through Narradrama, perhaps one focused on themes of growth, resilience, and strength which often arise when clients speak of their journeys with psychosis (Connell, Schweitzer, & King,2015), clients can discover the meaning they need to attribute to this experience it in order to integrate it as an important, yet not all encompassing, part of their life and identity.

Drama Therapy and Cross-Cultural Counselling. I believe that cross cultural humility is an important part of any therapy process, but I also believe that due to the flexible and malleable nature of drama therapy it is specially qualified to make space for such large and sometimes intimidating topics. Although drama therapy often borrows from related fields for the best practices in cross-cultural counselling there is also some strong research that exists within our own field.

Mayor (2012) addresses the *Three Approaches to Drama Therapy* (New York University, 2005) video, a drama therapy teaching tool which features two male and one female white drama therapists/ professors, and a black male drama therapy student, named Derek, in the client role. Mayor states:

Interestingly, it may have been the racial play, viewed by some as offensive, which allowed Derek to play with the seemingly deeper material of his traumatic history and relationship with his father. In playing with taboo topics like race, therapists may indicate to clients their ability to play with more personal issues, and the session may shift in a new direction that becomes more intimate. (p 218)

It is maintained that this example is not universal to all drama therapy sessions or clients, but does illustrate how potentially difficult cultural topics can be brought into drama therapy and played with in such a way that it is beneficial to the client, leading to deeper overall work. It seems to say that if a therapist is able to see, hold, and address something as huge as all of the implications that can come with race, then there is potentially no limit in what they are able to explore with their client.

Chandrasegaram (2009) speaks to utilizing drama therapy in Malaysia, a culturally diverse country, and emphasizes transparency in the therapist's knowledge, and lack thereof, in regards to different cultures, allowing for a place of humility and learning on the part of the therapist, and a sense of mastery on the part of the client (p 11). She continues to say that the process of educating the therapist is generally an experience of empowerment and beauty. This open, non-judgmental way of engaging in drama therapy via cultural humility is described as a challenge that is one of the best ways for this drama therapist to connect with their culturally diverse clientele.

In a study by Beauregard, Stone, Trytan, & Sajnani, (2016) where a survey was conducted across North America in hopes of determining the attitudes and implications of drama therapists working with lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) and gender nonconforming (GNC) communities it is stated, "While… the majority of drama

therapists are open, affirming and comfortable working with LGBTQI and GNC communities, it is also clear that more training and supervision is needed to better connect attitudes with actions" (p 58). Throughout the study it became clear that not all drama therapist who participated were educated on these topics, for example showing that many working drama therapists are still unaware of what the term "cisgender" means. It was posited that the reason for this was a lack of education and research available. This postulation is supported by Flickinger (2014) who stated great difficulties in finding drama therapy literature on LGBTQ populations in order to complete his thesis research. This is a similar experience to my own when I went in search of literature to help guide me at the beginning of my sessions with James. While it is important that discussions are happening in regards to counselling with LGBTQI populations, a gap has been discovered within the cross-cultural counselling skills within drama therapy.

Although we can see the field of drama therapy taking strong steps towards inclusive and open discussions, both with clients and between practitioners, there is still a lot of room for growth. In a world that is constantly moving and changing it can be difficult to feel as though we are keeping up to where we need to be, but it is important that we ensure our clients are receiving the best care we are able to give, and therefore strive for growth to meet them where they're at. Through this ongoing discussion and critique of the field of drama therapy it appears to be motivated and therefore growing, at least little by little.

Narradrama and Cross-Cultural Counselling. When living in a society so full of stories, whether in the books we read, the television we watch, or as simply as the way we learn to type (the quick red fox jumps over the lazy brown dog…), we are constantly subjected to the stories of the dominant culture (Freedman & Combs, 1996). "As stories help people to give structure and meaning to life, then individuals, who are influenced by the greater culture, also

maintain this imposed dominant narrative through the self-narratives they tell and thereby live"

(Wilson, 2011, p 8). One of the reasons Narradrama spoke so strongly to me when working with

this client is because of the opportunity for James to tell his own story, as truthfully as he wanted

to, disregarding the societal Narratives if that felt more right to him. Dunne (2009) states:

Narrative always emphasizes collaboration and respect between participant and

therapist… (it) inherently fosters respect for cultural minorities, children, and women…

meaning and values emerge through the interaction between participant and facilitator, so the

Narrative therapist endeavors do not reinforce the dominant culture or system (p 173)

She continues to say that a power differential is unavoidable in therapy relationships, but

because of this collaboration it becomes smaller than it could be, and actively works to minimize

this so that a strong, respectful therapeutic relationship can blossom.

Tomczyk (2015) details how using narrative tools in drama therapy can enable LGBTQ

populations to challenge the overarching and wide reaching straight and cisgender narratives in

our western society. This can help them to address historical and current inequalities and

prejudices, and to examine the questions of who defines what "normal" is, how that is

maintained in a society, and how can we work to change it. By giving James' the freedom to

write his own story, as will be later detailed in both the social atom intervention and the time line

intervention, he told his story exclusively from his point of view. Not only did his feelings and

perspectives take precedence over any others when speaking of injustices he had faced, but it

allowed him to define, explain, and share what normal was for him. It granted me, the drama

therapist, a deeper understanding of my client and a very concrete glimpse into what his day to

day reality is, how different it from my own as a straight, cisgender person, and also how unique

it is from others who may identify the same or similarly to him.

Chapter 3: Methodology

Why choose this type of research, and how was it conducted? In order to answer the proposed research question I completed a qualitative study utilizing an instrumental first person single case review design format. It was my hope that creating a well-designed and stimulating instrumental case study would be able to add literature in an area where currently little exists, as has been previously discussed. Much of the small amount of research that I was able to find on Drama Therapy and psychosis was dated and, although still useful, I was, at times, frustrated while searching for relevant, contemporary guidance. For resources on trans cross-cultural counselling skills I found that new literature is coming to light more and more, but there still wasn't as much as I had hoped for being a new therapist looking for aid from those with more experience and knowledge than I. These were the leading factors that pushed me to write about my own, current experience working with a client in this program, the hope being that I will be able to leave a bit of a record of what I discovered in my months of exploration, trial, and error. Creswell (2014) states:

One of the chief reasons for conducting a qualitative study is that the study is exploratory. This usually means that not much has been written about the topic or the population being studied, and the researcher seeks to listen to participants and build an understanding based on what is heard. (p 51)

For the above reasons, I chose to do an exploratory, qualitative study as opposed to utilizing a quantitative method.

Continuing to narrow the focus I developed an interest in case study research. A case study, as defined by Yin (2003), is, "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon

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and context are not clearly evident" (p 13). The seemingly perfect conduit to present my experience of what drama therapy (the phenomenon) looks like with a client in an early psychosis intervention program (the context). Furthermore, as I am mainly examining specifically the transgender/ cisgender dynamics which came into prevalence, this type of case study would fall within an instrumental case study definition, as it is utilizing the case in order to better understand this very particular phenomenon, as opposed to simply an interest in the case itself (Grandy, 2010).

I strongly believe that at this stage in the development of drama therapy as a greater field case studies are of utmost value. One the strengths of case study research is the profoundly in-depth picture that it is able to provide of an experience. This may lead to redefining previous assumptions, increased understanding of phenomenon and context, and open a doorway to further research (Flyvbjerg, 2011, p 314). Case studies not only provide building blocks for a developing field, but are incredible tools for furthering our knowledge of how a field works in unique circumstances, which is particularly prevalent to drama therapy as I would posit that every client we work with through a career will be their own unique case unto themselves.

Ethical Considerations

The topic of ethical considerations in case study research can seem daunting, but it is suggested that if a relationship of respect and trust is developed between the researcher and participant then at least one large part of these considerations will be taken care of (Simons, 2012, p 96).

There is a plethora of difficult situations that may arise when research involves human participants, including but not limited to: the participant changing their mind about what they are willing to do or what they are willing to submit to public record despite previous consent forms

or waivers, unexpected termination of participation, or the participant actively skewing the results in order to make themselves appear better in certain lights. Although none of these problems may have an obvious, clear-cut solution, Simons (2012) posits that when an attitude of openness and respect is adopted first and foremost, while always keeping in mind the clear moral code to "do no harm", then your ethical integrity will remain intact.

As someone who is doing a case with the utilization of a form of therapy, it is important to constantly be cognizant of the ethical codes to which our field holds us accountable. Two of the North America Drama Therapy Association's Code of Ethical Principles' (2013) that appear of utmost relevance and importance to me are, the therapeutic objective must always take precedence, despite the potentially unethical nature of the dual relationship of being a drama therapist and a researcher, and maintaining the integrity of the client's character via confidentiality practices. In this study all names and distinguishing details have been anonymized, and consent has been granted by the participant. The area more likely to cause friction within a case study/ therapy setting is the dual relationship of being both a researcher and a therapist. It is a common critique of the case study methodology that there is a tendency for the researcher to bias the study in order to get the desired results (Flyvbjerg, 2011, p 309). It could be argued that for a therapist this could even come to fruition through subconscious means in the therapy space, leading the client towards a forgone conclusion whether it is of benefit to the client or not. Redhouse (2015) states, "As a therapist one's emphasis is on the well-being of the client at all times, while as a researcher there is a concern to collect data that can contribute to our overall understandings about dramatherapy" (p 70). For my own process I was continually checking with myself on why I was bringing in specific interventions into the therapy space, and if they were truly the best choice for the James' journey. I also examined how my bias was

showing up and developing inside of me, as previously discussed, and tried to allow myself room for mistakes to happen, as they are bound to, and working towards repair with the client when necessary. I maintained this "continual check" by partaking in in-depth bi-weekly discussions alternating between my academic clinical supervisor and on-site clinical supervisor, in order to both clarify my own thoughts and to obtain their opinions about the process. By utilizing both supervisors in this way I also think I obtained multiple points of view and developed a more well-rounded therapy practice, one supervisor specializing in culturally diverse clients within drama therapy, and the other specializing in clients with diagnoses of psychosis.

Data

Yin (2009) suggests that there are six sources of evidence for case study research, they are: Documentation, archival records, interviews, direct observations, participant observation, and physical artifacts. For my research I used all of these types except for documentation, participant observation, and interviews. For archival records I utilized the information that was available to me through the client's records at the mental health facility, and for direct observations the meticulously recorded in a journal I kept by throughout the sessions. Physical artifacts in this context refer to anything that the client wrote, drew, or otherwise created within the therapy space, which will be exemplified later on. Although this is an instrumental case study focusing particularly on cross-cultural counselling dynamics I found that my strategy for data collection was to simply gather as much as possible whether it appeared directly related or not. Sorting the data into more and less relevant categories as per my research focus came into play during the analysis portion of this research, which will be further discussed later.

The Process

In order to address this method in an organic yet structured way I pulled from Redhouse (2015) who has explained the Therapeutic Narrative Analysis model (Aldridge & Aldridge, 2008) five distinct phases as such:

Phase 1: Gathering the material that will form the narrative.

Phase 2: Defining the setting in which the narrative occurred and within other theoretical ideas.

Phase 3: Identifying episodes for analysis.

Phase 4: Analyzing the episodes according to contents and framework of constructs.

Phase 5: Synthesizing interpretations to form a therapeutic narrative (PAGE)

Phase 1 was simply partaking in the predetermined weekly therapy sessions, while gathering the previously mentioned data in the form of journaling, record reading, and collecting of any created materials. Phase 2 began to take place closer to the end of the therapeutic journey when the prominent themes related to cross-cultural counselling had been strongly presented, and could be firmly located within drama therapy, creative arts therapies, or other relevant fields. Some of phase two was completed prior to the beginning of therapy. As was previously discussed there was some literature that was researched and taken into account when I first began working with this population. Phases 3 and 4 are the data analysis, to be discussed in an upcoming section, and Phase 5 is, of course, this final written documentation of the instrumental case review.

I set in place a boundary that should any ethical boundaries be crossed during this process the therapist will pause the research component of the therapeutic process and seek supervision, although this did not come into play throughout this journey. I believe that by allowing for an

organic therapeutic process to develop while remaining aware of potential researcher biases and potential ethical dilemmas the Therapeutic Narrative Analysis model allowed for the balance of freedom and structure to cultivate the strongest clinical case review possible.

Data Analysis

It has been suggested that the analysis is one of the most difficult parts of conducting case study research as, unlike most quantitative forms, there are no statistical procedures or maps to follow which can tell you exactly what you're looking at (Yin, 2003). For guidance I again turn my attentions back towards qualitative research as a whole, and the closely related data analysis methods described by Creswell (2014). It is suggested that after reading through and looking at all of the raw data the researcher begins the organization process of coding. To do this Creswell (2014) quotes Tesch's (1990) Eight Steps in the Coding Process where all documents are looked through and categorized by similar topics and themes that arise, for me this was specifically topics and themes relating to cis/ trans dynamics and cultural counselling skills. Although not all of Tech's (1990) steps will be applicable to my process something important to retain is that one should consider the subtext of a document as opposed to just the text. In this way the codes that are extracted will reflect a more universal and profound theme, as opposed to taking things at face value. I posit that in a modality where metaphor is so often employed this very valuable throughout the coding process. Creswell (2014) also notes that codes on expected topics as well as surprising ones that were perhaps not previously projected are important to note in the final analysis. After coding the entirety of the data I selected the interventions and sessions that appeared to be the most relevant to my focus and which held the most weight for the client, as defined by either a conversation we had while reviewing the therapy process as part of our termination, other direct statements he made throughout sessions, cycles that seemed to appear

within the sessions, or his perceived emotional investment. I think that asking the client to have a conversation in regards to important themes was very important as coding is an arguably biased procedure as the researcher only has their own perspective, and is analyzing the whole history of the therapeutic process with a knowledge of what may be relevant to their field, and may therefore skew the data, consciously or subconsciously. Taking this conversation into deep consideration during the analysis process was certainly key for my research process, in hopes of both negating some of my bias as well as to ensure that in this write-up I represent the clients experience to the best of my ability, maintaining our relationship built on respect and therefore ensuring the previously discussed ethical integrity.

Chapter 4: Summary of the Therapeutic Process

Although I named Narradrama as my primary influence through this drama therapy process there were multiple interventions used throughout the eight-months. I will now summarize two which display some key themes which arose from our sessions, and exemplify the importance of cross cultural counselling skills. Before speaking to these interventions I will touch on the importance that cultural humility regarding pronouns played in creating a safe enough space in order to do this work.

Pronouns

As my client stated in one mid-therapy session, he had previous experiences with cisgender mental health professionals who displayed what he felt was uncomfortableness with having a trans client. This perception arose due to James picking up on by their lack of LGBTQ+ knowledge and misuse of his pronouns. Although James would inform his team when his pronouns changed, as they did twice while he was at the clinic, first from her/ she to them/ they and then finally to his/ he, he found he was constantly correcting people who he felt did not give his transness its due importance. As a result when he came into the drama therapy office for the first time he was fearful that it could be another frustrating experience, a waste of time or, even more concerning, it could even lead him to digress from the progress he had made in finding his true identity. Fortunately James was reassured within the first 60 seconds of the assessment interview when I asked him what his preferred pronoun was, and I then responded by telling him my own. It has been previously discussed why pronouns are so important to culturally competent work, and James affirmed this by later reporting to me that he had found it refreshing to come into a space with someone who was comfortable enough with these concepts to invite them into the space immediately. He noted that even though he is appreciative of the clinic we were

working within, where many clinicians are working very hard to update their language and best practices in regards to LBGTQ+ populations, it spoke volumes that with me he may not have to take the educator role as much or potentially at all. Even though it was literally one of the first interactions between us it thrust us forward in our therapeutic relationship, already initiating a trusting bond. By continuing to respect his pronouns and subsequent name change I continuously reaffirmed my support for my client of who he is and how his culture, although different from my own, is still totally valid and important in the context of our sessions.

Stating this, I was not without mistakes. There was one particular session, about midway through the therapy, where I could not seem to get a single pronoun correct. The client and I were discussing his social atom, an intervention to be discussed shortly, which examines an individual's social relationships. I seemed to continuously and repetitively misgender every single person that we spoke about in his life. James would correct me, to which I would apologize and rephrase my sentence with the correct pronouns, before seeming to have the exact same interaction immediately preceding. The session ended and I was appalled by what I deemed my own incompetence in respecting James, the people in his life, and GNC people at large. I thought about this interaction a great deal until the following week. One of the first things I did in our next session was apologize again to James, noting that I wasn't sure if I was tired, out of focus, or what was happening, but I was truly sorry that I came across as so ignorant in the previous session. I was hoping that by owning up to my ignorance I would be able to repair some of the perceived damage. Isaacson (2014) supports this notion by explaining that the practice of cultural humility is not to be without fault or to have a sense of expertise over another culture, but instead being humble enough to admit when a mistake has been made or there is something the therapist does not know. James' response was surprising to me, and yet very in line with the

cited literature as well as his compassionate personality. He stated that he had barely thought about it after the session ended. Although constantly correcting his therapist was not ideal he also knew that that was not my normal demeanor and I had listened to him and apologized each time I made a mistake, giving the misgendered pronoun a bit of space an importance rather than pushing it away, ignoring it, and not valuing its significance. As a cisgender person it could have been very easy to forget how important a pronoun is to someone who doesn't have the privilege of being correctly gendered based on assumptions, but the fact that I knew this and acknowledged it by taking responsibility for my mistakes was very important. He had essentially forgiven me in the moment, allotting me the same respect, empathy, and non-judgmental attitude that I had tried to show him throughout our sessions. I truly believe that by following a cultural humility model we were able to jointly create a culturally open space which resulted in our strong therapeutic relationship and led James to know that, even when I make mistakes, I'm always on his team. Turban, Ferraiolo, Martin, and Olezeski (2017) note how important it is for trans clients to truly feel that their mental health team is on their side. This feeling results from encounters based in mutual respect and innate inclusiveness on the part of the therapist, and are key elements to developing culturally competent and effective therapy spaces.

Social Atom

The first of the two interventions I will look at is the social atom. I was initially drawn to bring this into sessions because James, although noting in the second session that he was a very creative person and had been involved in dramatic arts for years, was afraid to play a character in the context of our sessions. He was worried that he could feel too close to a role and then become psychotic again, not being able to distinguish himself from the role. The social atom encourages engagement with reality and social relationships, therefore focusing on what he was concretely

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experiencing in his everyday life as opposed to jumping straight into imaginative play. He displayed a lot of engagement with this intervention, which lead me to realize that we needed to start at the opposite place from where he wanted to go. Beginning in reality and moving closer to a place where imagination, fiction, and characters were at a later date when he genuinely felt ready.

Simply explained the social atom is the process of using a shape, commonly a circle, written on a paper for a client to represent themselves, followed by drawing more circle representative of other people in their lives leading to the opportunity for the client can to delve into these relationships, exploring any aspect they feel they need to (Jones, 2007, p 297). It is in essence a map of their social world. Although the social atom was developed by Moreno (1941), this also reminded me of how Dunne (2009) speaks to Michael White's (1989) Narrative Therapy technique of *re-membering*. She notes that it is the idea that people's identities are shaped by the social world that we locate ourselves within, the voices of those within our world speak to us throughout our lives, influencing us both positively and negatively, and our agency over who we let into this world can sometimes be lost, leading us to forget that we have the power to expel negative entities and increase the positive (p 175). By examining these social relationships we can gain deeper insight into who we are and the difficulties that face us.

By drawing out his life in terms of social relationships James was able to have a concrete representation of something strong and present in his reality, but it also started to become an assessment for himself where he enjoyed looking at growth and progress in his life. Jones (2007) states that it is most often employed as a means of assessment for the therapist to gain information on the client, and this was certainly true for me in terms of James' social relationships, but also into what polyamory meant to him. As with the other cultural differences

between James and I, I had made sure to have some background knowledge in these topics, but as with every piece of an individual's cultural background, the way they interpret it and how it is incorporated into their unique lifestyle is of utmost importance. Just because I knew what different articles and interviewees said about polyamory, did not mean that I knew what it meant to James. By first normalizing it with an intervention such as social atom which is highly adaptable to many different social structures, and then giving him the free, non-judgmental space to show exactly what his world looked like I was able to learn a great deal about how James fits into his world.

This intervention also spoke deeply to James who stated that seeing his social world laid out this way was deeply clarifying, both about the people he surrounded himself with, how he addresses relationships in his life, and how he might want to grow or change. He asked twice after the initial social atom if he could do others as a way for him to see this change and growth manifesting in his life. It also ended up being a very literal representation we could use to view his gender journey through our therapeutic time together. Cumulatively he did three social atoms, one at the beginning, one at about the half way point, and one at the end of the therapy process, all three of which I will discuss, further digging into the cross cultural aspects.

First social atom. In James' first social atom, done on our second session together, he was still referring to himself by his dead name and the page was completely filled with names of his romantic partners, friends, acquaintances, old relationships, new relationships, people that he had lost touch with, people that caused him distress and more. The page had a lot of notes, arrows connecting who was related to who, scribbles, and highlighted portions. It short, in my opinion, it looked complicated and messy. James spent a great deal of time during this session focusing on who each of these people were, how he knew them, and how they related to each

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other. I believe that at this time James was partially still testing me, to see if I was okay with discussion of something like polyamory which can be viewed as out of the norm. He also extended help to me by writing down everyone's preferred pronoun beside their name so that I was able to properly speak about them. He was still using our session time to test the waters, to find the extent my abilities to accept and discuss all the different parts of his life despite the fact that they may be different from my own. By maintaining my cultural humility and an air of respectful curiosity while utilizing my prior knowledge in regards to these topics I was able to continue the development of our therapeutic relationship.

When we came to the end of this session and were reviewing the work that had been done he used the words/ phrases, "Chaotic, forced, baggage, connections with each other versus connections with me, need to feel *me* enough" in order to describe it. Naming these key words/ phrases that resonated with him through this intervention would become one of the key methods of analysis we used when looking back and forth between this social atom and the next two he would create.

Second social atom. The second social atom was something James requested to do when he changed his name as this symbolized a shift in many areas of his life, to which I gladly accepted and included in our session. He wrote 'James' at the center of the page all in capitals and with a circle around it. He stated how good it felt to see this name at the center of his social atom instead of his dead name, and that it really emphasized how he was beginning to take real ownership over his name and his true identity. It is worth noting that this also occurred shortly after he came out to the majority of his family as trans. It was a big time in his life for change and transitions, and the social atom reflected this. He did not include as many people, noting that he hoped that this upcoming year he could be more focused on certain relationships that were

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important to him, and he did include much of his family who were not included on the first atom. When talking about the different relations this time he was very focused on what they meant to him and what *his* relationship was like with them, as opposed to before when he focused a lot on who they were separate of him. He noted that moving forward he wanted to focus on what a strong relationship could be absent of sex, noting that many times when he tries to engage in friendships he ends up bringing a sexual component into it. He stated that he was unsure of why he always did this, but wanted to experience what it was like to be confident enough that he was interesting and engaging enough to spend time with even when a sexual component was off the table. A great deal of time was spent focusing on one of his partners with whom he was experiencing difficulties, and his frustrations in regards to them. Together we explored how he thought they might respond to the different ways he could approach these frustrations with them utilizing more imaginative work than he had been comfortable with before, practicing what he could say to them, how they may respond, and back and forth.

In this session he also spoke about his relationship with his parents with whom he was feeling a lot of conflicting feelings towards since his coming out. Together we explored both what he was feeling and what his parents may be feeling. We focused largely on how although these emotions may be contradictory they could all be valid and appropriate for the situation. He stated that it was hard to imagine being them and coming from a place where trans education was not a part of everyday life growing up, as he felt it had been for him, especially once he began in middle school. This was the first time of many where we initiated in conversations that validated both frustration and pain from his point of view, and the difficulties and timeliness of LGBTQ+ education some people can experience. In review the phrase he found to describe what he saw while looking at the atom was simply, "Work in progress." I believe that this phrase reflected

both his blossoming confidence with his transness, as well as his relational work with the people in his life, among other nuanced themes.

The previous work that had been done to strengthen the therapeutic relationship and relay that no matter what topics arose in the sessions I, the drama therapist, would always be on the side of the client allowed the client to bring in a lot of different topics in this session. By ensuring that my biases as a cisgender person who did not receive any education on trans topics until I was in my undergraduate degree, much later in life than James, were not interfering with the session I think we were both able to leave behind defensiveness and engage in deep, meaningful and non-judgmental work. For example James knew that although he, his parents, and I all had different experiences in trans education and how we currently relate to these topics, he and I could engage in these conversations and unpack his emotions with respect, openness, and understanding. As well we could talk about his partners without judgement or an excess of questions on polyamory, as well as sexual relationships in general without worry of inappropriate questions arising regarding anatomy or transness. Turban, Ferraiolo, Martin, and Olezeski (2017) note that health professionals who ask a client about their genitals or sexual practices without it being medically necessary are doing a true disservice creating awkward, uncomfortable, and therapeutically distancing environments. They note that something so deeply private would not be asked of a cisgender individual and that having or fear of having experiences like this may be one of the reasons that GNC people sometimes avoid seeking services at all. By having this as knowledge prior to the session I was able to bypass any awkward moments that may have come to be if I was hoping to solely fulfill any curiosities I may have had, and we were able to focus on what was actually important to James.

Third social atom. His final social atom was completed on the second to last session. This one had "ME" at the center with approximately the same number of people surrounding him as in the second atom. Some names were the same and some were different, he did not write down the names of his family as he had on the second atom, noting that he didn't feel the need to as his bond with them would always be there, unspoken yet strong. He excluded the previously mentioned partner, noting that he felt so relieved that he had ended up breaking up with them and subtracted such a negative influence in his life. He stated that that is where he hopes his future atom will continue to grow, removing negative influences and encouraging positive ones. Comparing this atom to his previous two he noted that he has started thinking more about himself, what it really means to put himself at the center of his world instead of other people, their needs, and their relationships. One of the ways he described this social atom was, "Letting go of things I don't have to be." In relation to the first social atom he created James noted that he now realizes that he was constantly feeling as though he needed to prove himself, as previously stated "needed to feel me enough" as though he needed to be trans enough, activist enough, polyamorous enough, or any number of other descriptors enough. Now, seeing them side by side, he was struck by how he was really able to see this and acknowledge his growth towards being enough just as he is, without needing to prove this. He said that he is not totally there yet, but he can see this growth and knows that this is how he wants to continue. Other descriptions he attributed to this social atom were, fresh, exciting, unlimited, unconfined, friends, in between states are worthwhile, and we write our own scripts.

By stepping into James' shoes and really taking stock of what "letting go of things I don't have to be" could mean to him I was employing cross-cultural counselling skills of suspending any preconceptions about my client's identity (Cardemil & Battle, 2003). By letting go of all of

the knowledge that I had gained, the definitions and theory, I was able to see this statement for what it was. I was able to empathize with this person who I had the pleasure of getting to work with for many months and I knew that it spoke to a deep part of his personality that existed despite all of the labels that were pushed upon him, or even the labels that he liked and had a sense of ownership over. This phrase spoke to his desire to simply be himself. This person who had felt pressure to conform to what it means to be a girl or a boy, a daughter or son, a student, a romantic partner, a friend, an artist, an activist, and a plethora of other things, simply wanted to be enough as he was. As they chose to define and inhibit all of these roles. By first doing all of the work, educating myself, bringing curiosity and discussions on cultural differences into the session, and creating a safe enough space for us both, I was then able to let it all slide away for a moment and appreciate this unique individual in front of me; And my hope is that because of all of this work he was able to do the same, knowing that despite his knowledge of what all of these different aspects he identifies as are defined as, how he represents them in his own way is exactly enough, and exactly how they're supposed to be.

Timeline

The last piece of our therapy process that I will touch on is what I deemed the "Timeline" intervention. I first encountered this as an exercise in one of my first university acting classes during my undergraduate degree. We were asked to imagine a timeline stretching from one end of the room to the other, the beginning of our life on one side and the present day on the other, and we walked the line, stopping at different, important moments in our lives to help display how we got to where we are today (Henderson, 2007). James noted that although he was very motivated to explore the story of his psychosis he was also very afraid to jump into it. Connell,

Schweitzer, & King's (2015) study exemplifies that this can be a common feeling for those who have experienced psychosis:

> The drive to make meaning from the experience and position it within a broader, coherent life narrative also underpins the process of consolidation of self after trauma. Those participants progressing in their recovery actively sought to "gain something" from their psychotic experience and render it comprehensible and controllable, consistent with concepts of posttraumatic growth (p 363)

Taking this into consideration I suggested that we begin with an embodied timeline, but we started it from the very beginning of his life up until the age of approximately 13 years. In this sense we were framing the traumatic experience, his experience with psychosis, having already talked about his present day life and now looking at the pre-trauma life we were giving it a border, hopefully, in my opinion, to give more structure and safety to this process. As well, because it wasn't until he was 13 when he said that he experienced "full blown psychosis" we were able to use the first 13 years to examine other important moments in his life, specifically those related to his gender and sexuality.

One of the modifications we made for this intervention was to create a four-pronged timeline. From the ages of 0 – 13 it was one timeline, but when his psychosis began to take hold we split the timeline into: psychosis, gender and sexuality, social, and logistical. In this way we were given the option to switch which element of the timeline we were looking at if one became overwhelming. For example, at one point in the psychosis timeline James was describing a period where he was experiencing a lot of stress and chaos, often feeling as though he was being asked to undertake more than should be asked of someone in their early teens. With so much happening in this world we made a shift into his "logistical world" and spent a few minutes

speaking about the grade he was in, the school, a French teacher he remembered, the music he liked to listen to, and his annoyance, which still remained, at the dress code that the school enforced. By being able to switch back into things very grounded in reality we maintained a sense of groundedness. No matter what was happening in the psychosis world we would not float away into that world completely, because we three other prongs to anchor us.

Although the primary focus of this intervention was on James' psychosis I think it important to mention in the context of this research focusing on culturally competent counselling skills. Having the "gender and sexuality" prong running parallel to the three others acknowledged that this is a very important part of his life and always has been, despite the fact that other aspects of his identity sometimes draw more focus. As we dug through the mass of content related to his experiences with psychosis we were also able to track everything from his initial dislike of the color pink at a young age, due to what it was starting to represent for him, all the way up to future goals, the timeline that continued into the next 5 years, where he hoped to make greater strides in altering his wardrobe to better reflect who he is, where he looked forward introducing himself to people who will only every know him as James and not have the background of his dead name, and potentially beginning gender affirmative treatments.

The client noted that it made him feel more safe to have these options, and too see them written down so concretely on a piece of paper. It made the psychosis seem less scary and more like something he had a sense of agency over. If that wasn't what he wanted to remember about that point in his life then he didn't have to, he was part of a whole, big world at the same time that all of that had been happening, and if he wanted he could choose to remember that instead. In the end the client ended up detailing his whole life, including his entire experience with

psychosis and his hopes and goals for the next year of his life after the end of the therapy sessions.

Mizock and Fleming (2011) advocate that it is important to validate the gender identity of someone with psychosis noting, "Denial of the presenting gender identity of the patient by treatment staff may only add stress to the disposition, interfering with a treatment alliance, and pose additional barriers to treatment" (p 212). By allowing this room to explore James' gender and sexuality along side his psychosis I was able to validate how important this part of his identity is, while concurrently addressing other therapeutic goals. It became something that was always present in our sessions, and yet did not dominate and become the only part of his identity that we examined. By finding the balance of all of the different aspects of his identity we were able to create an open, respectful, and effective therapeutic space.

Chapter 5: Discussion

In order to properly discuss this case study I will recall my research question: How does a focus in cross-cultural counselling skills help a cisgender drama therapist work with a transgender individual in recovery for psychosis? Although I did not always act in an ideal manner, making mistakes related to pronouns or other pitfalls, I constantly and consciously engaged in making cross-cultural counselling skills and cultural humility cornerstones of this therapy process. This proved to not only beneficial for James as someone who identifies as LGBTQ+ but also for someone who has a comorbid diagnosis related to psychosis as well. Hellman, Klein, Huygen, Chew, and Uttaro's (2010) study of of LGBT populations in treatment for major mental illness, including 35% of whom lived with psychosis, who partook in a culturally focused advocacy program stated, "a majority of study participants reported improved compliance with psychiatric treatment, psychiatric symptoms, maintenance of sobriety, relationships, self-esteem, stress-tolerance, and hopefulness" (p 13). Would James have been able to do as deep or engaged therapeutic work without this specific cross-cultural focus? Based on his past experiences with mental health professionals who did not I would be inclined to say no, although there is no way to know this definitively. I do believe that focusing in culturally competent counselling through this process aided exponentially in the development of our therapeutic relationship, which in turn allowed James to feel safe enough to do the other work that needed to be done.

Using a drama therapy, specifically narradrama, also turned out to be a positive step in this research, allotting the freedom and space to alter interventions to James' specific needs. Drama therapy, as was previously discussed, innately welcomes cultural differences and collaborations between therapist and client in a way that we utilized immensely in this case

study. This case had a generally positive outcome, the work that we were able to do via culturally

aware drama therapeutic means was beneficial for James, and I believe that in the future it could

be for other people searching for psychotherapeutic treatment options as well.

Chapter 6: Conclusion

Although there seems to be an ever developing array of literature on cross-cultural counselling skills there is still a lack that exists in regards to LGBT+ populations (Flickinger, 2014). This is exemplified in the reported lack of education for many mental health professionals on these topics (Marwick, 2016; McCann & Sharer, 2016). This can result in frustrations for LGBTQ+ populations and may lead to people away from accessing the already limited resources. Although this case study will add one voice to the literature pool more research is still required in order for us to advance in the realm of cross cultural counselling.

This should be of utmost importance to our fields for, as it became clear in James' case, the benefits of focusing on cross-cultural aspects are innumerable and vital within a therapeutic journey. For James the atmosphere of mutual respect, openness, and non-judgmental listening lead to an important therapeutic relationship for him which allowed for deeper work than he had previously been able to engage in. By taking a stance of cultural humility in where I educated myself and yet remained humble towards James and his culture, I was able to aid my client in his journey more proficiently than if I had not.

To further develop literature on LBGTQ+ cross cultural counselling skills and cultural humility practices, as well as continuing to integrate them into mental health professional education, I believe that we can expect great improvements within mental health fields. Until this happens I believe that the three most important pieces that I as a developing drama therapist learned from this process were: Truly listen to the client, never assume based on perceptions or past experiences; a little education on my part can go a long way in a therapy session; and mistakes will happen but if you respond to them humbly repair is possible. This is an exciting time for me us in the mental health professions as we are at the beginning of a new chapter for

cross cultural counselling skills. With the right focus, drive, and momentum there is no telling

how far this will be able to go.

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