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Drama Therapy with Queer Adults: Identity Reflection and Expression

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Drama Therapy with Queer Adults: Identity Reflection and Expression

Development of a Method

Capstone Thesis

Lesley University

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Drama Therapy

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Abstract

There are people of every age, race, religion, ability, socioeconomic status, and area of the world that identify as part of the queer community, and drama therapists have the opportunity to address their specific needs. The current literature regarding effective drama therapy with queer people is limited. Affirming and identity-focused psychotherapy that allows queer people to relate to one another has been found to be beneficial for this population. The discussed development of a method is designed to contribute to an understanding of the strengths and limitations drama therapy, specifically projective techniques, narrative writing, narrative performance, and small group embodiment have when implemented with queer adults, and how this work can create opportunities for identity reflection and expression. This method was implemented with queer adults at a partial hospitalization program, and it was observed that the use of projective objects, narrative writing, and narrative sharing led to vulnerable and detailed sharing of identity. Hesitation was observed in response to embodied interventions, which may be related to the discomfort many queer people have with their bodies. Future research should examine why projective techniques and the use of narratives appear to be comfortable interventions for this population, and why embodied interventions are more challenging. Drama therapists should continue to explore how their professional skills can best be applied to clinical work with queer adults.

Drama Therapy with Queer Adults: Identity Reflection and Expression

Introduction

There are people of every age, race, religion, ability, socioeconomic status, and area of the world that identify as part of the LGBTQIAP+, or queer community. A population that historically, and in many contexts continues to be marginalized, has specific needs that mental health professionals have the obligation to be aware of and the opportunity to address (Hendricks & Testa, 2012; Meyer, 2003). Drama therapists are equipped with the tools of play, projection, embodiment, narrative, role theory, and more that can be applied to fit the vulnerabilities and areas of need for queer people if these professionals are knowledgeable about how their work can benefit this community. This paper discusses the implementation of a drama therapy method designed to support queer adults in identity reflection and expression, and hopefully will generate a conversation about the intersection of drama therapy and clinical work with the queer population.

As the queer community continuously grows in size and complexity, the words used within and in reference to it have evolved (Zosky & Alberts, 2016). In my literature search I have chosen to primarily highlight work that uses the most current and appropriate language in reference to queer people, specifically transgender and gender nonconforming individuals. Some significant pieces of queer research have therefore been excluded from my reference list due to their language usage, as I aim to contribute to this body of literature in a way that honors all queer people to the best of my ability. In this paper I choose to use the word queer rather than LGBTQIAP+, because queer is an umbrella term that can be applied to people of various non-heterosexual and non-cisgender identities (Zosky & Alberts, 2016).

Throughout the last few years I have focused both academically and clinically on the use of drama therapy with queer communities. This is an application of drama therapy that is notably under-researched, and I want to know how to use drama therapy in ways that best fit the needs of my patients (Beauregard, Stone, Trytan, & Sajani, 2016). In field placements I have observed playfulness, expressiveness, and a focus on identity from queer patients that may point to identify-focused drama therapy as an effective treatment modality for this population. I have noticed that regardless of the therapeutic intervention chosen, themes of identity are often brought up by the group. This is consistent with Halverson's findings (2005), that when queer youth were given the opportunity to develop personal narratives they typically focused on at least one aspect of identity in their writing. McEntarfer and McVee (2014) engaged in similar research and found that witnessing one's story as an embodied and vocalized piece can lead to empowerment of identity and feelings of validation. While my field placement is with adults, I am curious if applying these findings (Halverson, 2005; McEntarfer & McVee, 2014) and using narrative performance in therapy may be an effective way to engage my patients in self-exploratory and validating identity work, at a level of distance that is appropriate.

My current field training placement allows me to engage directly with queer adults, and I would be remiss if I did not use the day to day experiences I have at my field training placement to learn how to be a better clinician for this population. In my work thus far with queer adults in a partial hospitalization program, I have noticed less hesitation and discomfort when using distance, metaphor, projective techniques, and group embodiment than when using individual embodiment, or role theory. It is possible that queer, and specifically transgender and gender nonconforming people have complicated relationships to their bodies that may make engagement in embodied interventions both challenging, and uniquely powerful (Hanan, 2018).

For the last few months I have been playing with interventions to try and understand what my patients are comfortable trying, and what they are not. As Scheff (1981) explained, distance in psychotherapy is the closeness at which a person observes and experiences their emotions. An essential job of any psychotherapist is to choose interventions that join the patient at whatever level of distance they are most able to engage with their emotions, and modulate that distance as necessary (Scheff, 1981). Ideally, patients are ultimately brought to a place of aesthetic distance where they are able to experience and work with emotional states without becoming overwhelmed (Scheff, 1981). A goal of my developed intervention is to explore where aesthetic distance may lie for queer adults exploring identity.

I have developed a drama therapy method for my Capstone Thesis Project, intended to guide queer adults in reflection and expression of identity. After consulting with literature about various psychotherapeutic approaches for queer clients, I developed a group drama therapy intervention and implemented it twice with a total of 15 patients. In this paper I share the details of my intervention, observations, and key recommendations for future research and practice. I aim to contribute to an understanding in the field of drama therapy regarding the strengths and limitations of projective techniques, narrative writing, narrative performance, and small group embodiment when implemented with queer adults, and how this work can create opportunities for identity reflection and expression.

Literature Review

Stressors Affecting Queer Populations

People identifying as part of the queer community face specific challenges from both internal and external sources that impact their overall well-being. Many queer people experience high rates of violence, discrimination, rejection, and harassment, often living in fear of when

they will next be subjected to this treatment from other people and systems (Hendricks & Testa, 2012). Data collected over an 18-month period from a suicide prevention service provider for queer youth made clear that this group of young people struggle more than their peers, as it was indicated that queer youth are more likely to contemplate and attempt suicide than non-queer youth (Goldbach, Rhoades, Green, Fulfinti, & Marshal, 2018)

The minority stress model outlines how experiences of prejudice and rejection, hiding one's identity, internalizing homophobia and transphobia, and coping with stress in ways that are unhelpful make queer people susceptible to mental health challenges (Meyer, 2003). Minority stress factors are correlated with increased risk of substance abuse, mood disorders, suicidality, incidents of abuse and assault, homelessness, and unemployment (Hendricks & Testa, 2012). In their review of the literature, Hendricks and Testa (2012) observed that if queer people respond to fear of discrimination by trying to hide their identities, the act of not being their authentic selves can then become its own form of distress. Additionally, queer people may internalize the ways they are treated by society, leading to decreased resiliency skills with which to handle external minority stress incidents (Hendricks & Testa, 2012).

While all queer people face minority stress, transgender and gender nonconforming people have higher rates of depression, suicidality, workplace discrimination, and violence than those identifying as sexual minorities (Heck, Croot, & Robohm, 2015). Transgender and gender nonconforming people are also less likely to have family or social support than other queer people, leading to isolation (Heck et al., 2015). In a quantitative study of stigma, gender dysphoria, and nonsuicidal self-injury in transgender teenagers and adults, it was found that engagement in such self-harm is associated with poor body image, limited support system, and low levels of self-esteem (Jackman, Dolezal, Levin, Honig, & Bockting, 2018). It has also been

observed that gender incongruence, or feelings of one's appearance not matching their gender identity and a key diagnostic factor of Gender Dysphoria, puts transgender people at higher risk of engaging in self-harm behaviors (Jackman et al., 2018).

Queer people of color (POC) face stressors specific to their intersecting marginalized identities (Chang & Singh, 2016; Hudson & Romanelli, 2019; Singh & McKleroy, 2011). Individuals existing at this overlap are at increased risk of homelessness, mental illness, poverty, incarceration, sexual abuse, unemployment, workplace discrimination, and police brutality than white queer people or cisgender, heterosexual POC (Hudson & Romanelli, 2019). For transgender and gender nonconforming POC, coinciding identities can be made more difficult to navigate due to the majority of society's binary gender norms resulting from white, western cultures and colonialism (Chang & Singh, 2016). When evaluating the needs of this population it is crucial to identify that much of the trauma faced by queer POC is underreported (Singh & McKleroy, 2011), and the majority of mental health treatments supported by evidence have not been evaluated with individuals of this community (Chang & Singh, 2016).

Psychotherapy with Queer Populations

Psychotherapy intended to treat symptoms of depression, suicidality, anxiety, and substance abuse in queer people must be approached from a minority stress perspective, if it is to be validating and effective (Hendricks & Testa, 2012). Minority stress experienced by queer people can make engagement in psychotherapy more difficult; validation, affirmation of identity, and experiences with similarly-identified peers is crucial for queer people to feel supported enough to face the challenges associated with minority stress (Hendricks & Testa, 2012; Hudson & Romanelli, 2019). It has been found that working with a therapist who does not understand issues related to queerness, race, and other marginalized identities is not helpful and in fact can

lead to increased feelings of loneliness and frustration (Goldbach et al., 2018; Hudson & Romanelli, 2019). A space that is specifically designed to affirm identity and allow for positive social engagement with similarly-identified peers is ideal for effective psychotherapy (Chang & Singh, 2016; Goldbach et al., 2018).

As recently as last year, Vosvick and Stem (2018) recognized the lack of research surrounding effective therapeutic approaches for queer populations. Their quantitative study aimed to fill that gap and used Meyer's (2003) minority stress model to examine how mindful acceptance, self-esteem, and minority stress impact the psychological health of queer people (Vosvick & Stem, 2018). The writers reviewed the current understanding of how mindful acceptance and self-esteem can reduce feelings of stress and increase psychological well-being, and specifically applied this approach to benefit the queer community. The authors hypothesized that people with high levels of self-esteem and mindful acceptance would be less psychologically affected by minority stress and found that mindfulness and high levels of self-esteem can decrease the impact of minority stress on psychological well-being. Therefore, it was suggested that therapists working with queer people focus specifically on these factors (Vosvick & Stem, 2018).

Further, transgender and gender nonconforming people, many of whom often struggle with understanding their identity and how to express it, may benefit from therapeutic work focused on identity development (Heck et al., 2015). The same authors identified that disclosure of personal challenges and goals with peers can be difficult for this population (Heck et al., 2015). Group therapy can provide clients with the opportunity to be surrounded by others who face many of the same challenges and are working towards similar goals, and can assist transgender and gender nonconforming clients in building an authentic sense of self and

beginning to feel comfortable sharing that with others (Heck et al., 2015). It is essential that clinicians are aware of factors in treatment that may lead to clients sharing less openly or engaging less comfortably (Heck et al., 2015). It was found in interviews with 45 transgender and gender nonconforming people that psychotherapists often overemphasize, underemphasize, or even stigmatize identities (Mizock & Lundquist, 2016). It can be helpful in treatment for clinicians to support gender diversity and intentionally develop identity-affirming care (Mizock & Lundquist, 2016).

In addition to the relative lack of research on effective treatment for queer individuals, receiving adequate mental health care is made more difficult for queer people due to financial challenges, systems not working to support the needs of queer people, difficulty finding providers prepared to fit the needs of queer clients, low numbers of providers who are knowledgeable about work with queer clients, and fear of discrimination (Beauregard, Stone, Trytan, & Sajnani, 2017). Mental health programs still are often unprepared to provide transgender and gender nonconforming clients with appropriate, effective care (Heck et al., 2015). The World Professional Association for Transgender Health (WPATH) suggests that psychotherapists working with transgender and gender nonconforming clients should create opportunities to increase overall quality of life and self-fulfillment, explore gender, find ways to alleviate feelings of gender dysphoria, address goals of identity expression, experience peer support, develop interpersonal skills and resilience, and freely express identity (Mallory, Brown, Conner, & Henry, 2017).

The experience of gender is fluid, and transgender and gender nonconforming people often experience gender beyond constricting categories (Mallory et al., 2017). It is important that when working with individuals in this community, clinicians provide clients with choice,

freedom, and space for exploration (Mallory et al., 2017). It can also be beneficial for clinicians to join clients throughout the therapeutic process, to break patterns of isolation and othering (Mallory et al., 2017). Clinicians working with queer people with multiple marginalized identities should recognize those overlaps and inquire how those intersections impact traumatic experiences, mental well-being, and resilience (Singh & McKleroy, 2011). Therapy designed for queer people should foster space where clients are, and feel safe, and are given permission to explore and be their entire selves without apologizing for their identities (Heck et al., 2015).

Identity Work with Queer Populations

Story, narrative and identity. Storytelling, through all its various forms, can provide clients with the opportunity to reflect on and share their experiences in creative ways. Bardhoshi, Grieve, Swanston, Suing, and Booth (2018) used photovoice, a tool involving photography and discussion, and a public art exhibit as a research method in a community-based participatory action study to understand the experiences of queer college students and give participants the opportunity to tell their stories. During each research session students discussed the photographs taken by the group throughout the previous week, selected a few photographs that best described experiences shared by the group, and identified a photograph theme for the following week. The authors found that four types of experiences emerged in the photography and discussion content: feeling categorized, censoring the self, finding and spending time in safe spaces, and advocacy. It was found that shifting back and forth from individual reflection to group collaboration in their methods gave participants time to explore their experiences privately and feel understood and supported by their peers (Bardhoshi et al., 2018).

Halverson (2005) conducted an ethnographic case study with a performing arts organization in Chicago, IL. About Face Youth Theatre (AFYT) engaged young queer people in

months of personal narrative development, created a script inspired by the group themes, and produced a play in which participants performed their own stories and the stories of others.

Halverson (2005) analyzed 34 narratives during the AFYT process and interviewed two groups of six participants following their experiences in the program, using triangulation to support findings. Outcomes of this study showed a focus in the majority of personal narratives on at least one dimension of identity, more than half exploring at least two. In analysis of interviews it was found that participants experienced empathy, perspective, and self-exploration by performing another person's story and acceptance, distance, and release by seeing their story performed by someone else (Halverson, 2005).

Elderton, Clarke, Jones, and Stacey (2013) used storytelling and mixed-media timelines throughout four workshops to give queer adults in England with learning disabilities opportunities to develop and strengthen identity, and tell stories that often are not heard. Throughout four sessions participants in this study made group and individual life timelines, and shared personal stories with others through artistic mediums. Researchers hypothesized that if participants were able to externalize their stories with art and share personal experiences that have not been heard or supported by others, they would experience increased self-confidence and feelings of acceptance. Themes of stories shared at the beginning and end of the sessions were compared in analysis, and almost all participants demonstrated an improvement in positive self-talk and hopefulness. Most participants reported in interviews and feedback forms that they felt closer to one another and happy with themselves following the workshops (Elderton et al., 2013).

McEntarfer and McVee (2014) examined monologues of lesbian, gay, bisexual, and straight ally college students who performed personal stories for their conservative campus community. It was found in this qualitative study that when sharing experiences of activism,

students described themselves as strong individuals who challenged what the world expected of them. However, in stories of feeling silenced or rejected, students described themselves as vulnerable and silenced. The discussion implied that giving marginalized communities an opportunity to tell their stories can allow people to feel heard and aware of their own power (McEntarfer & McVee, 2014).

Narrative therapy can allow for a person's stories that may not be told by the dominant culture to be heard and validated (Steelman, 2016). By writing something down that causes emotional distress, one can externalize their experiences, name what has happened to them, and allow painful moments in the past to be observed and transformed (Loue, 2018; Steelman, 2016). Affirmative narrative therapy with queer people may provide autonomy over the labels they have been given and allow them to use language in ways that feel empowering rather than discriminating or narrowing (Steelman, 2016). If narratives are performed, the validation from peers can lead to increased self-confidence and socialization abilities and give queer individuals the courage to continue sharing their stories with others (Loue, 2018).

Embodiment and identity. Hanan (2018) discussed the use of embodied therapies with clients exploring gender. People identifying as transgender or gender nonconforming often report discomfort with their own bodies, and with how their bodies are seen by others (Hanan, 2018). The body is a tool for queer people to express who they are, but it simultaneously can be the part of the self that creates the most discord, leading to feelings of gender incongruence or Gender Dysphoria (Hanan, 2018; Jackman et al., 2018). For queer people who experience physical or sexual trauma, or who are harassed or attacked due their use of the body to communicate identity, the body becomes a target of minority stress (Meyer, 2003; Hendricks & Testa, 2012). Therapists implementing embodied techniques with queer people must be knowledgeable about

their embodied stressors and which interventions will both affirm identity and provide clients with opportunity for transformation.

It has been found that creative movement, specifically dance movement therapy, can give transgender and gender nonconforming people an opportunity to reconnect with their physical selves and experience bodily autonomy (Hanan, 2018). In Hanan's (2018) observation of dance movement therapy with transgender and gender nonconforming people, themes of genuine self-expression, acknowledging experienced violence, gendered movement, and physical gender transition have emerged. This author found that transgender and gender nonconforming people experiencing gender incongruence often feel isolated and engaging in creative movement with peers can provide validating and cathartic experiences of social engagement. Identity is tied to the body, and therapeutic interventions asking queer clients to explore identity may be most effective if some embodied activity is included (Hanan, 2018).

Drama Therapy with Queer Populations

The current literature specific to drama therapy with queer people is notably limited, and has primarily been focused on the preparedness, or lack thereof, that drama therapists have to work with this population. However, this literature will be expanded by a forthcoming book titled *Creative Arts Therapies and the LGBTQ Community: Theory and Practice*, which may lead to professionals in the field developing an understanding of how to serve queer people (MacWilliam, Harris, Trottier, & Long, 2019). There is no current literature on the application of drama therapy with queer people of color. As drama therapists become more knowledgeable about the use of their work with the queer community, hopefully research will be conducted on individuals in this population with intersecting marginalized identities.

Beauregard et al. (2016, 2017) distributed a survey to drama therapists intending to assess the competence, awareness, and needs regarding their work with queer clients. During analysis of 102 questions, authors identified that respondents require further education on LGBTQI language, issues, and needs (Beauregard et al., 2016). The researchers modeled their survey from one used in music therapy in 2013, thus supporting internal validity (Beauregard et al., 2016). In recent years, the NADTA has taken steps towards supporting queer drama therapists and asking drama therapists to be better prepared to serve queer clients (Beauregard et al., 2017). However, while most drama therapists appear to be open minded and well-intentioned, their workplaces often create barriers to effectively treating queer people (Beauregard et al., 2017). Drama therapists also reported having inadequate training regarding affirmative care for queer clients (Beauregard et al., 2017). Some obstacles are out of the clinician's control, but with more knowledge about the needs of queer people and the specific issues facing this population drama therapists can appropriately and effectively use their skills to treat this dynamic community.

Additionally, Beauregard and Moore (2011) described various use of creative therapies with gender variant and sexual minority boys. The authors commented on the ways drama therapy can increase confidence and socialization, and empower queer, male youth to explore potential resolutions to family conflicts and to take on roles they do not usually play on in their lives (Beauregard & Moore, 2011). Many queer people are expected to play the roles of heterosexual and cisgender from birth. To be authentically themselves, individuals in the queer community must find ways to play with the roles they are given or develop entirely new ones. In my work with queer adults, I have noticed a palpable playfulness in my patients, which drama therapists might encourage in order to help queer people express their authentic selves.

Role theory. Role theory operates with the belief that if people can increase the number of roles they play in their lives, they expand the dynamic ways they can exist in the world (Landy, R. J., Luck, B., Conner, E., & McMullian, S., 2003). For queer people who feel like who they are does not fit with their body or what the world expects of them, having the opportunity to explore roles beyond what they have experienced could be transformative (Jackman et al., 2018). Within role theory, for each role a person plays, a counter role exists (Landy et al., 2003). The guide, or the part of a person that transitions them in and out all roles that they play, helps integrate each role and counter role (Landy et al., 2003). People can achieve a sense of balance when they are able to bring together their roles and counter roles (Landy et al., 2003). While Beaugard and Moore (2011) briefly discussed a few ways that roles can be used with young, queer boys, no literature currently explores the use of role theory work with queer populations. However, the assumptions of role theory seem to fit many of the identity-based needs of queer clients (Landy et al., 2003).

Aesthetic distance via projective techniques. People constantly choose how physically, emotionally, or intellectually close to another person, situation, role, object, or their own thoughts and feelings they want to be (Landy, 1983). This closeness, or distance, can be used therapeutically to help a client engage with their experiences in productive ways. When underdistanced, a person experiences their emotions too intensely and may become dysregulated, and when overdistanced they may not experience their feelings at all (Scheff, 1981). In therapeutic uses of distancing, the goal is to bring the client to a place of aesthetic distance, somewhere between the ends of the distancing spectrum, where a person is both an observer to their life and plays the role of themselves (Scheff, 1981). In aesthetic distance, individuals can reflect without becoming overwhelmed and healing can occur. Distancing is often modulated

using projective techniques, whereby clients can project their thoughts, feelings, needs, and goals onto an external object (Landy, 1983).

Enactment of the self, often in metaphoric ways, can be cathartic (Landy, 1984).

Therapeutic enactment can occur within various drama therapy interventions, one being the use of external objects to explain parts of the self that may not be expressed otherwise (Landy, 1984). When implementing projective techniques, provided objects should be chosen by the therapist to fit the needs of each client or group (Landy, 1984). Neutral, inanimate objects provide more distance than animals or human features (Landy, 1984). Again, while no drama therapy literature regarding projective techniques with queer populations currently exists, this approach holds promise. For queer people who have complicated relationships with their bodies (Hanan, 2018), reflecting on and expressing the self to others using an object separate from the body may be a way to therapeutically work with identity from a place of aesthetic distance.

Methods

I implemented this method twice at a partial hospitalization program for queer adults in the Boston, MA area, where I completed my second field training placement. It was implemented during two consecutive group therapy sessions, each lasting 45 minutes with a lunch break of the same length in between. The method was agreed upon by my academic and clinical supervisors, and by clinicians at the site. The method was approved to occur on two dates, one in January 2019 and one in February 2019, intentionally placed one month apart so to not be repetitive for patients. A clinician from the site observed each of the sessions.

Preceding the first session of both method implementation series, I explained to the milieu of the site that I would be running a drama therapy intervention I created for purposes of identity reflection and expression. I asked that any patients attending the first group would also

attend the second group after the lunch break, and explained that any patients who did not choose to attend my first group would not be able to join for the second group. I specified that the method was created as part of my Capstone Thesis, and that I would not be collecting any data or including any identifiable information about any patients or the program in my writing. I offered to be available afterwards to answer any questions about the project. On the January date, there was a large enough milieu for patients to choose to attend either my sessions or alternative group therapy sessions that were led by other clinicians during the same time.

The intervention was developed with a focus on identity affirmation and development as suggested by Mizock and Lundquist (2016), Heck et al., (2015), and Vosvick and Stem (2018), and with an intention of exploring how to use drama therapeutic and psychotherapeutic tools to fit the specific needs of queer people (Beauregard et al., 2016; Beauregard et al., 2017; Goldbach et al., 2018; Heck et al., 2015; Hendricks & Testa, 2012; Jackman et al., 2018; Mallory et al., 2017; Meyer, 2003; Mizock & Lundquist, 2016). Embodiment was used in various forms throughout both method implementations as opportunities for participants to connect their emotional and physical states (Hanan, 2018). Projective techniques with inanimate objects were included for participants to distance themselves from the roles they play in life and discuss how those roles engage with one another (Beauregard & Moore, 2011; Landy, 1983; Landy, 1984; Landy et al., 2003; Scheff, 1981). Creative storytelling and narrative were implemented for identity exploration and expression, an intention discussed by Bardoshi et al. (2018), Halverson (2005), Elderton et al. (2013), McEntarfer & McVee (2014), Steelman (2016), and Loue (2018).

Before patients entered the group, I arranged 98 colorful, playful objects on the table in the middle of the room (see Appendix A). The group began by checking in with names and pronouns, as customary at the site. I asked everyone to also share a sound and movement and

explained we would all mirror each sound and movement back. To model, I introduced myself, shared a sound and movement and asked everyone to reflect it back to me. After introductions and mirroring I asked the patients to reflect on all the ways they identify as I led them through a series of questions including, “When someone asks who you are or how do you identify, what things come to mind? What comes to your mind first? What comes to your mind second? What are the things you often leave out? What are identities others will share about themselves that remind you of how you identify? Which identity traits are private to you and which do you present to the world?”

I then asked the patients to choose an object from the table to represent some piece of their identity. A moment was given for the group to engage with and explore their objects, and then I explained we would hear from each person what they chose, why they chose it, and how it represents their identity. Both my observing clinician and I chose objects and introduced them along with the patients. I then handed out lined paper and asked patients to quickly write down what they said about the object, and anything they felt about it but did not share. After a few minutes, I asked the group to think about what their first object may need help with and choose a second object from the table that could offer that support. While I did not intend to use the role and counter role as described by Landy (2003), the ideas behind role theory were present in my second object prompt. Again, my observer and I chose objects. I shared my second object to model how it can help or support the first object, and then asked the patients to do the same.

In line with best practices of including explicit identity work with queer populations (Heck et al., 2015; Mallory et al., 2017; Mizock & Lundquist, 2016; Vosvick & Stem, 2018), with ten minutes left of the first session, I asked the group to write in response to the prompt, “I am...” I explained their writing could be abstract or literal, a monologue, a story, a song, a poem,

or anything else they needed. Patients were given the choice to write about themselves, their objects, or both. I informed the group that during the next session they would be asked to share their written pieces. I did not write a narrative, instead observed the patients and answered clarifying questions. My observing clinician did write a narrative. At the end of the first group, I asked the patients to finish writing and place their objects in a clear bucket in the center of the table. I explained I would bring the objects back to the second session and reminded the patients to attend my group after the lunch break.

I prepared for the second group by placing all the patients' chosen objects on the table and removing objects that were not chosen from the room. The second session began with introductions of names and pronouns, and I asked the patients to share one thing that was on their minds during the lunch break. I went first, to model sharing something related to the first session. I then gave the patients about three minutes to read over their written pieces, reconnect to what was on the page, and add anything if needed. I checked that standing was okay for everyone in the room, and then asked the patients to stand in a circle with their written pieces. I explained each person would read as much of their piece as they wanted, in line with Mallory et al.'s (2017) recommendation that queer people are given autonomy over their reflection and expression processes.

During the first series, I asked that the group take a moment to silently acknowledge what was shared after each piece, and then another person would begin. I asked that when not reading their piece, each patient stand in support of whoever was sharing. During the second series, adjusted the intervention and explained to the group that we would respond to each person's narrative in a way that felt right to them with silence, verbal thoughts, or sound and movement.

Following each narrative, I asked the person who shared if they wanted a response from the group, and if so what kind of response they wanted.

After the narrative sharing of the first series, I asked the group to think about which piece read aloud they felt most drawn to and partner with the person who wrote it. Relating to others facing similar challenges can provide validation and can support the development of social skills (Bardhoshi et al., 2018; Elderton et al., 2013; Halverson, 2005; Hanan, 2018; Heck et al., 2015; Loue, 2018; McEntarfer & McVee, 2014). I asked the patients to take their objects from the table and bring them to their conversations. My observing clinician partnered with one patient and I formed a small group with two patients. The patients were asked to share with their partners why they felt drawn to one other and identify a similarity between their written pieces or processes. After five minutes, I explained that each pair or small group would create a picture or sculpture with their bodies and their objects representing their identified similarity. Hanan (2018) identifies the importance of embodied interventions for queer people exploring identity. I explained the picture could move or have sound but did not have to. I reminded the patients of the program's policy not allowing physical touch. I gave the small groups five minutes to create their sculptures, and we looked at each sculpture. While looking at each sculpture, I asked the patients not part of that image to call out what they noticed or interpreted from it. Each small group was then given the opportunity to explain their sculpture.

I then explained we would create a sculpture with our objects, as an opportunity for the patients to connect and relate to one another in embodied ways (Hanan, 2018). Each of us would place our objects on the table, one person at a time, in a way that felt either symbolic of the past two groups or looked right with the objects already placed. When all objects were placed, I asked the group to circle around the table and look at the sculpture from different angles. I asked if

anyone had a title for the sculpture. To close, I asked everyone to give a sound and movement while standing around the object sculpture. Each person gave a sound and movement, and the group mirrored.

Following the narrative sharing of the second series I asked the group to read through what they had written and choose a line from their piece that each of their objects would say if they could speak. I gave the group a few minutes to read over their narratives and assign text to their objects, and then asked the patients to pair up and discuss with a partner the lines that they chose. While everyone discussed with their partners, I listened to the conversations and paid attention to the mood and affect expressed while sharing. After about five minutes, I asked the group to come back together and discuss what came up in their conversations with their partners.

I again used the object sculpture intervention but asked each patient to say the line assigned to each object as they placed it on the table. I asked the patients to give their collaborative sculpture a title. With five minutes left, I opened the group up to discuss anything that was on their minds as they finished the second session. I ended the group with the same sound, movement, and mirroring closure that I used during the first series.

Following both sessions of both series I used the Voice Memos application on my cell phone to dictate what occurred during the groups. Before implementing the method, I wrote the following questions for myself to think about during the sessions and reflect upon:

- Are the patients engaged in the method?
- Which directives lead to the most genuine and vulnerable sharing?
- Are the patients more comfortable reflecting individually, in small groups, or in the full group?
- How do patients engage with the objects?

- What shared themes emerged in narratives?
- Do the patients write hesitantly or quickly?
- Are the object explanations and narrative content abstract and imaginary, or literal?
- What level of distance seems more appropriate for identity work?
- How do the patients relate to each other?
- What do I notice in the patients' bodies during the sessions, specifically during partner sculptures?

I transcribed my dictations of the sessions during the week after they occurred. I organized the information chronologically, and by intervention used.

Results

Ten patients attended the first series and five attended the second, most of whom identified as transgender or gender nonconforming. All participants were white-presenting, and therefore the results of both method implementations may not be applicable to queer people of color. I felt nervous about the size of the second group, in comparison to that of the first, and how my interventions would fill the time and fit the needs of the patients in the room. The first group included patients who were leaders in the milieu, and most had been in the program for at least a week. The second group was comprised of patients who tended to observe rather than engage, most admitted to the program within the three days prior. Participants of the second series had varying levels of physical ability, which I took into consideration with regards to the introduction of embodied interventions. Most patients in both groups checked in with a comedic or lighthearted sound and movement, while a few chose to do something more serious. One person in the first group did not participate. I noticed lower energy levels from patients during check-in of the second series than the first.

When I asked the first group to choose Object 1, most patients jumped towards the table, chose something, and began physically engaging with it. One person in the first group did not choose an object. The second group was more hesitant, and took their time looking at all of the objects before choosing. In both groups, the sharing of Object 1 was mostly abstract. Patients related the function, ambiguity, construction, and texture of their objects to their personality, current goals, challenges, needs, likes, and dislikes. Most patients looked at their objects while sharing, rather than up at their peers, but were attentive and supportive to one another. In the second series two patients chose shells for Object 1 and shovels for Object 2, and both explained the shovels could help the shells by digging them out of the dirt when they could not get out by themselves. No one in either group related their object only to their identity as queer, and in fact no one in the second series mentioned their gender or sexuality when sharing.

During the writing reflection following Object 1 sharing, patients were engaged and focused. Some people looked up for a moment, but otherwise had their eyes down at their papers. One person in the first series chose not to write anything. The patients in the first series wrote quickly, while those in the second series wrote slowly and deliberately.

The groups were more hesitant when choosing Object 2, meant to help or support Object 1, and a few people asked for clarification. Patients in both series spent time walking around the table and looking at the objects before choosing, and moved slowly back to their seats once they chose. A patient in the first series who did not choose a first object, did not choose a second either. Noticing the groups' uncertainties, I shared first in both series to model relating the two objects. In this round of sharing, more literal explanations were brought in to support abstract concepts. For example, a few of the patients shared the physical way their second object could

combine or attach to their first object and related that connection to a personality trait, hope, or need of theirs.

During Object 2 sharing in the first series, a theme of opposites emerged. About half of the patients shared that their Object 2 in some way was an opposite of their Object 1. These group members spoke about how their two objects represented different sides of themselves and balanced one another. Patients who did not feel their second object was an opposite to their first object, instead shared that their objects completed one another or that their second object helped their first object express itself more fully. I specifically looked for this theme during the second series but did not notice it.

My initial plan was to use the prompt, “My identity is...” for narrative writing. I changed my mind during the first series and introduced, “I am...” because the patients shared pieces of themselves far beyond their identity labels during object sharing. The groups demonstrated that they were not focused on how they identify, but instead on who they were beyond that. Most patients, in both series, immediately began writing when I introduced the prompt. I noticed deep breaths, shifting in chairs, moments of stillness and thinking, and patients leaning towards and over their papers while writing. Group members did not look around to see what others were writing. A few people in the first series finished writing before I asked everyone to stop, while all patients in the second series later expressed wishing they had more time to write. As with the earlier writing activity, patients in the first series wrote more quickly than patients in the second.

The small group size of the second series led to some time left at the end of the first session, which I used to discuss what thoughts and feelings patients had following narrative writing. Patients shared feeling inspired, inquisitive, reflective, and creative in ways they had not been for a long time. I asked the group to place each of their objects in a jar that I would bring to

the second session and say one word that was on their minds. Participants shared words that summarized what each of their objects represented to them.

As the second session of the first series began, all ten patients were sitting in the same seats they had been in previously and had their written pieces on their laps. They were chatting with each other and laughing, and their bodies seemed relaxed. While I had laid their objects out on the table, they did not pick them up. It seemed as if they had collectively moved from needing individual reflection with to engagement with others, which informed me they were ready for the second session. The second session of the second series began very differently, with only three of the five original patients in attendance. One patient returned late from lunch and was not allowed in group in accordance with group guidelines, and another patient chose to attend a CBT group that was held at the same time. I felt nervous as the second session began about how I would implement the embodied activity of my intervention with a group of three patients with varying physical abilities. I decided that I would adjust the intervention if needed, to fit the therapeutic needs of the patients in the room. During check in of the second session, in both series, most patients either shared feeling excited about exploring their narratives further, or something unrelated they were thinking about during the lunch break.

During the few minutes I gave everyone to reconnect to their narratives, about half the group added to what they had written. As the patients in the first series read over their pieces I noticed less hovering over or leaning towards the page; they seemed to be less protective over what they had written which made me think they were ready to share. When I asked the first group to stand in a circle, they all walked closer to one another and the table in the middle of the room with their objects. Instead of forming a large circle and standing in front of their chairs, they gravitated towards physical proximity. In the second series, my observing clinician brought

a chair with him to the circle so to not single out any patients with varying physical abilities who may not be comfortable standing. All patients in the second series followed his lead by bringing their chairs. I was interested to observe how seated narrative sharing would differ from the standing, more performative sharing of the first series. In the second series, narrative sharing felt like a settled conversation rather than a temporary performance.

The patient in the first series who did not write a narrative stood in the circle in support of those who did. The pieces were written in the styles of poems, raps, journal entries, and stories. Most were written on about one side of a page, while some were a bit shorter or longer. In the first series, more patients placed emphasis on their gender and sexual identities in their narratives. While sharing narratives, the groups were attentive and respectful to one another. Almost everyone looked at each person while they read their pieces, and some nodded along or leaned towards the person reading. I thought during the first series that some people may have felt uncomfortable or unheard during the silent moment of recognition after they read their narratives. Because we had less narratives to hear during the second series, I wanted to offer the option for responses from the group. Everyone in the second series chose to have verbal responses, which made me wonder what that option could have allowed for during the first series. Patients in the second series responded to one another's narratives by sharing how the piece made them feel and what they liked about it.

Patients in the second series did not mention their queerness during any intervention. The narratives during the second series were longer than those during the first, all at least one page. The pace of reading and responding matched the slow and intentional energy level I had noticed throughout the second series. These narratives included a poem, a song, a journal entry, and a children's story. During sharing, I noticed the patients make eye contact and pay attention to one

another more than any other time during the sessions. Most of the group intertwined elements of their first object, their second object, and a broad sense of themselves and their treatment goals in their narratives. In both series, one or two narratives were written as completely literal journal entries. Narrative writing and sharing seemed to allow the patients to integrate various aspects of the self, both in and out and treatment, and communicate that sense of self to others.

In the first series, when asked to partner with someone in the room whose narrative they felt drawn to, most patients immediately connected with another person. Neither the patient who did not choose objects nor the patient who did not write a narrative took initiative to connect with partners. I formed a group with them both and tried to have them relate to one another. They positioned their bodies away from each other and answered my questions with brief responses. They were the two patients in the group who had been admitted to the program most recently. Three of the other pairs in the room were talkative and laughing, and one pair communicated quietly and with seriousness.

When asked to find a similarity in their narratives or processes, most patients in the first series eagerly discussed with their partners. They spoke loudly, gestured towards each other, referred to their objects, and made eye contact. When asked to represent that similarity in a physical sculpture with their bodies and objects most patients hesitated, looked inquisitively or with worry at each other and me, and asked for clarification. I felt the restraint in the room and mentioned that the sculptures could be seated in hopes of making the exercise more comfortable. In hindsight, I wish I had not provided that option and instead urged them to decide their needs regarding distance and embodiment in the sculptures.

While the four pairs in the first series created their sculptures, my small group began engaging with one another. They did not want to create a sculpture but used the time to discuss

their narratives and objects with one another. Of the four sculptures created, one used movement of the body without integration of objects, two used body movement and integration of objects, and one used only their objects with no use of the body. This may indicate that the levels of distance needed for queer adults in a partial hospitalization program to express identity differ for everyone and exist along a spectrum. The hesitance exhibited toward this embodied intervention may indicate the discomfort many queer people have with their bodies, which I observed throughout the year I worked with this population before implementing this method. Pairs appeared more comfortable discussing their sculptures than presenting them. The themes that emerged in sculpture presentation and discussion of the first series included connection, organized chaos, support, fun, growth, and revealing the self.

I chose to have patients in the second series assign lines to their objects, rather than create group sculptures, because I wanted to match their level of energy. We stayed seated during narrative sharing, and I felt that asking them to engage in collaborative embodiment would have been jarring and difficult due to the small number of participants and their varying physical abilities. While discussing their objects' lines with partners, patients intently shared and listened. Some patients even spoke the lines from the roles of their objects.

During closure of both series, patients were intentional and specific about how and where they placed their objects. Most objects were placed around the center of the table and touched one another. In the first series the patient who did not choose objects did not join in the activity, and the patient who chose objects but did not write or share a narrative placed her objects after everyone else, notably distanced from the rest of the objects but facing their direction. The object sculpture in the second series was more compact and layered than that of the first. The titles given for the object sculpture in the first series included connection, organized chaos, support,

and rainbow, which overlapped with the named themes that emerged during the discussion of embodied sculptures. In the second series, I asked the patients to speak the lines they assigned each of their objects as they placed them in the object sculpture. Themes from the spoken lines included hopefulness, nature, and 'I am' statements. Object sculpture titles in the second series included smorgasbord and community, similar thematically to the first series' titles.

During the sound and movement check-outs of both series I noticed movements that seemed to let go, or take something in. In the first series, the patients also included movements that were silly and appeared as lifting upwards. After the first series closed, most of the patients wanted to take photographs on their phones of the object sculpture. I noticed the patients offering support to one another, feeling comfortable taking up space in the room, and making plans to go to their next group together. At the conclusion of the first series, it felt as if the group of ten patients knew each other well and had been working together for longer than two sessions. Patients in the second series were noticeably less social at the conclusion of their groups and shared wishing they had more time to write their narratives.

Responses to My Questions About the Method

I observed patients in both groups engage with their objects physically and become excitement when sharing how objects represented parts of identity. Of all included interventions, patients appeared most comfortable in their bodies and mentally focused while reflecting individually through writing. In both implementations, I noticed that narrative writing and sharing led to the most genuine, vulnerable expression of identity. I suspect the use of projective objects prepared patients for narrative writing, and the combination of the interventions allowed patients to reflect deeply and prepare something they felt comfortable sharing.

Themes of patients identifying things they like about themselves, recognizing things that hold them back, and overcoming difficulties emerged in the narratives of both method implementations. Nature was mentioned in object sharing and narratives. In both the first and second series, Object 1 sharing was mostly abstract while Object 2 sharing involved literal components of the objects in relation to one another. The narratives were abstract in content and structure, with only one or two people in each group writing literally as if a journal entry.

In the first series, I noticed the most hesitation during group sculptures. In the second series I noticed some hesitation throughout, but predominantly during the sound and movement check-in and check-out. The theme of queerness emerged in the narratives of the first group, but not did arise in any sharing of the second group. The first group talked to and leaned towards one another throughout both sessions, while the second group engaged with one another only when directed to by an intervention.

From my experiences in the sessions, I speculate that using objects as projective techniques to represent identity, followed by narrative writing, is an effective way for queer adults in a partial hospitalization program to reflect on and express identity. It is possible that embodied interventions, in this case small group sculptures and sound and movement exercises, are less comfortable and allow for less genuine expression with this population than interventions with more distance, such as narrative writing or the use of projective objects. My intuition is that the complicated relationships many transgender and gender nonconforming people have with their bodies may lead to embodied drama therapy exercises being more challenging for them than for other communities.

Discussion

During the first method implementation, I noticed differences in engagement levels during projective object, narrative, and embodiment interventions. One of the ten patients did not choose objects or share with the group, but wrote a narrative about themselves and objects on the table that they related to. Another patient chose objects and was able to share them but did not write a narrative. Neither of these two patients participated in any embodied activity. An intention of my developed method was to provide patients with opportunities to engage in multiple drama therapy interventions, at various levels of distance, collaboration with others, and embodiment in the hope that at least one activity would be beneficial to each person. As a drama therapy student, I am interested in why certain interventions were more comfortable for some patients than others, and how I can use the tools of this profession to provide queer adults with appropriate and meaningful treatment. My observations of which exercises generated the most engagement, and which were overwhelming or difficult for some patients, are helpful in my continued growth as a drama therapist for queer people.

During the second series, I used a projective and discussion based intervention rather than embodied sculptures after narrative performances. This decision was made in response to the level of energy and the physical abilities I noticed in the room, as well as the small size of the group. In reflection of this choice, I wonder what would have happened if I had introduced the embodied sculpture intervention, and if the choice was made out of respect of the patients in the room, or out of my own fear about how it would go. In the first series I gave the option for seated embodied sculptures, and in the second series when a patient was in a wheelchair I abandoned the embodied sculpture activity altogether. In reflection of these choices, I recognize my own implicit biases and assumptions stemming from living in an ableist society. If I were to implement this method with the same groups of patients again, I would be interested to see the

response if I used the embodied intervention in both series. It is possible that the low energy in the second series would have led to resistance of group embodiment, but also it could have provided the patients with an opportunity to go beyond their areas of comfort and engage with others in a new way. I would also recommend that drama therapists critically reflect on their assumptions about who to use ‘embodied’ work with, particularly when planning for individuals who might be differently abled.

I intentionally chose to provide patients with objects that were colorful, playful, and the majority of which did not represent living beings. Objects provided during the first series can be seen in Appendix A, and objects provided during the second can be seen in Appendix B. Two miniature garden decorations, one of a rabbit and one of an owl, were included unintentionally. I chose to use inanimate objects, rather than animal or human figurines, because I wanted the patients to not be swayed by personality traits stereotypically ascribed to certain animals or people when projecting their identity. In my work with this population, I have found that patients are generally less abstract and complex in their projections when offered animals or people, than when choosing between various non-living objects. For future research it may be interesting to implement this intervention using figurines of animals or humans, to observe the way participants do or do not align their identities with the assumed characteristics of their objects.

Throughout my method, I observed the most focused engagement while patients chose and shared their objects, and while they wrote and shared their narratives. Narrative writing, specifically, was the intervention where I noticed the most energy during both series. I am curious if narrative writing would have generated as much genuine reflection if used alone, without following a projective object intervention. I also wonder what would have been shared about identity if the projective object exercise had been expanded, and narrative writing had not

been included. Future research should investigate how and what queer adults in a partial hospitalization program might share about identity through only projective objects, and then through only narrative writing. I speculate that using projective objects as a warm up to narrative writing allowed for both interventions to be meaningful in the ways that I observed.

While introducing the narrative writing exercise, I diverted from my original plan and used the prompt, “I am...” rather than, “My identity is...” I developed my intervention with the expectation that patients would mention identity labels referencing gender, sexuality, and other categorical facets of self that they view as part of their identities during projective object sharing. I planned for the narrative writing to follow by asking patients to explore what those labels meant. However, what I observed was that patients used their objects to share complex, abstract parts of themselves and rarely mentioned labels at all. Participants did not require scaffolding to bring them beyond a place of categorized identity. I adjusted the narrative prompt to match the multifaceted ways they explained themselves and provide the opportunity to expand further.

I was surprised that patients rarely mentioned their gender or sexuality during any of the interventions. It is possible that in a space specifically designed for queer people, participants did not feel the need to identify themselves with regards to this aspect of themselves. The partial hospitalization program where this method was implemented is designed to acknowledge and validate patients’ gender and sexual identities. Queer adults, many of whom spend enormous amounts of energy trying to explain to others who they are, may feel they have the opportunity to explore their identity beyond queerness when surrounded by people who do not question their pronouns, names, or expression. In both series, all patients presented as white; due to the power imbalance that often allows white people to see themselves as ‘neutral,’ it is unsurprising race did not explicitly emerge within these groups. If there had been patients in either group who

identified as people of color, it is possible that racial themes would have emerged in object sharing and narrative work.

While patients shared their objects during the first series I noticed that many positioned their second object as a counter role, or opposite, to their first (Landy et al., 2003). During the second series patients identified their second object as a helper role, or guide (Landy et al., 2003). I specifically asked patients to choose a second object that could help or support their first object with the intention of asking them to reflect on how they can help themselves with a challenge related to identity. I did not plan this method with role theory in mind, but in hindsight it is clear I should have anticipated the emergence of the guide and counter role. My prompt, unintentionally, asked patients to choose an object that represented the guide (Landy et al., 2003). It is interesting then, that so many patients during the first series viewed their second object as a counter role to their first.

I am curious as to what, if anything, led to this positioning of opposites emerging only during the first implementation and not the second. Even more so I am interested in how some were drawn to a role being helped by its opposite, and others created a guide to lead their initial role to a place of happiness or peace. Landy (2003) explains that the goal of role theory is to help clients reach a state of balance where each role and counter role are unified by way of the guide, which assists the role and counter role in understanding and accepting one another. In future research it would be helpful to give participants the opportunity to choose three objects specifically prompted to be a role, counter role, and guide. Facilitators should notice which role individuals are most drawn to, and how they feel each role can help the others. My intention in object projection was to expand the way patients understand themselves. This aligns with the objective of role theory, that if individuals are able to expand the number of roles they play in

their lives they can live a fuller and more flexible life (Landy et al., 2003). I am curious how a queer adult's sense of identity may be impacted by the expansion of their role repertoire.

My developed method was implemented with queer adults in a partial hospitalization program, and therefore may not be appropriate with similarly-identified people in other settings or non-queer adults at the same level of care. In reflection of the hesitations and excitement I observed during certain interventions, the themes that emerged, and the focus or lack thereof on queerness, it is essential that I consider whether or not this presentation is consistent with patients at a partial hospitalization program, or if it specific to the needs and tendencies of queer adults. In future clinical and research work with this population I hope to better understand how the presentation of my patients is consistent with the larger queer community, and how drama therapy can be applied to queer people in affirmative, and transformative ways.

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THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Christine Mayor