Spring 5-16-2020

The Queer Expansion of Role Theory: A Drama Therapy Intervention With LGBTQ+ Adults

Abigail Truax
atruax@lesley.edu

The Queer Expansion of Role Theory: A Drama Therapy Intervention With LGBTQ+ Adults

Capstone Thesis

Lesley University

05/03/2020

Abigail Truax

Drama Therapy

Laura L. Wood, PhD, RDT/BCT

Abstract

There is currently a lack of information in understanding LGBTQ+ specific needs in mental health care, thus creating a marginalized space in which queer people are significantly more dissatisfied with mental health treatment as opposed to heterosexual and cisgender people seeking treatment (Avery, Hellman & Sudderth, 2001). This thesis will focus on the development of a method in which I will expand upon Robert Landy's role theory and create a drama therapy role intervention crafted specifically for the queer population and their needs. Because of oppression within the LGBTQ+ community my focus will be on expanding role theory and its categories to make the taxonomy more applicable to the experience of being queer.

The Queer Expansion of Role Theory: A Drama Therapy Intervention With LGBTQ+ Adults

Introduction

A growing aspect of mental health includes creating treatment and spaces specifically for queer or LGTBQ+ people. Although these spaces and practices are being created, there is still a large need for continued creation of them, and research specific to the queer community (Clarke & Peel, 2007).

Because the language we use to refer to those in the queer community over time has changed and evolved, some previous language and reference to the community has become outdated and offensive in terms of language and explanation (Lunardi, 2019). Because of this I will be using the terms queer and LGBTQ+ to reference the community as a whole, both of which have become umbrella terms to identify people who do not fit in a heteronormative and/or cisgender category.

Because of discrimination against queer people and internalized homophobia, queer people tend to experience lower self-esteem (Drazdowski et al., 2016). Along with internalized discriminations, the Human Rights Campaign (2018) reported that LGBTQ+ people are twice as likely to be physically assaulted, and that most current LGBTQ+ youth were more honest about their identity online than they were in everyday life.

Through my experience of working clinically within a specifically queer setting, I've seen that all of these factors can influence an LGBTQ+ person's ability to be comfortably and authentically themselves. When taking authenticity into consideration, it is common practice that LGBTQ+ people tend to hide or cover parts of themselves in order to be straight passing, meaning no one would be able to identify them as queer by looking at them (Trottier, 2019). The

reasons LGBTQ+ people do this are vast and could involve safety, family, and discrimination in areas such as work or health care.

By using drama therapy with the queer population, there are more options to explore identity and coping, whereas using only words may not be enough to explain and explore the realities of being queer (Beauregard & Long, 2019). In the next section the literature review will support the discussion of why we need more queer inclusive therapy and will describe why drama therapy and role theory may be a helpful framework within LGBTQ+ mental health care.

Literature Review

Discrimination and the Queer Population

Although the queer population has made strides towards equality within the last ten years, including the expansion of legal rights for LGBTQ+ people, most of these rights have still been denied and discriminated against in most countries (Lee & Ostergard, 2017). In *Measuring Discrimination Against LGBTQ People: A Cross National Analysis*, Lee and Ostergard (2017) attempted to create a national measure of discrimination against LGBTQ groups and individuals based on a study of 175 countries. The authors' goal for this study was to expand beyond Europe in terms of international assessment of discrimination against the queer population. They found that many factors contributed to increase or decrease of discrimination of the LGBTQ+ population, including cultural beliefs, religiosity, age, education, socioeconomic status, and political ideas (Lee & Ostergard, 2017). Furthermore, it was found that even in places where LGBTQ+ people had full legal rights, it was dependent upon the tolerance of the state as to whether these rights were able to be exercised (Lee & Ostergard, 2017). Although it appears discrimination against LGBTQ+ people had diminished on legal levels, there were still grounds for discrimination based on if those legal rights were actually granted or not. The data also found

that 72% of states showed high levels of intolerance (Lee & Ostergard, 2017), meaning that along with legal and institutional discrimination, LGBTQ+ people also faced a high level of discrimination and stigma from others.

In *Creative Arts Therapist and the LGBTQ+ Population* (2019), there was a discussion on the importance of attuning to LGBTQ+ people and their needs based on discrimination and trauma in order to create a healing therapeutic relationship. Beauregard & Long (2019) discussed statistics of LGBTQ+ discrimination in their chapter, *Attuning to the Needs of LGBTQ Youth: Trauma, Attachment, and Healing Relationships*. The chapter set forth statistics and means of discrimination a clinician could use to help them understand the experience of LGBTQ+ people.

FBI research showed that the queer population is the most likely population to be targeted by hate crimes (Park & Mykhyalyshyn, 2016). Furthermore, because of recent improvements of LGBTQ+ rights, tolerance of the queer population became more of a threat to those who are not in favor of these rights (Beauregard & Long, 2019). Beauregard & Long (2019) also stated:

> In queer and trans communities, relational traumas often take the form of an erasure or disavowing of one's true self… Queer and trans youth often feel a need to keep silent about their identities, for fear of being teased or bullied, or even beaten." (p. 125)

This supports the notion that the queer experience needs different supports in mental health than someone of a heteronormative experience, which will be expanded upon in the next section.

Mental Health Treatment and the Queer Population

A text that outlined the history of the LGBTQ+ experience in psychology and mental health was, *Out in Psychology: Lesbian, Gay, Bisexual, Trans and Queer Perspectives* (2007). Something of key importance to this text was that it looked at psychology exhaustively through the LGBTQ+ umbrella and made sure to include all identities within the queer experience.

Clarke & Peel (2007) cited many examples and discussions on how LGBTQ+ experiences had been left out of the psychological lens in ways of heteronormativity and social constructs due to discrimination.

Because of the lack of understanding and amount of stigma against the queer population, mental health treatment for LGBTQ+ people has often been found as unhelpful, and sometimes can make a client's mental health situations worse. In *Satisfaction with Mental Health Services Among Sexual Minorities with Major Mental Illness* (2001), Avery, Hellman, and Sudderth attempted to expand information regarding treatment needs for the LGBTQ+ population. In doing so, they found that a significant number of LGBTQ+ people were more dissatisfied with their mental health treatment than their control group, and that the findings suggested a more specific experience towards the populations needs may create a more positive mental health experience (Avery, Hellman & Sudderth, 2001).

Semp's (2011), work also attempted to look at mental health treatment through a queer lens by critiquing the heteronormative structure that mental health care has been built upon. Semp's (2011) findings attempted to promote the normalization of discussing gender and sexuality within the mental health space among clients and clinicians. By doing this, Semp concluded that normalizing conversation of sexuality and gender identity and asking questions that can open a discussion rather than an answer to a question, could help create a less stigmatizing space (Semp, 2011).

In *Working with LGBT Individuals: Incorporating Positive Psychology into Training and Practice*, Lytle et al. (2014) showed the benefits of incorporating positive psychology principles in the training and practice of clinicians on how to work with the LGBTQ+ population. This article defined positive psychology as recognizing, "...the importance of complementary,

alternative perspectives on the human experience that depathologize individuals' experiences, beliefs and actions while helping them focus on their strengths (pp.1)."

The authors then used LGBTQ+ strengths to inform their work and conclusions (Lytle et al., 2014). The authors stated that if a queer individual must check off a box to identify themselves there should also be space for that individual to identify themselves in their own words (Lytle et al., 2014). It is hypothesized that by doing this, there is a formulation of positive emotion and experience by the queer client at hand (Lytle et al., 2014). The conclusion of the findings supported that using positive psychology and the strengths surrounding LGBTQ+ individuals when training clinicians would create a better environment for mental health care, thus increasing the likelihood of a positive impact on the queer population (Lytle et al., 2014).

Risk of Mental Health Issues Among LGBTQ+ Individuals

Up until 1973, the American Psychiatric Association listed homosexuality as a mental disorder (Veltman & Chaimowitz, 2014). Since removing the diagnosis of homosexuality, most major mental health organizations had taken a stance of support for the LGBTQ+ community (Veltman & Chaimowitz, 2014), but this has not lessened the high risk of mental health issues for the queer population.

In *Mental Health Care for People Who Identify as Lesbian, Gay, Bisexual, Transgender, and (or) Queer* (2014), Veltman & Chaimowitz outlined some of the statistics surrounding LGBTQ+ people and risk of mental health disorders. The study found that, in a recent surveying of the Canadian population, 77 percent of transgender people had considered suicide, and that 43 percent had actually attempted suicide, with 10 percent having attempted within the last year (Veltman & Chaimowitz, 2014). In an attempt to combat these findings, The Mental Health Strategy for Canada intended to address the specific needs for the LGBTQ+ population. They did

this by increasing recommendations of understanding by mental health professionals and increasing LGBTQ+ organizations and spaces that catered to queer mental health needs (Veltman & Chaimowitz, 2014).

It has also been noted that LGBTQ+ people show increased risk for numerous mental health problems. In *Typologies of Social Support and Associations with Mental Health Outcomes Among LGBT Youth*, McConnell, Birkett & Mustanski (2015) conducted a survey intending to examine mental health differences among LGBTQ+ people who received social support and those who did not. The data found that those with lower support reported more instances of hopelessness, loneliness, depression, anxiety, somatization, suicidality, and symptoms of Major Depressive Disorder (McConnell, Birkett & Mustanksi, 2015). These findings could also be used to advocate the need for a better understanding of the LGBTQ+ population within mental health treatment. Creating strictly LGBTQ+ treatment centers or programs could create social support, leading to less symptomatology.

Finally, more evidence of increased mental health issues within the LGBTQ+ population can be found in *Mental Health and Clinical Correlates in Lesbian, Gay, Bisexual, and Queer Young Adults* (2014). Grant et al. (2014) created a survey to assess mental health among a college population of LGBTQ+ people. The survey was voluntary and anonymous, and found that symptoms of depression, stress, poor self-image, and history of substance use were higher among the LGBTQ+ population surveyed. These conclusions again support the need for a safe space for LGBTQ+ people to discuss population specific struggles and issues.

Drama Therapy

Creative Arts Therapies and the LGBTQ Community (MacWilliam et al., 2019) was a more recent work that helped readers to explore not only drama therapy, but what all creative

arts therapies look like within the queer community. In favor of using drama therapy with the population, the chapter *Attuning to the Needs of LGBTQ Youth: Trauma, Attachment, and Healing Relationships* (Beauregard & Long, 2019) described why drama therapy can be beneficial with the queer population. By using the arts, Beauregard & Long (2019) believed that identity development and coping could become more accessible for the queer population due to words not always being accessible or seemingly enough to describe and explore the situations at hand.

Although drama therapy is shown as beneficial for the queer population, there is still a need for exploration and growth in terms of research and practice with queer clients within drama therapy. In a quantitative survey done of drama therapists, Beauregard, Stone, Trytan & Sajnani (2016), found that drama therapists were comfortable working with the queer community, but that there was still a lack of education among drama therapists around inclusivity and the queer community regarding their needs within drama therapy.

Role Theory. The basis of role theory lies in the assumption that all people are role players and takers (Landy, 2009). A deeper analysis into role theory and its meaning assumed that personality can be seen as an interactive system of many roles a person may hold and play in their life (Landy, 2009). Furthermore, role theory could be seen as a pattern of behaviors that relate to a certain way of thinking or acting based on relations to any role and its qualities, function, and style (Landy, 2009). A summary of these facets of role theory may assume that the roles a person plays both voluntary and involuntary are what create and define their personality.

Taking on a role and role playing has been shown to have therapeutic and healing value (Doyle, 1998). In *A Self Psychology Theory of Role in Drama Therapy* (1998), Doyle explored how role can be defined as a behavior or enactment that is assigned by society. People played

roles in reaction to relationships, environment, and how they wish to be perceived (Doyle, 1998). This all assumes that humans are role-players, which means analyzing and integrating role could be a tool for healing one's self (Doyle, 1998). Role could be used to help build self-structure (Doyle, 1998), which is something people in the LGBTQ+ community tend to have a difficult time doing authentically because of stigma and discrimination.

In *Role Profiles: a drama therapy assessment* instrument (2003), Landy et al. explored the use of role profiling as an assessment tool in drama therapy. Role is used to help assess spontaneity, what roles a person tends to play, patterns that arise, and personality styles (Landy et al., 2003). Landy et al. (2003) also suggested that therapeutic change could occur by increasing the roles a person may play and increasing a person's flexibility in moving from one role to the other. The way the assessment has been used involves a card sort, where the participant is given cards with roles printed on them. They are then asked to sort the cards into given categories of "Who I Am," "Who I Want To Be," "Who Is Standing in My Way," and "Who Is Helping Me." The way the participant organizes the roles may provide information about balance of roles, awareness of self, and importance of certain roles (Landy & Butler, 2012).

As stated earlier, *Creative Arts Therapies and the LGBTQ+ Community* (2019) attempted to bridge the gap between the creative arts therapies and its lack of LGBTQ+ literature. In Trottier's (2019) chapter, *Therapist as Guide: Role Profiles, Metaphor, and Story to Understand the Parallel Hero's Journey of the Queer Therapist and the Straight Client*, the author attempted to look at role theory through a queer lens as well as the eyes of the clinician. Trottier (2019), went into detail about the ideas of passing and how queer individuals sometimes believed they must act a certain way in order to fit into the role's society expected from them. Some examples

of these expected roles could include being heterosexual or cisgender. The role taxonomy as it is now doesn't specifically consider queer issues surrounding passing and what roles a queer person has been forced to take on in order to conform to societal norms.

The findings of this literature review make it clear that there is still work to be done in regard to discrimination against the LGBTQ+ populations. Currently, there seems to be a lack of researched knowledge surrounding drama therapy and the LGBTQ+ population, creating more space for stigma and misunderstanding when working with the population. This literature review also showed a clear need for LGBTQ+ specific mental health practices when caring for the population.

Methods

Participant Characteristics

For this thesis, I implemented a method at a partial hospitalization program specifically for queer adults in Boston, Massachusetts. The method included an exploration of role as queer people, by asking a group of LGBTQ+ participants to create their own role taxonomy based on their experiences of being queer. The method was implemented over two consecutive groups lasting 45 minutes with a lunch break of 45 minutes in between the two. The method was planned to be done twice, the first in March 2020 and the second in April 2020, as to allow a different milieu for each experience. Due to the impact of COVID-19, my method was only able to be implemented once in March of 2020.

Before the session, it was explained to the milieu that I would be running a new group created for my capstone thesis. I made the group aware that we would be exploring our roles in life through drama exercises. I also asked that if they chose to participate, that they would be present for both the first and second group. Along with that, I asked that if someone hadn't been

in the first group that they did not participate in the second. I let the participants know that no identifying information of theirs would be used within this thesis, and that no data would be taken or compiled as a result of their participation within the group.

Procedures

When my method was implemented in March of 2020, there was a large enough milieu that clients could decide whether they would like to partake in my group or not. I ended up with a group of 11 participants, the majority of the group identified as transgender, and the group was mostly Caucasian with two people of color present. This was known through previous information shared by the participants in group and individual therapy about their gender, sexual, and racial identities. All participants were present for both 45-minute groups. Most of the clients in this group had experienced some type of drama therapy group or intervention before and were somewhat familiar with what to expect from a drama therapy group.

Based on Landy's role profile assessment I set up the room with four large poster papers taped along the walls with headings of "Who I Am," "Who I Have To Be," "Who I Want To Be," and "Who Is Helping Me.". Many of the clients in the group were the current "leaders" of the milieu. They had been in treatment for almost a month and were very comfortable with others in the milieu, as well as talking about their experiences in the group.

To begin the group, we checked in with names and what pronouns we use, this is how we start most groups and was included in order to give the group a sense of comfort and familiarity. I also asked for the participants to check in using a gesture of how they were feeling in that moment in order to gauge the mood of the room. Most gestures during this check in were ones of stress and gestures that were seemingly closed off.

To continue, I then had the group split into two groups of four and one group of three. I explained to the group that we would be exploring the feelings of who we have to be and who we want to be through creation of group sculptures. My reasoning for only exploring these two categories through sculpture was due to both time and the creation of the new category of "Who I Have To Be." Because this is a new category that hasn't been explored before, I wanted to prime the group for exploring that category of role and what came along with it. I also wanted the group to be able to explore the differences between that category and another, and I thought the category of "Who I Want To Be" would help participants to find counterroles within the category of "Who I Have To Be." This meant the participants would be exploring roles that may contradict or "exist on the other side (pp. 150)" of a given role within the two categories (Landy & Butler, 2012).

I explained the creation of group sculptures to the group as a real-life photo that captured a moment or feeling for us all to look at and explore. I also made the group aware that they could come up with one unifying sculpture, or they could also create a sculpture by bringing their separate feelings and ideas together to create one sculpture. I wanted the group to be able to express individual feelings in a unified way, and I allowed them the space to decide as a group if their feelings were similar enough to create a common themed sculpture or if they would like to create the sculpture by bringing their individual ideas and feelings together as one.

I then asked the small groups to create two different sculptures, one that represents a time where they had to hide themselves or their beliefs, and one that represents how they want to feel or be in the future. I gave the groups about five minutes to discuss and create these sculptures, and then gave them the chance to perform them. I asked all the groups to present the sculptures of a time where they had to hide themselves or their beliefs first. As each group sculpture held its

final pose, I asked them to stay in it for about 30 seconds so the witnessing group could comment on what they saw and how it made them feel. Once each group had the opportunity to share the first round of sculptures, I asked them again in the same order to share their sculptures representing how they want to feel or be in the future. I again asked each group to hold their sculpture for about 30 seconds, so the group had a chance to associate feelings, thoughts, or words with what they saw.

We then moved into the start of creating the group taxonomy. To begin creating the group taxonomy, I had each group member explore four categories of role independently. I did this by having each group member create their own list of roles they've played in their life within the four categories of "Who I Am," "Who I Have To Be," "Who I Want To Be," and "Who Is Helping Me." I described role to the clients as anything they felt they have taken on in their life, examples being, "the strong one," "sibling," "the hero," and so on. I allotted about ten minutes for the clients to create their own taxonomy that was specific to their own experiences.

Then, I moved on to letting the clients create a group taxonomy by instructing them to put any roles from their own lists onto the poster paper on the walls with category labels. I allowed them to decide which roles they contributed to the group taxonomy and did not force them to include any personal roles they did not want to. I then gave the group about five to seven minutes to add roles to the group categories and asked them to put a star or mark next to any roles they did not write personally but may have experienced.

The first half of the group ended at this point. Once all participants had a chance to finish adding to the group taxonomy, we took a 45-minute break. Once the break was over, all 11 participants returned for the second half of the group.

I started the second half of the group with a discussion allowing the clients to share what they noticed in the first group, what feelings came up for them, if there was anything unexpected that occurred, and if there was anything that stayed with them and their thoughts during our 45-minute break. Once the group conversation ended, I explained to the group that for the next part of the session I was going to ask them to choose one role from each category to work with. I explained that it could be a role from their personal list, or it could be a role from the group taxonomy because those roles were offered to the group. I gave the group 5 minutes to look through their list and the group taxonomy to decide which role from each category they would like to explore further in the next part of the group.

Once each group member chose one role from each category to work with, they were asked to write a short monologue, or description of the role that may be presented to the group. I gave the participants ideas to support them in building their monologues with prompts such as answering: who the role is, what it does, what are its biggest strengths and weaknesses, and what its purpose is? These were not questions the participants had to answer within their monologue, but rather ideas for them to think about to get them started if they needed the support. I gave the group a time limit of fifteen minutes to write a short monologue for each role and let them know the next part of the group would involve volunteer participation to share these monologues with the group.

I then set up four empty chairs across one side of the room and assigned each chair to one of the four role categories the group was exploring. I set the chairs up in the order of "Who I Am," "Who I Have To Be," "Who I Want To Be," and "Who's Helping Me." I explained to the group that for the final part of the session we would be introducing each role they specified for each category to the group. To do this, I explained that each chair was assigned a category of

role, and that they would be allowed to read each monologue and introduce the group to the role they had personally chosen for each category.

I utilized the four chairs in order to implement distance and a way for the participants to detach themselves from the roles once they left the chairs. Because I was asking the participants to enroll in what might be difficult roles, especially in the category of "Who I Have To Be," I wanted to make sure to allow the clients to be able to step out of the role once they were done presenting it.

Limitations

Method Considerations. As I had the group sit and create their own personal role taxonomy for all four categories, it took much more priming and explaining of what role meant than I had anticipated. In order for the group to better understand what exactly I meant by "what roles do you play?" I had to take an unexpected 5 minutes or so to give examples such as the sibling, the patient, the kind one, the villain. Being able to give examples of the different types of role such as roles within a movie, roles you plan in a family, or roles that come with a feeling made the idea more solid and workable for the participants.

By assuming the group would know what role meant, the taxonomies could have been lacking or confusing in their construction. This made me aware of how much more specific my intervention and instructions should have been, and that I should have allotted time for a deeper discussion of what role is. This deeper discussion would allow the group a better understanding as well as a better experience with a role intervention.

Biases. Because of my own identity within the LGBTQ+ community, I find myself having a personal bias towards working with the queer population. The method in this thesis was created with my own personal bias of being a queer person and experiencing some of the

discrimination that queer people go through. Because of my identity, I was undoubtedly using my own bias to create a method informed by some of my own personal experiences.

It also must be noted that I identify as a cisgender person, meaning my personal identity and gender identity are in line with the gender I was assigned at birth. The bias in this case lives within the fact that many of the participants in my method were transgender, and because I am not transgender and have not had the experiences of living as a transgender person, I was not able to include their point of view personally within the creation of my method. Because of my personal identity there was an inherent bias towards the cisgender experience within my creation of my method. I did however attempt to create a method that the participants would spearhead, in order to lessen this bias. The way I attempted to do this was by having the participants create the role taxonomy based on their experiences, rather than me creating the taxonomy list for them to choose roles from.

Population. Because the space where I did my intervention is for the general LGBTQ+ population, I am only able to speak on my method within the umbrella term of queer. Although each participant had their own specific identity whether that be transgender, non-binary, gay, etc., the group was open to all queer identities. This means the method could not be tailored to one specific facet of queer identity but had to be broader in terms of analysis, conclusion, and will be expanded upon within the recommendations for future study.

This method was also broad in terms of race and ethnicity, and although there were participants of color, this method cannot speak entirely to the intersection of sexuality and race. It has been found that the experience of a white LGBTQ+ person and an LGBTQ+ person of color can be vastly different in terms of discrimination and minority stress (McConnell, et al., 2018). LGBTQ+ people of color are subject to increased stress due to experiences not only of

homophobia, but also racism (McConnell, et at., 2018). The intersection of race, gender, and sexuality contributes to a much different experience than if a queer person were white and did not experience racism. Because my method took place in a partial hospital setting there were a mixture of races present among participants, meaning that this method and its conclusions cannot account for the complete experience of LGBTQ+ people of color.

Another limitation was present regarding socioeconomic status (SES) among participants. SES is the combination of a person's education, income, and occupation and relates closely to power and privilege. Because participants were in a partial hospital setting, that meant they were required to have insurance either privately or through an employer. This insinuates that all participants have some level of privilege in the fact that they either have an income, can afford health insurance, or are covered through family or spouse. This means that any lower class or non-working queer people were not allowed to take part in the partial program, setting my participants at a higher SES than queer people who are not able to receive adequate health care due to lack of health insurance.

Results

While I will reference prominent or impactful roles later in this section, I have included a table of the complete role taxonomy created by the participants within the given categories.

Table 1

Group Role Taxonomy

Who I Am	**Who I Have To Be**	**Who I Want To Be**	**Who's Helping Me**
The "therapy dog" friend The partner The disempowered one	The giving one Responsibility Socially accepted one	The strong one The one who didn't stop fighting The loved one	The reliable one The rational one The homies

The one who wants to change	The patient patient	The protected one	Truth-tellers
The fearful one	The strong one	The friend	The music, my voice
The procrastinator	The one who gives in first	In control	The wood pile (for chopping)
The lover	The fixer	The believed one	The partner
The lost one	The one who can always keep going	The independent one	The free spirit
The quiet one	The dependent one	A controller	My dang self
The bitter one	The "experiment"	The one who doesn't fear closed doors	The cats
The jaded one	The liability	The best self	The one(s) I'm related to
The "bright" one	The warrior	The self-made	My drive for life
The one who can't ask for help	The caretaker	The one who makes it out	
	The one who kept the secret	Someone who quit [insert substance]	
	Quiet		

The first observation I noted about the group was the mood in their check-in gestures. Many were gestures of folded arms, perhaps signifying being closed off or angry. This theme of mood then continued into our first round of sharing sculptures. During the sharing of "Who I Have To Be" sculptures, I saw that most of the sculptures had an aspect of sadness, stress, or hiding. Some of the noted postures and gestures of these sculptures were hunching, someone stepping on and over another person, isolation, hidden faces, and hats or hands covering the eyes.

When the participants were asked to shout out words or feelings associated with this first round of sculptures, some of the most repeated words across all sculptures were scared, oppressed, fear, anxiety, sadness, disappointment, and anger. These expressions also seemed to bleed into the group mood as well, I noticed the energy becoming less and less among the group members as the small groups continued presenting their sculptures for this category.

As we transitioned into the second set of sculptures within the category of "Who I Want To Be," the group mood dramatically changed. Some of the significant associations noted with the sculptures were feelings of love, joyfulness, marriage, relaxation, excitement, individualism, strength, being unapologetic, and community support. The energy in the room upon the first sculpture in this category was heightened into an excitement and happiness almost immediately.

During our group conversation and check-in after the first session, I noticed some themes coming up within the discussion around identity, growth, and the experience of being queer in a world where the LGBTQ+ population is often discriminated against (Lee & Ostergard, 2017). The next step of the intervention following discussion, was the creation of the group taxonomy.

The second half of the intervention asked the group members to pick one role from each category to work with for the remainder of our time. I will list the roles chosen by two volunteers that were able to introduce their chosen roles from each category to the group during this second half. If time had allowed, I would have let anyone in the group the chance to perform and introduce their roles, but due to time I was only able to allow two of the group participants to share.

For the first volunteer, the chosen roles in the order of "Who I Am," "Who I Have To Be," "Who I Want To Be," and "Who's Helping Me," were "the hopeful one," "a warrior," "the one who makes it out," and "the homies [community/friends]." The role that the participant and group explored most through monologue and question was the role of the warrior. The second participant to volunteer chose the roles, in the order previously stated, of "dog dad," "the person with a secret." The role of "the person with the secret" within the category of "Who I Have To Be," was directly related to this participant's queer and transgender identity and was explored most by the group through question and answer.

Arts Based Work

After the sessions concluded, I recorded a video of myself dictating what happened during the sessions. I organized these videos by first letting myself give a word by word description of exactly what happened in the group with as much detail as I could remember. I then attempted to recount any moments that I felt were particularly important, or moments that were unexpected. I ended my video recordings by answering my initial question: "what could LGBTQ clients able to take away from my intervention, and was it in line with what I hoped this intervention would accomplish?"

I did this in order to track what happened during my intervention, and so I would have a fresh recollection with as much detail as possible when analyzing my method. I also focused on giving detail to prominent parts of the intervention so I would be able to better analyze them and conclude as to why they were such important moments. My final question to myself held the purpose of being able to criticize or expand upon my method based on the answer of what I thought the method was able to accomplish or failed to accomplish.

Discussion and Conclusion

In this section I will be detailing key points and findings from the implementation of my method. The major points I took away from this intervention were the impact of an inclusive space, the unique narratives within the queer experience, and how roles in the traditional taxonomy may be perceived differently through the queer experience.

My first observations during this intervention were of the participants moods and interactions during the group sculptures. The main difference in the group mood between the two categories of "Who I Have to Be," and "Who I Want To Be" noted by myself were the energy levels and group interaction. I noticed that trying to get the group to talk and shout out their

associations with sculptures in the first category was difficult, they did not want to speak, and I had to ask multiple times in order to get the groups ideas out into the space. On the other hand, it was almost impossible for me to quiet the excitement, laughing, and comments upon the showing of the second category of sculptures. I did not anticipate such a strong and fast mood shift within the group, it was a very abrupt and surprising shift from almost no energy into an over the top, excited, energy. These mood shifts also may have spoken to the comfortability the participants had with the roles within each category. Their eagerness to interact with the category of "Who I Want to Be" led me to think they were more comfortable exploring these roles, whereas the silence and hesitance towards "Who I Have To Be" made me believe the participants were less comfortable interacting with these roles.

Next was the creation of taxonomy, and my goal in having the group create the taxonomy rather than giving them the traditional taxonomy to take from was to give them autonomy over the roles they chose. I also wanted to see what roles came up that may apply specifically to the queer population, as well as what roles were most important to this groups experience of being queer.

When analyzing the group taxonomy created by the participants, I was able to identify roles that were highly resonant among participants as well as roles that stood out to myself personally. Within the new category of "Who I Have To Be," some of the roles that had the most marks indicating multiple group members identified with the role were "the experiment," "the liability," "a warrior," "the one who can always keep going," and "the socially accepted one." Many of the roles that were highly resonant with multiple participants implied a sense of needing to conform in some way due to the experience of being a hindrance, whether it be to society and its expectations, or a single person's expectations or complaints.

Something I also noticed within this category was the participants feeling they needed to be strong roles such as a warrior, or someone who must keep going even in times they feel they cannot. This may speak to the pressure that queer persons may be under, and how they feel they must continue to fight or power through the discrimination they face both personally and systemically. I believe this category creation within a queer space allowed participants to explore the nuances and oppression of being queer, as well as the positive and hopeful side of being a part of the queer community. It allowed the participants to interact with challenging roles in a space where they felt more comfortable to do so. The major focus in continuing to explore this category would then be on helping the participants find subroles and qualities of these roles that allow the participants to see their roles as well as themselves in a balanced way. Through the connection of these more charged roles with roles the participants are more comfortable with, the participant may achieve a better sense of self-awareness (Landy & Butler, 2012).

The importance of the category of "Who I Have To Be" within a queer setting was also analyzed by myself through the experiences of both participants who volunteered to introduce their chosen roles for each category. The first volunteer's role chosen for this new category was "the person with the secret." This is an excellent example of my notion that safe, queer specific spaces in mental health treatment are helpful and needed. This role, when explored through monologue and group questions, was asked why they couldn't reveal their secret. The answer to this question revolved around past experiences of violence and discrimination regarding the secret previously "getting out." The role explained to the group that due to this past treatment when the secret was "out," it must remain a secret to everyone else. This was an interesting dichotomy because at this point in the participant's treatment, all of the milieu and clinicians

were aware of this person's identity as transgender due to the participants own comfort towards disclosure within the queer treatment space.

Because of the nature of the queer specific space, this participant was able to tell their "secret" that they felt the rest of the world must not know. In a queer space, they didn't have to be this role that they described as confining, whereas in a space that is either more heteronormative or doesn't have an agreeance of acceptance of queerness, this participant may not feel safe enough to disclose something that highly affects their experiences and their mental health. This also might mean that in a non-queer space, this participant may not have received as many benefits from mental health care due to the stress of keeping this secret and not being able to incorporate the stress and reality of their transgender identity into their treatment. Giving the participant autonomy over this role that is seemingly uncomfortable to them helped to give them the ability to work with this role. Because of the creation of an inclusive space, the participant felt comfortable introducing roles they may have had difficulty working with in a less inclusive or non-queer space.

Because this was a group of only queer identifying people, they were able to share facets of their reality and experience that they may not have been able to safely or comfortably share in a space that was not strictly queer and supportive of queer identities. Perhaps, the most prominent aspect of an all queer space is the fact that all the participants knew their queerness would be accepted and sometimes even mirrored. As mentioned in my literature review (Avery, Hellman & Sudderth, 2001), there is the fear of not knowing if someone within the group may be discriminatory or harmful upon knowing someone else in the group is queer. In general, this method and queer specific space allowed the participants to share similar feelings, roles, and experiences as queer people that were both comfortable and uncomfortable for them which

created more opportunity for role integration. It's important to note the impact of a safe queer space because through my observations it led to an easier integration of counterroles, and an overall willingness to do role work.

The second volunteer's role chosen for the category of "Who I Have To Be" was the role of the "warrior." This role caught my attention because while it is a role that can be found in Landy's (2003) traditional taxonomy, the way the role was embodied offers important considerations for those drama therapists using role method with queer persons. The role was explained by the volunteer as the reality of a queer person, noting that right now there is almost always something to fight in terms of discrimination. This participant was also a person of color which I think made this role even more applicable due to the intersection of queerness and race which leads to an even higher amount of discrimination and prejudice. I think that the categorization of this role in "Who I Have To Be" rather than the category of "Who I Want To Be" or "Who's Helping Me," for a queer person, is also a significant piece of information that speaks to their realities of discrimination and oppression. The discrimination a queer person is faced with is not experienced by someone who is heterosexual and/or cisgender. Rather than wanting to be a warrior, someone who is queer perhaps has to be the warrior in order to exist in a world where their identity is often challenged. This example provides useful information for drama therapists working with the queer population in that it gives an example of an experience that may be different for someone who is queer versus someone who is not. For a drama therapist that may not be queer, it can provide a better understanding of a queer client's hardships and specific experiences in regard to their LGBTQ+ identity.

I also noticed that one of the questions asked to the participant while they were enrolled as the warrior seemed to surprise them. This was the question of what armor the warrior used for

protection, to which the warrior replied that their fashion was their armor. This answer was highly resonant with the group, and I think is especially applicable to the queer population and its emphasis on creativity, style, and individuality. This connected to the idea of positive psychology within the literature review (Lytle et al., 2014), by analyzing queer specific strengths the participant was able to find something positive even within a role they seemed uncomfortable playing in that moment. Drama therapists may use this information to enhance their work with a queer client by keeping in mind the effects of allowing the client to share positive connections to their queer identity.

Another observation I made through the volunteers sharing of their roles and the creation of group taxonomy was discovering what roles were essential to this groups experience of being queer. Because I allowed the group to create their own taxonomy, they were able to list what roles they felt were essential and important to their identities as queer people. Roles such as "the one who made it out" and "the homies [community/friends]" held strong meaning, importance, and resonance to this group. It may be considered that giving the participants the autonomy to create the role taxonomy allowed the opportunity for roles that were essential to the queer experience, but are not listed within the traditional taxonomy, to be discovered.

Something I noticed for both participants that shared was the role they chose for the category of "Who's Helping Me." Both volunteers chose the same role of "the homies" which each of them used to symbolize their friend groups and the queer community. This role also resonated deeply with the group, as I noticed head nods, snaps to signify agreeance. When the role of "the homies" was presented, both times the whole group became excited and responded with agreeance and a stated sense of pride for the support from within their community and their personal support of each other during treatment. This again led to the discussion of how grateful

the group was to be able to be honest and supportive within a queer space. The group reported that they felt accepted, which was something they reported not feeling often outside of a queer specific space. The presence of this role within the taxonomy created a more inclusive space for queer participants, showing it may be a vital part of role work with the queer population.

My speculation of the most notable roles within the category of "Who's Helping Me" as a whole included a theme of community and partnership within the queer community. Many of the roles presented had to do with connection to other queer people or allies to the queer community such as romantic partners, friends, or supporters of the community. I noted that there was only one role listed in the complete taxonomy referred to biological family members, which does not seem strange due to family stress around being part of the queer community within a family model that is typical heteronormative (Clark & Peel, 2007). This shows why the role of friend within a queer taxonomy may be important, because there were more roles that connected to friendship and community that seemed to be essential to this groups experience of queerness than there were familial roles.

Because the method took place in an inclusive and queer friendly setting, participants were comfortable working with roles they may have otherwise found uncomfortable sharing in a traditional mental health care setting. Furthermore, the autonomy given to the group in the creation of the taxonomy not only created more inclusivity but allowed for this LGBTQ+ groups representation of specific narratives and roles that were essential to them and their experiences. And finally, there were some roles presented by the group that were similar or identical to roles within the traditional taxonomy, but these roles held different meanings for this group of LGBTQ+ people than they would normally hold through a heteronormative lens on which the traditional taxonomy was built.

Recommendations

Moving forward I hope to explore queer role taxonomy further through the examination of the ways in which roles in a system interact with one another. One of the ways to assess a balanced integration of role is whether the participant can make meaningful connections between roles within different categories (Landy & Butler, 2012). This group had an almost even numbers of roles within each category which is also a sign of balance among roles, but we did not have the time to explore whether the roles were able to connect to each other between the categories. This would be my next step in carrying out this method along with exploring subroles that may exist within the roles presented.

I hope that the drama therapy community as a whole will see the need for queer specific care and focus not only when practicing role theory with LGBTQ+ clients, but with any sort of therapy done with this population. I hope this thesis will be used to help build upon the current literature in support of the need of more queer inclusive drama therapy practices and inclusive expansions of theories that already exist within drama therapy.

References

Avery, A. M., Hellman, R. E., & Sudderth, L. K. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health*, *91*(6), 990–991. doi: 10.2105/ajph.91.6.990

Beauregard, M. & Long, K. (2019). Attuning to the needs of LGBTQ youth: Trauma, attachment, and healing relationships. In MacWilliam, Harris, Trottier & Long (Eds.), *Creative arts therapies and the LGBTQ community: Theory and practice* (pp. 119-138). Jessica Kingsley Publishers.

Beauregard, M. & Long, K. (2019). Attuning to the needs of LGBTQ youth: Trauma, attachment, and healing relationships. In MacWilliam, Harris, Trottier & Long (Eds.), *Creative arts therapies and the LGBTQ community: Theory and practice* (pp. 119-138). Jessica Kingsley Publishers.

Beauregard, M., Stone, R., Trytan, N. and Sajnani, N. (2016). Drama therapists' attitudes and actions regarding LGBTQI and gender nonconforming communities. *Drama Therapy Review*. *2*(1), 41–63. doi: 10.1386/dtr.2.1.41_1

Clarke, V., & Peel, E. (2007). O*ut in psychology: lesbian, gay, bisexual, trans, and queer perspectives.* Chichester, West Sussex, England: Wiley.

Doyle, C. (1998). A self psychology theory of role in drama therapy. *The Arts in Psychotherapy, 25*(4), 223–235. doi: 10.1016/s0197-4556(98)00018-5

Drazdowski, T. K., Perrin, P. B., Trujillo, M., Sutter, M., Benotsch, E. G., & Snipes, D. J. (2016). Structural equation modeling of the effects of racism, LGBTQ discrimination, and internalized oppression on illicit drug use in LGBTQ people of color. *Drug and Alcohol Dependence*, *159*, 255–262. doi: 10.1016/j.drugalcdep.2015.12.029

Grant, J. E., Odlaug, B. L., Derbyshire, K., Schreiber, L. R. N., Lust, K., & Christenson, G. (2013). Mental health and clinical correlates in lesbian, gay, bisexual, and queer young adults. *Journal of American College Health*, *62*(1), 75–78. doi: 10.1080/07448481.2013.844697

Human Rights Campaign. (n.d.). 2018 LGBTQ Youth Report. Retrieved from https://www.hrc.org/resources/2018-lgbtq-youth-report

Landy, R. (2009). Role theory and the role method of drama therapy. In Emunah, R. & Johnson, D.R. (Eds.), *Current approaches in drama therapy* (pp. 65-88). Springfield, III: Charles C. Thomas.

Landy, R. J., & Butler, J. D. (2012). Assessment through role theory. In D. R. Johnson, S. Pendzik & S. Snow (Eds.), Assessment in drama therapy (pp. 148-176). Springfield, Ill.: Charles C. Thomas Publisher.

Landy, R. J., Luck, B., Conner, E., & Mcmullian, S. (2003). Role profiles: A drama therapy assessment instrument. *The arts in psychotherapy*, *30*(3), 151–161. doi: 10.1016/s0197-4556(03)00048-0

Lee, C., & Ostergard, R. L. (2017). Measuring discrimination against LGBTQ people: A cross-national analysis. *Human rights quarterly*, *39*(1), 37–72. doi: 10.1353/hrq.2017.0001

Legate, N., & Ryan, W. S. (2014). Autonomy support as acceptance for disclosing and developing a healthy lesbian, gay, bisexual or transgendered identity. In Weinstein, N. (Eds.), *Human motivation and interpersonal relationships: Theory, research, and applications* (pp. 191–212). Springer Science & Business Media. doi: 10.1007/978-94-017-8542-6_9

Lunardi, E. (2019). *Drama therapy with queer adults: Identity reflection and expression* (133). Lesley University. https://digitalcommons.lesley.edu/expressive_theses/133

Lytle, M. C., Vaughan, M. D., Rodriguez, E. M., & Shmerler, D. L. (2014). Working with LGBT individuals: Incorporating positive psychology into training and practice. *Psychology of Sexual Orientation and Gender Diversity*, *1*(4), 335–347. doi: 10.1037/sgd0000064

MacWilliam, Harris, Trottier, & Long. (2019). *Creative arts therapies and the LGBTQ community: theory and practice*. London: Jessica Kingsley Publishers.

Mcconnell, E. A., Birkett, M. A., & Mustanski, B. (2015). Typologies of social support and associations with mental health outcomes among LGBT youth. *LGBT Health*, *2*(1), 55–61. doi: 10.1089/lgbt.2014.0051

McConnell, E. A., Janulis, P., Phillips, G., 2nd, Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 1–12. doi: 10.1037/sgd0000265

Park, H. & Mykhyalyshyn, I. (2016) 'LGBT people are more likely to be targets of hate crimes than any other minority group.' *New York Times*, June 16, 2016. Accessed on 04/02/2020 at www.nytimes.com/interactive/2016/06/16/us/hate-crimes-against-lgbt.html.

Semp, D. (2011). Questioning heteronormativity: using queer theory to inform research and practice within public mental health services. *Psychology and Sexuality, 2*(1), 69-86. doi: 10.1080/19419899.2011.536317

Trottier, D. (2019). Therapist as guide: Role profiles, metaphor, and story to understand the parallel hero's journey of the queer therapist and the straight client. In MacWilliam, Harris, Trottier & Long (Eds.), *Creative arts therapies and the LGBTQ community: Theory and practice* (pp. 75-100). Jessica Kingsley Publishers.

Veltman, A., & Chaimowitz, G. (2014). Mental health care for people who identify as lesbian, gay, bisexual, transgender, and (or) queer. *The Canadian Journal of Psychiatry, 59*(11), 1-8.

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Drama Therapy, MA

Student's Name: Abigail Truax

Type of Project: Thesis

Title: The Queer Expansion of Role Theory: A Drama Therapy Intervention With LGBTQ+ Adults

Date of Graduation: May 16th, 2020
In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: ___Laura L. Wood, Ph.D.
5.3.2020 9:21pm EST Electronic Signature