Integrating Narrative Therapy and Playback Theatre into a Drama Therapy Intervention for LGBT Adolescents

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Abstract

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Lesbian, gay, bisexual, and transgender (LGBT) adolescents remain under-researched and underserved. These youth must face identity development in hostile environments and do not have the support systems afforded to their heterosexual peers. Their status as stigmatized minorities in a heterosexist culture creates and maintains multiple psychosocial problems for these people. Depression, suicide, low self-esteem, substance abuse, social rejection, and homelessness are common problems for LGBT adolescents. Despite these issues, therapy-training programs do not sufficiently address the special considerations for working with these people. This study aims to speak to this deficit by using a qualitative and theoretical approach to inform the design of a therapeutic intervention for LGBT youth. Drama therapists, narrative therapists, and playback theatre specialists with relevant experience were interviewed and the grounded theory method was used to collect and analyze the data. Through a narrative theoretical lens, a psychosocial needs theory emerged, which includes indications of how these needs might be addressed by each of the 3 therapeutic modalities. Drawing on the research, the strengths of each modality were examined to create an intervention for the populations. The research findings, grounded theory, proposed intervention, and future directions are discussed.

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Introduction

LGBT People: A Definition of Terms

Lesbian, gay, bisexual, and transgender (LGBT) people are increasingly referred to collectively as *sexual minorities* in public and professional spheres (Fassinger & Arseneau, 2007). However many transgender people identify as heterosexual and it is a misconception that gender expression and sexual orientation are necessarily linked. Nevertheless, the term sexual minority is applicable given that LGBT people do not conform to social conventions associated with gendered behaviour. These broken social norms can include the gender of romantic partners and other gender-stereotypical behaviours.

Micucci (2009) defined some terms that may be confused when discussing sexual minority individuals:

> *Sexual orientation* refers to the pattern of one's sexual attractions, fantasies, and behavior… *Sexual identity* overlaps with but is distinct from sexual orientation. Sexual identity implies that one has adopted for oneself a label selected from those commonly available (i.e., gay, lesbian, bisexual, or heterosexual)… *Gender identity* refers to one's subjective experience of oneself as male or female. Some individuals (including adolescents) experience themselves as *transgendered*, which means that their subjective experience of gender does not match with their biological sex. (p. 31)

In the Western world there exists a widespread mistaken belief that bisexual and transgender people are "really just" homosexual (Weiss, 2003). This belief is not only

inaccurate but can be offensive and even damaging for those who identify as bisexual or transgender.

LGBT Youth: Psychological Health and Developmental Challenges

The *minority stress model* succinctly explains psychological health issues for LGBT people framed within a psychosocial context (Garnets, 2007). These individuals experience higher risk for mental distress as a result of stressors related to social stigma. Psychological resilience and healthy coping strategies are also acknowledged in the model. Sexual minorities share common struggles in developing positive identities due to social stigma, oppression, and minority status, although experiences that affect identity development and enactment differ within and across the four LGBT groups (Fassinger & Arseneau, 2007). Common problems for all sexual minority youth are "elevated rates of physical/verbal victimization, suicide, depression, substance abuse, homelessness, and familial and peer rejection" (Lemoire & Chen, 2005, p. 151).

Lesbian and gay youth often deal with feelings of isolation in the midst of their heterosexual peers, families, and school environments (Davies, 1996). A lack of peer support, peer bullying, and fear of disclosing sexual orientation to parents and teachers adversely affects the self-esteem and the psychological health of lesbian and gay youth. They may withdrawal socially under pressures of harassment and violence. To avoid aversive conditions, they may drop out of school, which can lead to employment and economic inequity. Ryan and Futterman (1998) explained that in addition to the health and mental health challenges that all adolescents face, lesbian and gay youth must also deal with the pressures of identity stigmatization. A main developmental challenge for these adolescents is forming and integrating a positive adult identity from an identity that

has been stigmatized. This process must occur in the midst of social condemnation and antagonism without the support systems that are available to their heterosexual peers.

Citing recent empirical research, Firestein (2007) discussed that bisexual people may experience "double discrimination", which stems from both heterosexual and homosexual sources. This may put them at a higher risk of psychological problems compared to homosexual and heterosexual people. Transgender people are even more stigmatized and experience more contempt in Western societies than lesbian and gay people (Ryan & Futterman, 1998). Often experiencing rejection from their families, many transgender youth end up living on the streets, undereducated, and at risk for drug use, prostitution, and HIV. Puberty is often especially difficult because the developing secondary sexual characteristics of the body are inconsistent with the gender identity of the individual (Lev, 2004). Ryan and Futterman explained that many transgender people rely on lesbian and gay-friendly service providers, because they are likely to be more open to providing for their needs even though transgender people may be heterosexual, homosexual, bisexual, or asexual. Bieschke, Perez and DeBord (2007) wrote that to understand the LGB community it is necessary to also understand transgender individuals who are frequently included as a part of the LGB community.

External/Internal Heterosexism, Homophobia, Biphobia and Transphobia

Firestein (2007) explained, "*Heteronormative culture* refers to the fact that society is structured to reflect the unquestioned and largely unconscious assumption that everyone living in the culture is heterosexual – or should be heterosexual" (p. 98). *Heterosexism* is a systematic expression of the biases of heteronomative culture, which restricts the rights of LGBT people and portrays these people as abnormal. Heterosexism

also seeks to impose restrictions on how gender should be expressed (Fassinger & Arseneau, 2007).

Homophobia referrers to "the fear or aversion to homosexuals" and similarly, *transphobia* is defined as "an emotional disgust toward individuals who do not conform to society's gender expectations" (Hill & Willoughby, 2005, p. 533). Somewhat different is the definition for *biphobia*, which locates two distinct sources of discriminatory attitudes. Hutchins and Ka'ahumanu (1991) defined biphobia as "the fear of intimacy and closeness to people who don't identify with either the hetero- or homosexual orientation, manifested as homophobia in the heterosexual community and heterophobia in the homosexual community" (p. 369). These attitudes pervasively affect the identity development and life experiences of sexual minorities (Firestein, 2007).

Social stigma may be internalized as self-hate and low self-esteem referred to by the popular umbrella term, *internalized homophobia* (Ryan & Futterman, 1998). This results in psychological distress and increasing the risks of unhealthy behaviours and suicide. Lemoire and Chen (2005) argued that internalized homophobia adversely affects the self-image all sexual minority adolescents, including transgender youth, while acknowledging their application of the term is not accounting for the gender identity issues of transgender people. Perhaps a more appropriate expression in the case of transgender people might be "internalized transphobia". When referring to bisexual people's internalized oppressive ideas the phrase, "internalized biphobia" is often used (Firestein, 2007; Potoczniak, 2007).

Weiss (2003) argued that the terms, heterosexism and "internalized heterosexism" are more appropriate when discussing LGBT people collectively and that the use of the

expression internalized homophobia, implies that bisexual and transgender people are really homosexual (Weiss, 2003). He also discussed how gay and lesbian individuals in addition to heterosexual people have discriminatory attitudes towards bisexual and transgender persons. Weiss argued, "biphobia and transphobia are not good descriptions of the phenomenon of heterosexist prejudice against bisexuals [*sic*] and transgenders [*sic*], and are particularly inappropriate in the case of heterosexist prejudices within the [LGBT] community" (p. 33). However, he acknowledged that it is useful to understand the phenomena of biphobia and transphobia as different from homophobia.

Therapeutic Guidelines for Working with LGBT Clients

An APA taskforce put forward guidelines, which mandate that therapists should adopt an affirmative stance when working with LGB clients (APA, Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, 2000). The affirmative perspective requires that therapists assist LGB people to understand and accept their sexual orientation, develop positive self-concepts, and to help them cope in the face of stigma and minority status. Affirmative therapy has also been recommended for transgender clients (Korell & Lorah, 2007; Lev, 2004). These authors (among many others) assert that gender identity variance is not indicative of pathology despite the lack of inclusion of transgender people in the affirmative therapy recommendations listed above. Discussing affirmative therapy for sexual minorities, Perez (2007) advised that therapists should affirm LGBT culture while opposing heterosexist values and homophobia, and attend to LGBT clients' sexual orientation or gender identity issues.

Korell & Lorah (2007) explained that affirmative transgender counselling should be approached in a similar manner to counselling with any client. That is, getting to

know the person and attending to the issues that they bring to treatment. Therapists should discover and use the gender pronouns that the client prefers (i.e., she, he, her or him) and efforts should be made to help these clients understand that gender variance is not pathological. Lev (2004) explained that most transgender people do not have mental illness but that due to sociopolitical issues surrounding gender variance, it is inevitable that transgender people "will experience some dysphoria and distress while coming to terms with his or her authentic self" (p. 227). The term "authentic self" does not refer to the natal sex of the transgender person but rather, the true gender identity of the person. Lev advised that therapists should take a collaborative standpoint that empowers the transgender client in his or her authentic identity development.

For therapy with LGB youth, guidelines have been put forward that also recommend client empowerment (Davies, 1996). Therapists should affirm the "ego identity and integrity of the client… (and) clearly identify homophobia, not the client's sexuality as pathological" (p. 148). They should also offer space for the reflection on experiences and feelings and offer information about LGB issues. Moreover, the therapist has to find ways of enhancing the self-esteem of lesbian, gay or bisexual youth. Lev (2004) advised that "supportive psychotherapy" should be provided for transgender youth, which is similar to the guidelines above. This also entails empowering the client and providing information for the youth and parents (if available) although this information has to do with gender diversity rather than sexual orientation. Gender diversity should be supported rather than pathologized while helping the youth to cope with stigma and oppression. Group therapy is said to be especially valuable if the transgender youth is living without familial support.

Aronson (2002) discussed the wide range of benefits that therapy groups composed of lesbian, gay, and bisexual adolescent peers can provide such as creating a safe space for information exchange, emotional exploration, and the learning and practicing of social skills while promoting a universality of experience and reducing isolation. He continued that, "adolescents in these groups can "play" with various roles and identities (e.g., who or what is butch, a queen, who is "throwing shade" –translation giving attitude), all crucial to the promotion of healthy self-esteem and the development of identity" (p. 71). Aronson concluded that group therapy settings affords LGB adolescents a critical opportunity to experience openness, candidness and even fun while exploring their sexual orientations, an experience unavailable in heterosexual settings.

Two sources of literature that discuss the benefits of peer group therapy for sexual minority youth give research examples of groups that are divided based on either sexual orientation (Aronson, 2002) or sexual orientation and gender identity (Medeiros, Seehaus, Elliot & Melaney, 2004). This implies perhaps, that this group structure is indicated for treatment. However, Beckstead and Israel (2007) argued that, at least for LGB people, a group composed of female and male clients could have a strong effect of promoting self-acceptance and positive identity development. They listed benefits of this heterogeneous group structure as "the potential to increase exploration of a variety of solutions, provide feedback about misinformation… enhance respect for diversity… desensitize anxiety and provide opportunities to develop authentic relationships and emotional closeness" (p 238). Further research is needed to see if transgender people can also reap these benefits by their inclusion in a compositionally diverse therapy group.

Narrative Therapy and the Narrative Approach with LGBT People

White and Epston (1990) developed the philosophy and process of narrative therapy, which rests on the tenet that people make sense of their lives by stories and that stories give meaning to one's "lived experience". Knowledge of the self, or personal identity is informed and shaped by stories and further, these stories continue to inform how individuals experience the world and behave. Stories inform performances and therefore have power. Drawing from various schools of thought, the authors believed that knowledge and power are inseparable and that the greater culture, which is in a position of power, influences what an individual believes to be true. Self-stories and social narratives are created and maintained within this social context. The narrative viewpoint recognizes that there is no objective reality and that all knowledge results from interpretation. As such, any story told is necessarily incomplete and has many different possible interpretations.

Narrative therapy functions from a postmodernist viewpoint that recognizes that reality is a social construct, and that "truth", power, and knowledge are socially negotiated (Freedman & Combs, 1996). Narrative therapy also looks at the sociopolitical forces in stories and "how the narratives of the dominant culture are… imposed on people of marginalized cultures" (p. 32). Although this process does not usually require force and is largely maintained by the marginalized individuals themselves because the dominant culture's discourse is internalized as an ultimate truth (Brown & Augusta-Scott, 2007). As stories help people to give structure and meaning to life, then individuals, who are influenced by the greater culture, also maintain this imposed dominant narrative through the self-narratives they tell and thereby live.

Dysfunction occurs when the *dominant story*, or the main theme portrayed, is "problem-saturated", and does not reflect the totality of one's lived experience (White & Epston, 1990). It is assumed that there are always times when the problem has not been present and when the person has overcome the problem. Then, problem-saturated dominant stories omit details of non-problematic life history and are inaccurate and incomplete accounts of lived experience. Personal and social narratives maintain these problematic dominant stories via labeling (e.g., "I am depressed" or "he is depressed"). This restricts the view of identity to this problem theme and hampers personal growth. White and Epston believed that people should not view their identity as a problem but rather view the "problem as the problem". *Externalizing conversations,* or discussion-based questioning techniques are used to *externalize the problem* as a separate entity in order to deconstruct assumptions about it (e.g., "What does *The Depression* try to convince you to believe about yourself?"). This process seeks to diminish the labeling and pathologizing that has previously occurred while returning the power to "know" what is "true" about the self (i.e., personal identity) back to the individual.

Externalizing the problem occurs throughout the therapeutic process and is a part of *deconstructing the story* (Brown & Augusta-Scott, 2007). Problem-saturated stories are critically examined or deconstructed, beginning with externalizing conversations, which helps to separate the client from problematic identity assumptions and the dominant social narrative. The client is now in a position to critically examine the greater context of the problem. The therapist facilitates this process through *deconstructive questioning*. Freedman and Combs (1996) explained, "deconstructive questioning invites people to see their stories from different perspectives, to notice how they are constructed

(or *that* they are constructed), to note their limits, and to discover that there are other possible narratives" (p. 57). Life histories are examined by questioning what has happened and what meanings have been attributed to those life events and further, where those meanings come from. Additional questioning reveals what has supported the problem and when the problem has been at its weakest (Brown & Augusta-Scott, 2007).

This process assists in the discovery of *unique outcomes*, moments of personal agency and strength when the problem has not dominated the story, and by making these unique outcomes salient and available, the client along with the therapist can coauthor a healthier and preferred *alternate story* (White & Epston, 1990). Yet, it is insufficient to merely *plot* the alternate story (i.e., illustrate a series of events), it must be "thickened" in order to keep it alive. Whereas deconstruction involves examining the effects of the problem on the client, thickening the alternate story involves exploring the influence that the client has on the problem in the past, present, and future (Brown & Augusta-Scott, 2007). Questioning about a unique outcome invites discussion about change, breakthroughs, progress, and a history of defying the problem (e.g., "Tell me more about when you stood up to The Depression and the things it was telling you"). New meanings are generated for life events through additional questioning (e.g., "What does this story say about you as a person). These conversations help the client to restructure self-stories into a more authentic biographical account of lived experience, which plots the client's effective defiance of the problem and includes and reinforces strengths, thereby encouraging personal growth.

The alternate story is also thickened by marking breakthroughs and achievements (Freedman & Combs, 1996). A number of written techniques can be used, including

therapeutic letters, the client's writings, and symbols of achievement (certificates, cards, awards, etc.). Finally, to keep the alternate story alive, it is shared. An audience of supportive others may attend therapy meetings or the audience may be other therapy group members. Circulating recordings, letters and documents that were used to thicken the alternate story can be used to spread the word and keep the alternate story alive.

There is little literature available for narrative therapy with sexual minorities (Mclean & Marini, 2008). Saltzburg (2007) discussed narrative family therapy with LGB adolescents and their parents. Specifically, the therapeutic approach focuses on the immediate family during the process of the youth *coming-out*, or self-identifying to others as either lesbian, gay or bisexual. Heterosexism and homophobia are identified as existing within culture within the parents and the within the adolescents. The effects of these beliefs are identified, externalized, and scrutinized. Personal, familial, and social problem-saturated stories are identified and deconstructed by critically challenging the effects they have in lives of the clients while a simultaneous re-authoring process occurs focusing on illuminating strengths and resilient aspects of their personal and collective narratives. It is a family and therapist collaborative effort to normalize LGB developmental experiences. Rather than viewing these experiences as pathological, they are viewed as stories of difference – an aspect of diversity. Finally, *definitional ceremonies* take place to connect multiple families with LGB youth where an important witnessing function of lived-experience occurs to diminish invisibility and give voice to the new narratives.

Mclean and Marini (2008) detailed the steps involved in a similar method of individual narrative therapy for adult gay men. The method also assumes that

homophobia and its location within culture and the client are oppressive and destructive. Homophobia is externalized and its influence is mapped. Unique outcomes are identified to aid in the re-authoring process of a healthier, empowered, and authentic account of the client's identity. The therapist encourages the client to maintain his new narrative through ritual, progress documentation, connection to communal supports, and social activism.

Lev (2004) discussed the application of narrative ideologies as "tools" for therapy with transgender people. She argued that coming out for transgender people is even more of a social process than coming out as gay or lesbian because the latter two groups can hide their sexual orientation from the public, whereas gender expression is inherently more visible. Like the LGB approaches described above, the assumption is that social forces have pathologized the client's narrative. The goal is also to coauthor a new narrative that is a more authentic account of lived experience. This includes externalizing the problem so that the client no longer internalizes it as psychological dysfunction but rather learns to cope with the social forces that maintain the problem.

Drama Therapy and Narradrama

Drama can be defined as a "physical expression and enactment in general" while theatre has a "specific structure of performers separated from spectators, usually with a discrete performance area or stage" (Langley, 2006, p.3). Drama has been a vehicle for expressing the human condition both within theatre and within healing rituals for centuries (Kedem-Tahar & Felix-Kellermann, 1996). It has been said that drama therapy is founded on the base structures of healing rituals, which have developed over the course of approximately 30,000 years (Snow, 2009). Langley wrote, "theatre and drama can be

randomly therapeutic because they raise awareness to issues, attitudes and one's own emotions" (p. 1), although the first professional application of theatrical techniques as a means of therapy can be traced to the early part of the twentieth century (Jones, 2007). Drama therapy has been defined as "the intentional and systematic use of drama/theatre processes to achieve psychological growth and change. The tools are derived from theatre, the goals are rooted in psychotherapy" (Emunah, 1994, p. 3).

Drama therapy may be conducted individually with a client and therapist but is also often a group therapy method. There are many approaches to drama therapy and since they place emphasis on creativity, spontaneity and, playfulness, there is much room for experimentation and modification to each approach (Kedem-Tahar & Felix-Kellermann, 1996). This can make it difficult to detail what exactly drama therapy is. Further, as Emunah (1994) pointed out, drama therapy can be practiced within nearly any psychotherapeutic framework. However, Lewis (2000) identified some common theoretical concepts shared by most methods, among them, *role* and *story*. Socially located and enacted patterns of thought, feeling and behaviour are described as roles by drama therapists. A story or script that people have about their lives originates from past events and often continues to influence behaviour.

When considering the postmodernist viewpoints of narrative therapy detailed above, it appears that drama therapy's views of role and story are similar to the narrative therapy concept that stories held influence the lives of people. The drama therapy conceptualization of story and role shares the narrative viewpoint that historically and socially located stories influence past, present, and future life performances. In drama

therapy terminology, these life performances are called roles, which are enacted within a scripted story.

In drama therapy, creativity, spontaneity, imagination, and playfulness are viewed as essential not only for the therapeutic process but also for general mental health (Lewis, 2000). A healthy individual is able to utilize these traits to adapt to new situations and to face daily challenges. Conversely, dysfunction occurs when an individual is unable to access these qualities and relies on a limited number of roles that are either dysfunctional in nature or inappropriate for the situation at hand (Landy, 2000; Lewis, 2000). Lewis added that drama therapists also view health as having, " a realistic sense of self and other… the capacity for intimacy, attachment, and full encounter with another… the capacity to continuously respond and adapt throughout one's life span, expanding one's repertoire of roles and new alternative stories with flexibility (p.477).

Again, dysfunction is present when an individual is unable or unwilling to access and enact these qualities in everyday life (Lewis, 2000). Then, some of the goals of drama therapy are to enhance creativity, spontaneity, imagination, flexibility, and playfulness and to foster connection to the true self and with others. Another goal is to evaluate and increase the role repertoire by playing with existing roles (dysfunctional or otherwise) while trying out new roles within the drama therapy session. These processes once experienced and enhanced through dramatic enactments can be carried forward into everyday life. A basic tenet of drama therapy is that one learns best through doing rather than by simply talking about.

When considering the therapeutic advantages for group work with LGBT adolescents listed above, drama therapy's processes and goals seem well suited to

providing for the needs of these clients. Most notably as Aronson (2002) pointed out, the need to playfully experimenting with roles is necessary for healthy self-esteem and identity development. This could be addressed through *actual* role-play in drama therapy. This should facilitate a process of creative playfulness to enhance the abilities of these youth to adapt to daily challenges due to their stigmatized minority status. Surprisingly, a literature review on the subject yielded virtually nothing for drama therapy with lesbian, gay, bisexual or transgender youth. However, literature searches reveal that ethno-dramas have been performed for and by "young gay men" (Bailey, 2009) and interactive theatre has occurred with lesbian and gay street youth (Laffoon & Diamond, 2000). It is clear that there is a need for more literature concerning drama therapy with LBGT people.

Dunne (2010) the originator of *narradrama,* drama therapy framed within a narrative therapy orientation, discussed the method's appropriateness of use with marginalized groups. She mentioned examples of these groups but did not discuss sexual minorities. When compared with conventional narrative therapy, a narrative approach to drama therapy has the advantage of using the body as a means of understanding, which further concretizes knowledge gained (Dunne, 2009). The client and therapist can explore dominant stories, unique outcomes and alternate stories through drama and through other expressive arts. Problems can be externalized and deconstructed through the use of objects, puppets, artwork and scene work. Role-play involving unique outcome scenes helps to model more adaptive behaviours and alternate stories can be enacted to restructure identity apart from the problem. Narrative talk therapy only uses language for the same purposes. Then, a narrative approach to drama therapy with LGBT

adolescents could have a powerful effect for externalizing and deconstructing heterosexism and for re-authoring preferred narratives through embodied role-play. As Bird (2010) stated, "dramatherapy has the potential to realise narrative therapy to its full potential by enabling the body to become a gateway for a new narrative" (p.12).

Playback Theatre

Playback theatre was developed by Jonathan Fox (1994), as a form of non-scripted theatre, which involves actors spontaneously enacting a story that has been told by a participant, who is referred to as the *teller*. There is an audience area and a stage that has seats for the actors and to their right, a "prop tree" with different coloured fabrics to be used as props. Downstage right are two more seats, one for the teller who comes up from the audience to tell a personal story and the other for the *conductor*. The conductor (also known as the master of ceremonies, the emcee or the coordinator) has the central role of overseeing the entire process. He or she serves as the "conduit" between the tellers of the stories, the actors and the audience. The conductor invites the teller to the stage and directs him or her to communicate words, feelings, and the essential content of a story. The conductor also attempts to elicit the meanings behind the story being shared for the actors and the audience.

During the storytelling process, the conductor will ask the teller to choose actors to play him or her self and the other characters in the story (Fox, 1994). These characters may be people, animals, objects, or even spiritual figures. The conductor summarizes the story and initiates the improvisational performance with the words "let's watch". After the story has been performed, the teller remains seated and is invited by the conductor to give a reaction to the story. If the scene has not captured the essence of the teller's story

the conductor may ask for the scene to be redone. Another possibility is a *transformation* in which "the scene is redone according the teller's ideal image… from defeat, say, to triumph" (p.103).

Playback theatre may come in the form of *performance playback* or *workshop playback*, the former involving a company of actors who perform for the audience and the latter involving the entire workshop group (serving as tellers, audience, *and* actors) being introduced to playback techniques by an experienced leader (Chesner, 2002). In both performance and workshop, a number of *short forms* are usually employed prior to the *long form* method of story sharing and enactment. Short forms are relatively brief enactments that are performed by audience members, which function as warm-ups for the performance to come. For example, *fluid sculptures* are a short form that involves responding to an emotion or idea through movement, facial expression, sound and a chosen word. Short forms create a sense of safety and facilitate the process of sharing and risk-taking by moving from a collective effort to the more individual focused long form. The ritualistic structure of the entire process of playback theatre creates a safe container for disclosure much like the therapeutic frame in psychotherapy maintains the sense of safety for sharing.

Salas (2009) describes playback as "theatre with the power and intention to heal and transform individuals and social groups" (p. 445). Although it has the ability to heal, playback theatre is not a therapy method per se, yet it is used for this purpose, often by drama therapists in clinical applications (Chesner, 2002; Salas, 2009). Chesner explained that playback theatre can be incorporated into a drama therapy group or used clinically as

singular method on its own. Salas elaborated that workshop playback is the most common method used in clinical applications.

Therapeutic effects for the group as a whole are reducing isolation, creating connections, enhanced empathy via witnessing, and giving meaning to suffering by communicating it aesthetically (Salas, 2009). The tellers of stories experience a great sense of validation by having their stories enacted and a sense of visibility by having their stories witnessed by all involved. Watching the story, the teller may experience a sense of distance and have a new sense of mastery over a problem story. Further, they often gain new insights and experience a release of pent-up emotion. For actors, in both performance and workshop models, playback theatre "promotes expressiveness, receptiveness to others, self-confidence, self-esteem, creativity, teamwork, [and] playfulness (p.447). The stories shared will have impact on the teller and also the other members of the group often creating a *red thread* or a shared theme (Chesner, 2002). A common effect of playback theatre is that people who were strangers at the beginning of the show will linger and socialize with each other (Salas, 2009). It appears clear that playback theatre has the power to bring people together as well as heal.

Again considering the needs of LGBT youth discussed earlier and what this modality has to offer, it can be seen that playback theatre could be a helpful way of working with these people. While drama therapy may be an individual treatment format, playback theatre is always a group method. The power of this method to connect people, validate experiences, and illuminate shared themes could address LGBT needs for a safe, supportive environment where reduced isolation and universality of experience could be promoted. Suffering that has occurred due to sexual orientation or gender identity could

achieve meaning in aesthetic presentation and tellers could gain senses of mastery over these difficult experiences. In a workshop model, LGBT adolescents could experience a much-needed boost to self-esteem and self-confidence while expanding their role-repertoires as a group of actors responding creatively and collaboratively to the stories of tellers.

A peer-reviewed literature search revealed nothing for playback theatre with LGBT adolescents, although playback theatre has occurred with sexual minority youth (S. Snow, personal communication, January 3, 2011). Non-academic Internet resources also reveal that LGBT playback theatre groups have occurred in various countries such as Canada (Creative Alternatives, 2011) and the United Kingdom (Hoy, 2011). Nothing could be found for the application of playback theatre as a means of therapy with these people. A need for further research and publication on the subject is clear.

Aim of the Current Study

Lesbian, gay, bisexual, and especially transgender people remain under-researched and therapy-training programs do not adequately address the unique considerations for working with these people (Korell & Lorah, 2007). The lack of literature concerning LGBT people involved with drama therapy, narrative therapy, and playback theatre (as a therapeutic method) greatly reflects this deficit. The aim of this research project was to contribute to this literature by using a hybrid qualitative and theoretical approach (detailed below) to inform the construction of a research-supported, drama therapy intervention for LGBT adolescents. More specifically, this study aimed to discover how narrative therapy and playback theatre could be incorporated into a group drama therapy program that is in line with therapy recommendations discussed earlier.

Available literature informed the theoretical component of the research while the qualitative inquiry was used to fill in the gaps of the available information.

The primary research question was how could narrative therapy and playback theatre be incorporated into a drama therapy intervention for LGBT adolescents? To further inform the therapeutic program, two subsidiary research questions were devised. To understand the needs of LGBT adolescents from the people who work with them, another question was, what are any special considerations about working with LGBT adolescents with each modality (narrative therapy, drama therapy and playback theatre)? Since it was necessary to understand how a therapy group should be structured, the final question was, what are any advantages or disadvantages to working with LGBT adolescents collectively in a group? A foreseeable limitation was that because the study would only use interview data collected from therapists and other relevant professionals, the data could lack depth from the client perspective. However, given the nature of time limitations and logistical concerns for recruiting client-participants, this restriction was deemed necessary.

Method

Data Collection and Analysis

The method of inquiry borrowed qualitative research procedures from *grounded theory* (Straus & Corbin, 1990) to answer the research questions and inform the therapeutic program. In the grounded theory method the researcher starts with an idea of a phenomenon that he or she would like to study, chooses a starting point (purposeful sampling), and then allows the preliminary data to guide the development of the research providing cues for what is to be studied next (Glaser & Strauss, 1967; Straus & Corbin,

1990). This latter step is referred to as *theoretical sampling* and is based on the premise that the researcher cannot have foreknowledge of the most rich and appropriate data sources before beginning the grounded theory research process. Theoretical sampling ensures study validity by informing the researcher where to look for data that is representative of the reality that he or she is tying to uncover.

Additionally, the method employs a process of *constant comparative analysis* that requires the researcher to continuously compare new data, conceptualizations, and the emerging theory against previous data and conceptualizations (Glaser & Strauss, 1967; Straus & Corbin, 1990). Reliability is ensured because the researcher must look for occurrences (or the lack there of) in the data that support previously developed concepts while looking for novel concepts in the new sample. The researcher can use interviews, field observations, and academic literature to inform the research process (Straus & Corbin, 1990). For obvious ethical reasons, field observations of therapy sessions were not conducted for use in this study.

Internet searches provided contact information for therapists or professionals with relevant experience who could be contacted directly via email (see Appendix A for recruitment letter). Once the research process began and data was collected, preliminary findings were used as a guide for what to study next, which is consistent with the theoretical sampling process. *Snowball sampling* was used after theoretical sampling commenced. That is, personal recommendations from participants, the research supervisor, and other relevant professionals were used to identify potentially rich sources of data. This approach was used in a grounded theory study that involved interviewing

occupational therapists about how they carried out their practice (Freeman, McWilliam, MacKinnon, DeLuca & Rappolt, 2009).

Interview data was coded and analyzed using grounded theory procedures explained by Strauss and Corbin (1990). These authors emphasized the researcher and her or his *theoretical sensitivity* or insight and abilities to understand the data. Relevant literature, professional, and personal experiences are factors deemed to increase theoretical sensitivity. Additionally, these authors recognized that intuition or hunches and the researcher's creativity are factors in theory development. For Straus and Corbin, grounded theory is seen as a balance of the researcher's creative abilities and scientific rigor that leads to interactions with the data to subsequently uncover theory. This methodological interpretation of grounded theory was selected because it seemed more in line (when compared to other options) with the grounded theory/theoretical approach that was chosen to inform the creation of the intervention.

Rolls and Relf (2006) recommended reflexive journaling during the research process as a means discovering hidden biases that might otherwise go unnoticed. The grounded theory method requires the use of *theoretical memos* to record the formulation of and constant revisions to the emerging product (Glaser & Strauss, 1967). The researcher kept a personal process journal to uncover any assumptions during the research and used it in conjunction with theoretical memo writing to guard against researcher bias.

Participants

Seven individuals consented to be interviewed. There were 5 women and 2 men in the sample. Six participants spontaneously volunteered that they identified as either

lesbian or gay, but it should be noted that this information was not requested as a part of the interview process. Some individuals had training in more than 1 modality, but each person was interviewed for his or her expertise in a single area only. To safeguard anonymity where this cross training may lead to identification, the participants will be referred to as therapists or specialists according to the focus of their interview. With this in mind, interviewees will be hereunto referred to as drama therapists ($n = 3$), narrative therapists ($n = 2$), and playback theatre specialists ($n = 2$). Participants were residing within a wide rage of global locations but – again to protect anonymity – the specific details of this information have been withheld. All participants were recruited via email.

Procedure

Individuals who sent a response to the original recruitment email were then sent the informed consent form (see Appendix B) for their review. After indicating that they had read and understood the form and consented to participation via email, a time was set up for a telephone interview. Participants were called at the telephone number given and a request was made to transfer them to speakerphone. An Apple iPad was used to record each conversation and afterwards, the recording was transferred to a password-protected computer and was deleted from the iPad. After manual transcription, the audio recordings were securely deleted from the computer.

The semi-structured interviews were conducted using open-ended questions and ranged from 16 minutes to 79 minutes in duration. The lower end of the range was due to an interview that was cut short by a participant who was unavailable to resume the interview at a later time. Five participants were interviewed with the original interview schedule (Appendix C). A second, interview schedule (Appendix D) had to be devised

during the study to account for the fact that a playback theatre specialist was not a therapist and for consistency, this interview schedule was used with the next professional with playback theatre expertise. Each transcription was analyzed using open coding, axial coding, and selective coding procedures detailed by Strauss and Corbin (1990). Open coding reveals *concepts*, axial coding reveals *categories*, and selective coding reveals an organizing system of the categories that allows a theory to emerge. Categories are higher-level and more abstract groupings of concepts. Concepts are basic displays of phenomena be it incidents, events, or happenings (Corbin & Strauss, 1990).

Findings

A category system emerged from the interview data for explaining the psychosocial needs of LGBT adolescents, the socio-political influence that creates and maintains this deficit, and how this problem can be successfully addressed through drama therapy, narrative therapy and playback theatre. This allowed for a grounded theory to emerge from the data to explain the relationships between the core category and the 3 sub-categories. The therapeutic intervention construction that follows was designed with this theory in mind, other therapeutic theories found in the literature review and also with specific recommendations that were given by the participants in the interviews.

(1) Need for Communal Re-connection Due to Heterosexist Dominance

A core category entitled the *need for communal re-connection* was developed, as it was the single most recurring concept found within the drama therapy, narrative therapy and playback theatre interviews. Further, the hierarchy of this core category was established as it is related to all other subcategories in important ways. Findings indicated that LGBT adolescents have been marginalized by or pushed away from

societal institutions (e.g., schools, churches), and in many cases also from their own families, which creates a sense of aloneness. It was indicated that these communal structures are all dominated by heterosexist values, which creates and maintains this problem. In all modalities, participants reported group therapy/work as a means of creating community and reconnection to others. As one participant in a drama therapy interview put it, “What I’ve noticed mostly is the need for community. It seems to be that the thing that I really approach with them is strength, working with strength in community because it’s so good not to feel alone”. Another participant made the distinction of how this need is particularly unique to LGBT adolescents by comparing their plights with those of other minority groups:

> Then a sense of community… is more unique to gay and lesbian individuals, or queer people. In that, you know, often times you can be an African American family in a White community but they [the African American family] still have each other as a family but often, especially young [LGBT] people, they either get thrown out directly or even if they’re not thrown out directly, there’s other subtle ways that they’re pushed out.

This problem with communal non-acceptance is also represented within the greater LGBT community itself and this was another reoccurring concept, as explained below in the following sub-category.

(2) Intergroup Biases: The Doubled Discrimination from Heterosexist Dominance

All of the drama therapists and 1 playback theatre specialist remarked on how discriminatory attitudes and behaviours exist between the 4 groups of LGBT people. One drama therapist said, “Well there’s definitely a need to build community within our

community; we are not free of prejudice towards one another". A playback theatre specialist put it this way:

> There is a kind of tension between the gay community, the lesbian community and, the trans [transgender] community in terms of competing oppression and the denial, the denial in the kinds of transphobia that is alive and well in the gay community.

Transgender and bisexual individuals appear particularly doubly discriminated against by society in general *and* by the greater LGBT community. A drama therapist said:

> Often times, transgenders [*sic*] are marginalized within the gay community, there's a lot of bias around them and fear… around bisexuality. That's the *internalized homophobia* part, that's the internalized homophobia out, when we try to then turn and label other people within our community and try to make people fixed in a ridged way.

As argued by the participant above, internalized homophobia (or in the case of transgender and bisexual people, transphobia and biphobia respectively) explains intergroup biases and leads to the double marginalization of LGBT people. When LGBT adolescents are already pushed out of and marginalized by societal structures due to heterosexist dominance, the internalization of these values leads to a further breakdown of communal connections between the 4 LGBT groups. This is particularly the case for transgender and bisexual individuals who are often misunderstood and receive messages by gay and lesbian people and the greater society that they should self-identify in a fixed manner. LGBT adolescents who may already feel alone may then in turn, exacerbate

their shared problems by shunning others who have been discriminated against due to their own sexual orientations or gender identities.

(3) Heterosexist Dominance Supplanting the LGBT Voice

The findings also revealed that that heterosexist values (which are often internalized as homophobia, biphobia and transphobia) supplant LGBT people's voices and affects their stories. This is congruent with a narrative therapy concept that the problem-saturated, dominant story has sociopolitical influences in its creation and maintenance and that the more accurate and preferred narrative is hidden by this dominance. When asked about her thoughts about the concept of internalized homophobia, a playback theatre specialist remarked:

> The silencers that exist in societies are introjected and internalized and as a result, people will act upon what they feel will be preferred and what will garner them status or acceptance and recognition or love. And sometimes, those behaviours mean shunning and excluding and marginalizing *yourself*, some aspect of yourself, and *others like you* and it leads to an unfortunate cycle of denial, which makes it all that much harder and is what makes the idea of coming out – there is such a punctuation on that because it requires an unveiling, a revealing of something that is so un-preferred.

This not only illustrates how heterosexist values disconnect LGBT adolescents from communities, create self-hate, low self-esteem and intergroup biases but also (interpreted from a narrative perspective) how this problem silences a more authentic, healthier and preferred alternate story from being told and from being lived.

A narrative therapist put it another way when asked the same question about his thoughts on the concept of internalized homophobia:

> It's certainly a lot of what's done with most queer clients, is trying to externalize these negative feelings and things like that. And homophobia is the shorthand word… it depends very much on the experience of the client and what the language [is] of the client, so it could be anti-gay bullying or it could be prejudice or it could be any number of things. And yeah, it's to talk about the things, which you use to fight back, and the things that defend you from it… can be really, really powerful with queer kids.

An important distinction made here is how the *language*, the words used to describe the effects of heterosexist dominance can be expressed in any number of ways. Heterosexist dominance has been found to explain the 3 categories above. Therefore as the narrative approach requires careful listening for identifying, externalizing, and deconstructing socio-political forces supporting the problem, then the narrative approach to group work with LGBT adolescents should attend to how clients describe their own experiences with heterosexist dominance.

(4) Re-connecting LGBT Adolescents for Story Telling

While community estrangements and heterosexism supplanting a minority voice were often described as major problems, proposed solutions were found in the interview data. In each modality, there were reports of how each method, used in a group format, could help to create a powerful sense of community. As one participant put it, "drama therapy has the advantages… which invites communities and connection, which is so important because that gets disrupted for many, many people in our community".

Discussing group narrative therapy with LGBT adolescents another participant said, "There is also a tremendous power in people connecting with people, who are in important ways like themselves". Discussing her work in playback theatre, a participant said, "we are bringing together a group of people who may or may not feel that sense of community as they gather together to hear some very intimate stories coming from one another… and so what we hear… is a sense of closeness with each other and with their own stories".

Regarding giving a forum for LGBT adolescents to have a voice for their stories, a drama therapist said:

> I think the beauty of it [drama therapy], is that it gives people voice in a nonthreatening way… however you want to do whether it's through playback, narrative work, the creation of stories, [or] the creation of characters. It's giving somebody a voice. So when you've got somebody who's not engaging verbally or just sort of disconnected, it can be helpful to give them something else, some other form of expressing themselves and connecting.

Commenting on sharing personal stories with a group, a narrative therapist said, "The most important part is that people feel really seen, they feel that they have something to offer and they really feel a kind of validation they don't always experience".

In playback theatre, the dramatization of a narrative gives voice for what is said and *unsaid* as explained by one participant. She recounted, "What audience members have told us when people come up to tell their stories [is that] you picked up on something I didn't even say that got to the heart of the matter or that you picked up on the feelings behind the story". This "unsaid" component of the teller's story could also be

interpreted to be similar to the un-storied aspects of a narrative that are made salient and available to the client in narrative therapy.

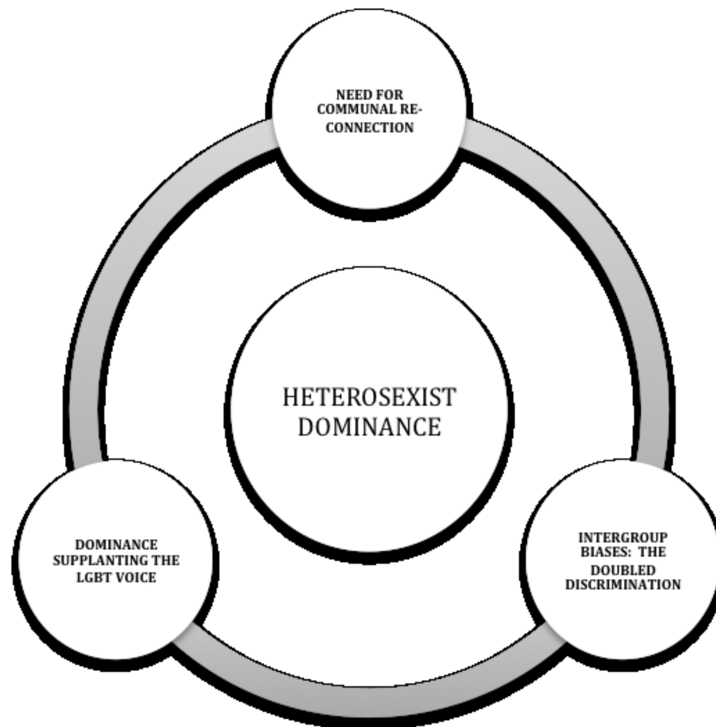
Group drama therapy, group narrative therapy and playback theatre used in conjunction should provide a unique and powerful way of connecting LGBT adolescents and creating community: giving voice to suppressed stories, engaging these clients when they are not verbally communicating, creating visibility for the story tellers and the unsaid while validating personal experiences. Looking at the interactions between the core category and the subcategories illustrates the theory developed for explaining the psychosocial problems of LGBT youth and further, how these needs can be served by a group therapy intervention that focuses on personal stories.

LGBT youth are disconnected from communities on multiple levels due to heterosexism. This creates problems for the individual via socially directed and internalized heterosexist values (i.e., homophobia, biphobia and transphobia), which create and maintain shame, low self-esteem and LGBT intergroup discrimination. These youth's stories remain unheard, as there is no audience for and no permission to give voice to stories. From a narrative standpoint, this theory shows how heterosexist dominance imposes a silencing of the LGBT voice, supplanting it with the dominant culture's narrative, which is incongruent with the authentic accounts of the identities of LGBT adolescents. Heterosexist dominance and its effects will be described in many ways by LGBT people and not necessarily as homophobia, internalized or otherwise. Heterosexist dominance can be conceived as the overarching mediator variable in this reality (see Figure 1).

From the interview data it can be seen how providing a forum for story telling and by applying a narrative therapy interpretation, a re-authoring of these stories can help combat these psychosocial issues. Exposing heterosexist dominance, deconstructing its effects and by reconnecting LGBT adolescents with similar others in a story-based therapeutic forum where personal voices can be heard, validated, and understood should empower these individuals and combat marginalization. These youth then should be able to reclaim the authorship of their personal and collective narratives to combat the problems that heterosexist dominance creates and maintains.

Figure 1.

Grounded Theory of Psychosocial Issues for LGBT Adolescents



Intervention Construction

One important question was asked in the research interviews and the responses to it would inform the overall structure of the group intervention. This question concerned *mixed groups* (members including lesbian, gay, bisexual, and transgender persons) and *specialized groups* (homogenous groups that consist of *either* lesbian or gay or bisexual or transgender persons). All participants were asked (except for 1 who terminated the interview early), "In a group treatment plan (or in a playback theatre group) would you work with each group separately or include members from each of the 4 groups and why"? Despite one participant having a strong inclination to working with a mixed group, the unequivocal answer was that there are benefits to both group structures.

The strengths for a mixed group were explained as, decreasing intergroup bias, creating a broader perspective, and enhancing the ability to learn from one another. The primary benefit explained for specialized groups was being able to attend to the more specific needs of each group. This was found to be especially the case for transgender adolescents who face unique identity development issues. Some participants discussed how a lesbian group might focus on issues pertaining to gender dynamics. Other responses indicated that a gay group might focus on issues concerning the masculine ideal.

One participant cautioned against the use of labels and imposing homogenous group structures. She shared information about her bisexual clients' experiences with being labeled: "They say don't stereotype me, you don't label me. And it's terrible when you feel that way, when somebody's boxing you in, having certain perceptions of you". Later in the interview, she responded to the group format question by saying, "I'm of the

mind that it’s better to mix people together and that we learn from each other. The separation really is artificial at the end of the day. Not that there’s not difference but there’s *differences* and there’s *separation*”. Taken together, it could be interpreted that creating specialized groups might be a form of labeling and maintaining intergroup bias. The entire program should also take into account that labelling and mislabelling can be damaging (Weiss, 2002) and consequently, the labels (if any) and the gender pronouns that the client prefers should be used.

In order to take all of these recommendations in account, the treatment plan will include both a larger mixed group and smaller specialized groups. However, by allowing the *clients* to choose whom they would like to work with in the smaller groups, external labeling will not occur and artificial divisions will not be promoted by the intervention or by its coordinator(s). The only criteria that will be put forward is that clients should find other individuals, who’s stories have impacted them in a certain way and who they would like to work with more as smaller group work commences. This approach to the treatment program should allow the clients to experience the benefits of the mixed group listed above while allowing them to choose specialized group membership composition where more specific needs can be addressed. Specialized group membership should be decided based on a felt connection through stories that have been shared (rather than labels), which could pave the way for further re-connection through story telling.

The intervention could be offered at a LGBT specialized school program for adolescents or at other community agencies that serve this population. Workshop playback theatre would be introduced as a means of facilitating the larger group process of building community and giving voice to stories. Participants would have the

opportunity to develop dramatic skills and comfort with dramatic enactment needed for drama therapy while simultaneously enhance self-esteem, self-confidence, empathy and capacity for teamwork (Salas, 2009). Drama therapy would then follow, incorporating narrative therapy and playback theatre. The entire therapeutic program is somewhat similar to Emunah's (1994) *Five Sequential Phases in Drama Therapy* that "progress from interactive dramatic play, to developed theatrical scenework, to role play dealing with personal situations, to culminating psychodramatic enactment exploring deep-seated issues, to ritual related to closure" (p. 34). Emunah wrote about the Five Phases based on observations of how the process of drama therapy tends to unfold.

In the intervention presented here, workshop playback theatre would facilitate the processes of dramatic play (playback short forms) and theatrical scenework (playback long form). Drama therapy sessions would then focus on role-play so that clients could explore any number of issues (e.g., gender dynamics, the masculine idea, double discrimination, gender variance) while simultaneously aiding the clients in exploring and expanding available life roles. Transitioning into a more narrative focused method of drama therapy that includes playback theatre; more personal problem stories would be explored, deconstructed, and re-authored. This is similar to Emunah's psychodramatic enactment phase in that group member's personal issues are explored and transformed, yet different because narrative therapy and playback theater would also be employed. Finally, a ritualistic closing would be achieved by a narrative approach to drama therapy in which stories are performed for an audience. These dramatic closing rituals would serve to solidify and give visibility to re-authored LGBT narratives similar to definitional

ceremonies (Salzburg, 2007) discussed earlier. The therapeutic program is detailed more clearly below.

The first and subsequent sessions would begin and end with clients seated or standing in a large circle; as Emunah (1994) explained, the circle formation creates senses of connection, containment and continuity through ritual. The therapeutic program would begin by explaining the goals of the program, obtaining consent to participate and explaining the forms of playback theatre. The coordinator(s) would invite the group to start moving together synchronically to energize the group and prepare them for dramatic embodiment. Group rhythmic action provides senses of strength, security, community and ritual (Chaiklin & Schmais, 1993). With the group sufficiently warmed up and moving, a number of short forms would be introduced with the theme of heteronormative culture. For example, the entire group could be asked to create a fluid sculpture in response to a word such as homophobia, biphobia, or transphobia. Not only would this serve to introduce the subject matter but would also begin the process of eternalizing the problem through the dramatic representation.

Moving from a collective effort to a more individualized one, another short form *pairs* could be used "in which ambivalent and conflicting feelings are expressed" (Chesner, 2002, p. 43). Group members could work in pairs to embody any number of sources of conflict or uncertainty. For example, self-image might be offered as a suggestion and teams of two could show both pride and shame reversing roles so that each concept is embodied. The use of pairs could prepare the client-actors to notice and embody multiple possible meanings that can be found in words and stories. Before moving to the long form of story, the group would have to demonstrate a sufficient

amount of self-confidence and comfort with dramatic enactment. Any number of drama therapy exercises designed for this purpose could be used (see Emunah, 1994).

The story form would be initiated by arranging chairs to make stage and audience area (described earlier). Clients would be invited to volunteer, taking turns being the actors for the story. If there were two or more coordinators then one might take the role of conductor while the others serve as additional actors to facilitate the process. A teller would be asked to describe a story about his or her life and the process would begin. After the teller has given a response and the scene has been redone as necessary, others would be invited to give their own responses.

During the interviews, both playback theatre specialists discussed the importance of the actors listening for and enacting the layers of meaning in the teller's story. As one put it, the actors are "playing back the archetypal line that they hear… the narrative line that they hear… and the sociopolitical narrative in the stories". This appears similar to the narrative therapy approach of deconstructive listening, which realizes that stories have multiple meanings, some of which may have not been included in the story, as it has been told. So, the entire process will encourage group members to listen for and illuminate multiple possible meanings in the tellers' stories.

A "red thread" (Chesner, 2002) or theme should emerge and given the population and the focus of the short forms, this theme would likely have to do with the experience of being lesbian, gay, bisexual or transgender within heteronormative culture. This would be another opportunity to apply the narrative therapy perspective. During the interviews, the narrative therapists both discussed the power of having a *reflection team.* Freedman and Combs (1996) explained that clients watch this reflection team, comprised

of therapists, having a brief conversation about the client's story. The goal of the team is not to evaluate, instruct, or lead the client. Instead the team members acknowledge their subjectivity and open up a wondering area of thought-provoking questions and helpful observations. This can also be an avenue for inviting the deconstruction of problem stories and the illumination of unique outcomes.

This process is more interventionist than playback theatre's approach to reflection and would be included in the intervention, with the coordinators serving as a reflection team. As Dunne (2010) wrote, that the reflection team could be "people from other groups who have experienced similar struggles. Other members might be therapists, social workers, teachers or members of the larger group" (p. 31). Then coordinators, say a drama therapist and LGBT agency members could serve as the reflection team. That is, after a story has been enacted and the teller has given a response, then the coordinators would share their subjective reflections through a brief discussion with each other that serves to open up a helpful and thought-provoking wondering space.

To give a hypothetical example to illustrate this thinking, say that a lesbian teen shared a story about being bullied at school because of her sexual orientation, and then she reported being fearful and ashamed as she returned to school the next day. Then, perhaps the reflection team might say things like: "When I watched that scene, it really reminded me of how I felt when I faced the problem of Homophobic Bullying" (acknowledging subjectivity, externalizing the problem). Another might respond, "Yes, and it makes me wonder what is Jean's special strength since she returned to school the very next day in defiance of The Shame and The Fear " (unique outcomes, illuminating strengths and externalizing the problems).

The client should have space for his or her own reflections after listening to a reflection team to ensure that any unique outcomes illuminated are a part of the client's preferred narrative (Freedman & Combs, 1996). Dunne (2010) called this *the re-telling of the re-telling*, which occurs when a marginalized group responds to the reflection team's discussion. In this playback theatre example, Jean might be asked if anything that the coordinators said had interested her in some way. Perhaps she might respond, "Well, I always just assumed that I retuned to school because I *had* to, but I guess that took a lot of courage on my part". A follow-up question might be "What do you suppose this says about you as a person"? Others in the audience might be asked for their own non-judgmental reflections of subjective experience that were inspired by the story and enactment. After a number of stories have been performed (preferably more than 1 from each of the 4 LGBT groups, if available) group members will be invited to mingle and find others whom they would like to work with later in smaller drama therapy groups.

In this manner of using playback theatre, the larger group will be encouraged to build connections through sharing, have a voice for their stories while beginning the narrative therapy process, of externalizing problems, deconstructing the dominant discourse, searching for unique outcomes and re-authoring stories as more authentic accounts which include strengths.

As discussed in the introduction, playback as a form of theatre is necessarily structured (in fact, this structure provides safety for sharing) and it is therefore possible to clearly detail the form of the playback theatre portion of the intervention. Also explained earlier, drama therapy is flexible and its structures are more difficult to detail precisely due to the emphasis on creativity, spontaneity, and playfulness. As such, the drama

therapy portion of the program that follows is not as detailed as the playback theatre segment, yet nevertheless, describes the goals and potential processes that could occur based upon the interview data and the literature review. In short, the goals of the smaller groups are to use drama therapy as a means of exploring identities, expanding role repertoires, developing positive self-concepts, externalizing problems, illuminating unique outcomes and re-authoring of stories as more authentic and preferred accounts that include strengths. Sessions would proceed with a focus on fictional character and role work, then move to a focus on personal stories and enactments.

Nearly all interviewees indicated that it is important for the adolescents to explore and "own" their self-descriptions whatever they may be: "gay woman", "straight transgender", "queer", "unsure", "a person first" and so on. Moreover, participants also said that identity is fluid and can change and that space should be provided for participants to explore identity on their own terms. The drama therapists all spoke of the power this modality has, in which clients can "try on" different roles, or expand aspects of their role system (Landy, 2009). As one person put it "What drama therapy could really offer is the flexibility of roles. You're allowed to experience, a lot of different types of roles or roles that you never played before… there may be variations of that role that you've never played". Indeed, Landy conceptualized dysfunction as "an inability to internalize and enact a number of roles competently" (p.74).

Discussing a specific application of role theory to work with LGBT youth, another drama therapist said:

> The beauty of drama therapy in that sense is allowing somebody to take on roles and play out *how they would like to be*. In terms of gender transition, you can do

> that through role-play, you can do that through improvisation and… at the same time you need to prepare them for the realities of outside so we do work in the office on developing a persona… becoming more comfortable with the inner but ultimately you're going to walk out the door so then you get into the logistics, practical things as a therapist. How are you going to deal with people saying something to you? How are you going to deal with the looks? What are you gonna [*sic*] tell so and so's mother when she asks you? And so all of the practical, skill-building stuff comes into it.

It can be seen how LGBT adolescents can explore ideal identities as a means of developing positive and preferred self-concepts through role work. In the case of transgender adolescents, this can give them a safe way of trying out what a gender identity role feels like through embodied role-play. Further as a means of role rehearsal, these youth can safely prepare for potential harsh realities outside of the therapy space.

The same participant also described how character use and the therapist acting as the dramatic projective object could be used to spark discussion on what it means to be lesbian or gay. In an example of his work he said:

> I had a group where they created a story as a group and they intentionally created a gay character and so they cast the whole thing and cast me as the gay character. And so, I intentionally played the character in the hyper-masculine form and… the entire group stopped and said wait a minute that's not right, that's not gay. And I asked, well then what does it mean to be gay… To sort of find ways in the conversation to extend the notion of gender or extend the notion of what it means to be gay [or] lesbian.

Here we see how character use and story creation in drama therapy and the therapist acting as the dramatic projective object can spark discussion on what it means to be lesbian or gay and further, facilitate the exploration of identity. This can be a useful approach to explore LGBT identity and can be used in tandem with role repertoire expansion and role rehearsal described earlier.

Role theory also shares similarities with the narrative postmodern perspective, which acknowledges there are multiple aspects of the self, although the former focuses on roles while the latter focuses on stories (Dunne, 2009). This similarity can be illustrated with a quote from Freedman and Combs (1996):

> Different selves come forth in different contexts, and no one self is truer than another… but a "preferred self" is different from an essential or "true self"… We work to assist them [clients] in living out narratives that support the growth and development of these "preferred" selves (p. 35).

In this respect it can be seen that roles or selves, however it is put, are socially located and finding and enacting a preferred way of being can foster personal growth. In the context of LGBT adolescents in drama therapy framed within a narrative approach, this can be a means of exploring identity options (roles or selves) and finding what is preferred and further, any number of presenting issues could be explored.

All throughout the specialized group drama therapy sessions and the entire intervention, deconstructive listening and questioning will occur to indentify the multiple levels of meaning behind problem stories. Particular attention will be drawn to the sociopolitical influences that create and maintain the problem. Keeping in mind the findings from the current research data, the client may describe the effects of heterosexist

dominance as bullying, homophobia, discrimination, shame, fear, etc. To aid in the separation of the problem from identity, externalizing conversations and playback theatre will be reintroduced to serve as “externalizing playback scenes”. In Dunne’s (2009) approach, the client can create a *living sculpture* by choosing group members to play his or her role and others to play the problem itself. This method of externalization allows the client to visualize his or her relationship to the problem and to make changes. The externalizing playback scenes proposed here takes this a step further by allowing the client to view a problem *event* while choosing others to figuratively represent the problem; this latter aspect is similar to Dunne’s living sculpture method.

Playback theatre involves mirroring principles, which promotes psychological distance and thereby facilitates the teller to make more realistic self-appraisals (Kellermann, 2007). Thus, playback theatre should provide more psychological distance from the problem so that the storyteller can critically examine the sociopolitical influences in the problem story. Conversations among the client-actors, other group members, and the therapist should help the client to socially negotiate new “truths” and knowledge about their stories while reclaiming power.

Part of this rebalancing of power will occur in the steps of illuminating unique outcomes and thickening the preferred story. As explained earlier, questioning to connect the alternate story to past events and hypothetical futures should help to thicken the plot. The inclusion of rich detail, other people and alternate perspectives helps to make the preferred story multi-layered. Dunne (2009) discussed the power of dramatizing unique outcomes (real or hypothetical) so the client can actually experience or re-experience a

defiance of the problem. Then when unique outcomes are identified, clients will be invited to dramatize these narratives to thicken the emerging alternate story.

Freedman & Combs (1996) wrote, “If people constitute their preferred selves by performing their preferred stories, then it is important that there be audiences for those stories” (p. 237). Taking a *dramatic* performance out of the therapy space, “group members create theatrical pieces that recount both their struggles and the discovery of new skills and knowledges… that recount the journey from marginalization to being seen” (Dunne, 2010, p. 51).

To have an audience for the alternate stories, enacting of the preferred story would occur both within the smaller groups and then (also for ritualistic closure) within the larger group that met for the original playback theatre performance. This should also help to increase visibility and re-connection. It is felt that playback theatre would not be indicated here given that clients need to embody the alternate stories and perform them with an audience of supportive others to keep them alive. In the larger group, seeing the similarities of each other’s journeys from marginalization to empowerment could further diminish intergroup bias. LGBT adolescents could learn from other by watching the performed preferred stories, have a broadened perspective, and unite to support each other. During the interviews 2 of the drama therapists all spoke of the need for celebration to take place in the therapy space. As one person put it, “Building community and celebration is really important”. Then, the final performances of the preferred ways of being can be celebrated through audience feedback and the giving of symbols of achievement. The entire therapeutic program has been summarized below in Table 1.

Table 1.

Therapeutic Program Overview

Step	Primary Modalities	Group Format	Major Goals
1	Playback theatre and narrative therapy	Mixed	Building community, a voice for stories, externalize problems, create a wondering space (reflection teams), and specialized groups formation
2	Drama therapy (character and role work) and narrative therapy	Specialized	Explore LGBT identity, develop positive and preferred self-concepts, role expansion and role rehearsal
3	Narrative therapy, drama therapy (personal stories), and playback theatre	Specialized	Deconstructive listening, externalizing conversations, externalizing playback scenes, illuminating unique outcomes, thickening the preferred story and enacting the preferred story
4	Drama therapy and narrative therapy	Mixed	Enacting the preferred story for a larger audience, keeping stories alive, building community, celebration and closure

Discussion

The primary research question was how could narrative therapy and playback theatre be incorporated into a drama therapy intervention for LGBT adolescents? The proposed therapeutic program above presents an answer to this question based on the qualitative investigation, the grounded theory that emerged, and the available literature. An advantage to this approach is that it helped to supplement the limited therapy literature regarding LGBT adolescents with the expertise of professionals who have used these methods with these people. This research approach should render the intervention more comprehensive than if it had been constructed based exclusively on the scarce or non-existent relevant literature.

It should be acknowledged that the proposed intervention is not the only possible way of implementing a narrative approach to drama therapy and playback theatre for LGBT adolescents. It does however detail one complete program of treatment that takes into account the psychosocial needs of these young people. As Freedman and Combs (1996) explained, it is not the techniques of the narrative approach that are most important but rather maintaining its worldview when working with clients. In practice, this intervention would likely be modified based upon the makeup and needs of the clientele and the aspects of the setting where the clients would be served.

The two subsidiary research questions were designed to understand the needs of these individuals, and how these needs might be addressed by a combination of 3 different yet, apparently compatible modalities. The first question was as follows: What are any special considerations about working with LGBT adolescents with each modality (narrative therapy, drama therapy and playback theatre)? In brief, the data indicated that there are a number of psychosocial problems that LGBT youth face and that each modality could successfully address these issues. From the interview data, a category system emerged and most importantly, the interrelationships between the categories that formed a grounded theory to explain this reality (discussed below).

The second subsidiary research question was: What are any advantages or disadvantages to working with LGBT adolescents collectively in a group? It was reported that there are advantages to working with each of the 4 groups of adolescents (lesbian, gay, bisexual and transgender) in mixed and specialized groups. This was an important finding because, to the best of this researcher's knowledge at the current time, the literature implies (but does not explicitly prescribe) group treatment for separate

groups in which member composition is based on sexual orientation or gender identity (Aronson, 2002; Seehaus, Elliot & Melaney, 2004). A source of literature that does prescribe a heterogeneous group structure only mentions the benefits for a mixed therapy group composed of lesbian, gay and bisexual people (Beckstead & Israel, 2007). The findings here suggest that the inclusion of transgender adolescents in a LGB youth treatment group is indicated. The intervention takes these findings into account and has been designed to take advantage of *both* heterogeneous and homogenous group composition structures.

To answer these subsidiary research questions, interviewees were asked about any special considerations for working with LGBT adolescents collectively; if any issues might be unique to each of the 4 groups; and any indications or contraindications for use of the specific modality. Not surprisingly, considering that all participants were therapists or professional helpers, the special consideration questions were responded to by detailing the needs of the populations and how the modality functions to meet these needs. What was interesting was that in data analysis, similar responses were found across all 3 modalities, an example of reliability ensured by the process of constant comparative analysis (Glaser & Strauss, 1967).

This suggests a number of things. Firstly, these are in fact the needs of LGBT adolescents. Secondly, those needs can be addressed by drama therapy, narrative therapy, or playback theatre. And third, that while these modalities function differently, they all can produce similar results. All participants responded that their respective modality would be indicated for use and this led to them detailing the advantages of each method. The only contraindication mentioned was that if a client was not in touch with

reality, in a state of crisis or in other ways unstable, then efforts should be made to stabilize the client first – a sensible precaution.

The grounded theory that developed from the research was based upon the 4 categories, (1) Need for Communal Re-connection, (2) Intergroup Biases: The Doubled Discrimination, (3) Dominance Supplanting the LGBT Voice and (4) Re-connecting LGBT Adolescents for Story Telling. The theory was developed through the lens of narrative therapy's postmodernist perspective (Brown & Augusta-Scott, 2007; Freedman & Combs, 1996; White & Epston, 1990). In summation: stories give meaning to life and are socially negotiated; stories inform identity and life performances; the dominant culture imposes its discourse on the narratives of marginalized groups; and marginalized individuals will internalize the dominant discourse as an ultimate "truth".

From this worldview, the first 3 categories explains the psychosocial problems that LGBT adolescents endure and that these problems are interrelated and due to systemic expression of the dominant discourse of heteronomative culture, which may be referred to as heterosexism or heterosexist dominance. Heterosexist dominance marginalizes LGBT youth and pushes them out of societal institutions creating a need for re-connection. The dominant discourse is internalized into the self-narratives of LGBT adolescents (as homophobia, biphobia and transphobia) and not only creates and maintains low self-esteem and self-hate but also supports intergroup biases. Intergroup biases exacerbate problems such as isolation, stigma, oppression and psychological dysfunction. The resulting inauthentic, problem-saturated story supports dysfunctional life performances and with a lack of connection to social support groups to serve as an audience, a more accurate, healthy, and preferred narrative remains un-storied and

unperformed. The fourth category shows that group drama therapy, group narrative therapy, and playback theatre can provide supportive forums for story telling in which, a re-authoring process can take place. Reconnecting LGBT adolescents with similar others could create a sense of community, reduce isolation, and combat marginalization.

Some of the concepts detailed above (i.e., social isolation, intergroup bias, and internalized heterosexism as the dominant culture's imposed narrative) were also found in the literature thereby increasing support for the theory. However, sources of literature typically *list* the issues LGBT adolescents face but do not provide a systematic model of how these problems interrelate (see Aronson, 2002; Davies, 1996; Lemoire & Chen, 2005; Ryan & Futterman, 1998). The minority stress model has been used to explain psychological distress and resilience of lesbian, gay and bisexual individuals within a psychosocial context of stigma-related stressors (Meyer, 2003). Support for this model has been shown in a study that found gay men were more likely to experience psychological distress with high levels of minority stress (Meyer, 1995) and similar results were more recently demonstrated for LGBT youth (Kelleher, 2009). What is different about what has been presented here is that, to the best of this author's knowledge, this grounded theory presents a unique model for understanding the pressing psychosocial problems of LGBT adolescents from a *narrative* standpoint. While the minority stress model also recognizes that communal social support can be a source of strength to combat the impact of stress, the model presented here indicates that a communal story-sharing forum could ameliorate problems.

This grounded theory is by no means a comprehensive model of all of the issues that these people face, nor is it complex in its discussion of possible interactions between

the categories or moderating variables that may impact the effects of these issues (e.g., personal factors, other available social support systems, etc.). It should also be addressed that this study had a small sample of only 7 participants and as explained earlier, did not explore the perspectives of LGBT adolescents directly (although, these perspectives were obtained indirectly from the interviewees). This might limit the scope of understanding of the phenomena under study. Further, field observations were not possible due to ethical concerns and people were sampled rather than "incidents, events and happenings" as recommended by Corbin & Strauss (1990, p. 8). Therefore this theory is admittedly incomplete and requires further development.

While not comprehensive, this study and the intervention presented here offer a starting point for the integration of drama therapy and playback theatre into a narrative approach to working with LGBT adolescents. The intervention is affirmative in that it seeks to help affirm LGBT culture by bringing these people together to share their stories while exposing heterosexist values as the problem, *not* the lesbian, gay, bisexual or transgender person. The empowering nature of the selected modalities could promote identity acceptance and its positive development while providing a supportive social environment to help these youth cope with stigma and minority status.

Playback theatre has been integrated into the intervention as a safe gateway to therapeutic work and has been conceptualized as means of enhancing the externalization and deconstruction of the problem. The method could effectively combat the problems such as the need for re-connection and intergroup biases by capitalizing on the capacity of playback theatre to reduce isolation, create connections, and enhance empathy (Salas, 2009). Participants would also benefit from enhanced self-esteem, self-confidence and

the capacity for teamwork. The feelings of validation and visibility that occur through the sharing, enacting and witnessing of stories can also meet the needs of giving voice to LGBT narratives.

The drama therapy component offers ways in which these adolescents can, quite literally, play with different roles as a way of promoting the healthy development of identity and self-esteem, as recommended by Aronson (2002). The clients will have space to “try on” various roles and discover what is preferred while expanding their role repertoire as a means of successfully navigating social arenas (Landy, 2000). Moreover, clients would have the opportunity develop their creativity, spontaneity, imagination and playfulness (Lewis, 2000) and this should further increase the ability to cope and adapt to the daily challenges of living as stigmatized minority. Alternate stories need not just be plotted and told but can also be enacted and thereby actualize these preferred narratives dramatically, theatrically, and beyond into daily life.

The intervention is also intended to diminish the intergroup discrimination that exists within the LGBT community, which has been indicated as a source of problems (Firestein, 2007b; Hill & Willoughby, 2005; Potoczniak, 2007; Weiss, 2003). A sense of belonging to a LGBT community can provide social support, psychological support, and have a critical impact the development of a positive identity for LGBT persons (Perez, 2007). This group intervention can also provide a safe space for information exchange, feedback about misconceptions, the appreciation for diversity and the chance to develop meaningful relationships (Beckstead & Israel, 2007). A collaborative effort can take place to re-write dysfunctional personal and communal LGBT narratives into preferred and healthier stories to inform life performances and improve the lives of these people.

Future Directions

This theory and intervention can be further developed by working with the population it is intended for. In Canada, The Triangle Program (2011) is the only classroom specifically for LGBTQ (i.e., questioning) secondary students. The program offers structure and support for the students and has 11-12 units of study in the current curriculum that focus on lesbian, gay and transgender issues, literature and history. One unit is entitled "Coming Out Stories". Perhaps this intervention or a variant there of could be introduced as an adjunctive supportive service for the students to explore their own stories.

Central Toronto Youth Services' Pride & Prejudice program provides a number of services for lesbian, gay, bisexual, intersex, transgender, transsexual and questioning youth and their parents (CTYS, 2008). The Pride & Prejudice program offers individual and group counselling and has published research about working with lesbian, gay and bisexual youth. This therapeutic program could also be introduced in this agency, perhaps with an additional focus on research. With the clients as research collaborators in further qualitative study, this psychosocial needs model could be further developed by investigating what the clients consider to be pressing issues in their lives. Another approach to study might be a pre-post, time series research design that uses standardized measures of depression and self-esteem, for example, to quantitatively determine the efficacy of the program.

The narrative approach to drama therapy and playback theatre developed here is not only a proposed intervention but also based on a worldview that stories inform what we believe, are changeable, and that reality is socially negotiated in its creation. Then

too, this intervention for LGBT adolescents, and the theoretical ideas they are based on need to be socially developed, co-authored, and move beyond the conceptual level.

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Appendix A

Recruitment Email Letter

Dear _______,

My name is Carlos Wilson and I am a second-year master's student in the Creative Arts Therapies Program (Drama Therapy Option) at Concordia University in Montreal, Canada. To fulfill the requirements of my program I am conducting a research project with the goal of creating a drama therapy intervention tailored to the needs of lesbian, gay, bisexual and transgender adolescents. I seek to incorporate narrative therapy and playback theatre into the intervention, which will be designed in accordance with LGBT affirmative therapy principles for ethical and effective practice. To better inform my research, I am interviewing mental health providers and other professionals with relevant experience in order to ensure that the intervention is as comprehensive as possible.

I am contacting you because of your expertise in the hopes that you might be interested in participating in a telephone interview with me. Should you choose to participate, your name and identifying circumstances will be omitted so that you will remain anonymous to all but myself. I have a detailed informed consent form outlining the project in more detail. If you think you might be interested in participating I could send you the form for your review. This in no way obligates you to participate. You may contact me at carlosdwilson@gmail.com for the form or to ask any questions. Your time and consideration is much appreciated!

Warmly,

Carlos Wilson

Appendix B

CONSENT FORM TO PARTICIPATE IN RESEARCH

This is to state that I agree to participate in a research project being conducted by Carlos Wilson for the purpose of designing a therapeutic program, which is entitled *A Narrative Approach to Drama Therapy and Playback Theatre for LGBT Adolescents*. This research is under the supervision of Dr. Stephen Snow (ssnow@alcor.concordia.ca) of the Department of Creative Arts Therapies at Concordia University.

PURPOSE

I have been informed that the purpose of the research is to investigate how narrative therapy and playback theatre can be incorporated into a drama therapy program for LGBT adolescents. The aim of the research is to create an ethical and effective affirmative therapy program that the researcher may use in his professional practice.

PROCEDURE

I understand that I will be asked questions about my thoughts about the therapeutic modality or modalities that I use and I that the interview will be recorded and later transcribed verbatim. I have been informed that audio recordings will be erased directly after transcription. If I agree to participate in an interview, I will notify the researcher whom may contact me to set up an interview date. This interview will last approximately 20-30 minutes. During this interview I will be asked to describe the effects of working with my modality or modalities with clients while no client-identifying information will be asked. I also understand that my name and identifying circumstances will be omitted so that I remain anonymous to all but the researcher. I have been informed that a code will be used for all of my information and it will be stored on a password-protected computer where only Carlos Wilson has access.

CONDITIONS OF PARTICIPATION

- I understand that I am free to withdraw my consent and discontinue my participation at any time without negative consequences.
- I understand that I may request any or all portions of the interview to be omitted from the study.
- I understand that my participation in this study is voluntary and there is no financial reimbursement.

CONFIDENTIALITY

- I understand that the researcher will know my name but will not disclose my identity to others or in publication.
- I understand that the data from this study may be published.
- I understand the purpose of this study and know that there is no hidden motive of which I have not been informed.

I have carefully studied the above and understand this agreement. I freely consent and agree to participate in this study.

Name (please print) ____________________

Signature ____________________

Witness Signature ____________________

Date ____________________

Appendix C

Semi-Structured Interview Schedule

What can you tell me about (relevant therapeutic modality or modalities)?

What are any special considerations about working with LGBT adolescents?

What are any special considerations that might be unique to working with each of the 4 groups, L, G, B and T adolescents?

What are the indications for using (relevant therapeutic modality or modalities) with each of the groups?

What are the contraindications for (relevant therapeutic modality or modalities) with each of the groups?

What are your thoughts about the concept of internalized homophobia?

In a group treatment plan, would you work with each group separately or include members from each of the groups and why?

Is there anything else you would like to add?

Appendix D

Semi-Structured Interview Schedule for Playback Theatre Specialists

What can you tell me about your work with playback theatre?

What can you tell me about playback theatre with LGBT people?

What are any common themes that present for LGBT people?

What are any differing themes that may be unique to each of the 4 groups, LGBT?

What are the effects of playback theatre for the individual and the group?

Why might you bring playback theatre to LGBT people?

Is there an instance when you would not do playback with LGBT people?

What are your thoughts on the concept of internalized homophobia?

In a playback theatre group for LGBT people, would you work with each group separately or include members from each of the groups and why?

Is there anything else you would like to add?