Art Therapy and Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents

A Literature Review

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Art Therapy and Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents

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Abstract

Queer adolescents often suffer from bullying, violence, abuse, abandonment by families or caretakers, and discrimination because of their sexual or gender orientation. These difficult circumstances often result in symptoms related to mental illness and mental health problems due to childhood trauma and other difficult experiences related to sexuality or gender placement.

Alfred Adler believed adolescents are at a crucial point in the development of identity and are especially sensitive to outside criticism and a perceived lack of safety to express individuality.

The purpose of this project is to address the need for an art therapy center for LGBTQIA+ adolescents. Community is especially vital for the queer individual’s health and well-being. By creating an adolescent art therapy-based center, queer adolescents would have a safe therapeutic place to express themselves through art therapy and create a community and support system to increase mental health, develop a healthy identity, and increase a sense of well-being.

*Keywords:* Adlerian art therapy, adolescents, LGBTQIA+, gender, identity, queer adolescents, sexual orientation, trauma
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Dedication

This project is dedicated to hardworking and brave individuals who advocate and fight for human rights, and the visionaries and warriors who came before us who paved the way toward positive change for the queer community. This project is also dedicated to my partner, friends and family who stood by me and have been immensely patient and supportive throughout my years of study and through the process of researching and writing this paper. This accomplishment would not have been possible without you. Thank you.
Table of Contents

Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents ........................................ 9
  Challenges for Queer Adolescents ........................................................................... 12
  Gender Identity ................................................................................................. 14
Trauma and Art Therapy .......................................................................................... 17
  Trauma and Brain Development ........................................................................ 19
  Gender Development ........................................................................................... 20
  Art Therapy and Trauma ..................................................................................... 22
Art Therapy .............................................................................................................. 24
  Metaphor and Adolescents .................................................................................. 28
  Adolescents and Art Therapy ............................................................................. 28
  Art Therapy with Queer Adolescents .................................................................. 29
  Art Therapy Programming .................................................................................. 31
    Art therapy directives ....................................................................................... 31
Individual Psychology ............................................................................................. 34
  Encouragement ................................................................................................... 34
  Lifestyle .............................................................................................................. 35
  Adlerian Sexuality and Gender Norms ............................................................... 36
  Striving and Feelings of Inferiority .................................................................... 37
  Adlerian Art Therapy ........................................................................................... 39
  Adlerian Views on Adolescents ........................................................................... 39
Community Feeling ................................................................................................ 39
  Special Interest Groups and Events .................................................................. 40
  Community Organizations .................................................................................. 41
Discussion ............................................................................................................... 44
  Implications for Practice .................................................................................... 44
  Recommendations for Future Research ............................................................ 46
Conclusion ............................................................................................................... 47
References .............................................................................................................. 49
Art Therapy and Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents

The purpose of this project is to address the struggle and needs of queer adolescents, how art therapy can assist with process trauma and problems, and the need for services in the form of an art therapy center for LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual, etc.) adolescents.

There is great need for additional mental health services for the queer adolescent population. Queer adolescents often suffer from bullying, violence, abuse, abandonment by family or caretakers, and discrimination because of their sexual or gender orientation (Rosenberg, 2003). These difficult circumstances often result in mental health problems due to these traumatic situations. Post-traumatic stress disorder (PTSD) sustained by trauma can result in a variety of long-lasting psychological problems that require emotional healing (van der Kolk, 2000). Art therapy can help heal these traumas, revolutionize self-understanding, bring comfort and personal insight, support positive neurological changes, explore identity, and express feelings and thoughts in a safe environment (Malchiodi, 2006).

Alfred Adler believed adolescents are at a crucial point in the development of identity (Ansbacher & Ansbacher, 1964). Community connection with safe and like-minded people is especially vital for a queer individual’s health and well-being. Adler believed that connection with community could decrease many problems that can lead to emotional and mental illness (Ansbacher & Ansbacher, 1964).

Rosenberg (2003) suggested the needs of queer adolescents can be more complex and resources to address those needs are severely lacking. By creating an adolescent art therapy-based center, queer adolescents would have access to queer-informed clinicians and a safe, therapeutic place to express themselves through art therapy. In addition, queer adolescents could
create a community, develop healthy identity, process trauma and difficult experiences, and
dercrease mental health problems.

**Definition of Terms**

For the purpose of this paper *queer* will be used in place of the wide variety of
identifications and orientations. Queer was a term that was once used as a derogatory label and
has since been reclaimed. At the time of this paper, queer is often used as an umbrella term that
can encompass both sexual and gender minorities and identifications and is therefore more inclusive. Terminology and definitions for the LGBTQIA+ community will continue to evolve
over time. Labels and terms have been placed on individuals in this minority group and used as
a means of oppression and control, often leading to stereotypes and invalidation of their identity.
The importance of self-identifying can be empowering and healing for many people, and often
individuals may choose more than one term. In addition, terms may be fluid and not static. Each
area of identification comes with challenges, stigmas, and discriminatory reactions even within
the queer community. As of 2018, there is no correct acronym; however, LGBTQIA+ is widely
used. These terms can include, but are not limited to, the following: lesbian, gay, bisexual,
transgender, trans, queer, questioning, intersex, asexual, aromantic, pansexual, polyamorous,
androsexual, same-gender loving, skoliosexual, demiromantic, demisexual, transsexual,
genderqueer, non-binary, agender, bigender, pangender, greygender, gender variant, gender-flux,
genderfluid, third gender, androgynous, MtF, FtM, transman, transwoman, transsexual,
transvestite, gender non-conforming, pangender, and two spirit (Green & Maurer, 2014; Human
Rights Campaign, 2018; National LGBT Health Education Center, n.d.). Many other terms and
identifications exist, and the terms are constantly evolving to improve inclusivity and expression.
Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents

Rosenberg (2003) stated queer adolescents suffer from bullying, violence, abuse, abandonment by their families or caretakers, and discrimination because of their sexual or gender orientation. These difficult circumstances often result in symptoms related to mental illness and mental health problems due to childhood trauma and other difficult experiences related to sexuality or gender. Mental illness can include depression, anxiety, gender dysphoria, self-harm, suicidal ideation, and other symptoms that interfere with life functioning (American Psychiatric Association, 2013). Rosenberg (2003) stated the mental health field is in the process of considering alternative sexualities and genders as a contributing factor of mental health rather than a disorder. Rosenberg affirmed sexuality and gender are not disorders. That is, sexuality and gender should be viewed as a component of a person’s complex life, not as a problem or the prevailing issue of interest. Rosenberg suggested the needs of queer adolescents can be more complex, and resources to address those needs are severely lacking.

Mental health and health services, research, public policy changes, and funds are attributed mainly to underserved populations of considerable size (Craft & Mulvey, 2001). Despite great need, the queer community receives a lesser amount of funds and services and has been historically short-changed (Craft & Mulvey, 2001). This is likely due in part to the difficulties of measuring the queer population numbers. Lack of funds, U.S. census polity, political strife, incorrectly worded or limited research survey questions, political and interpersonal discrimination, prejudice, and stigma contribute to the difficulty in measuring the funds and services dedicated to the queer population; however, there is more research on the lesbian and gay population than other identifiers. According to Hogan (2003), the personal decision for the queer person to refrain from sharing personal, sexual, and/or gender information
in a public survey or census is due to fear of retaliation and discrimination that can include loss of employment, home, or being “outed” (i.e., revealed without permission).

As of summer, 2016, Deschamps and Singer (2017) suggested wide-ranging figures from 1.7% to 7.5% of adults identify as either lesbian, gay, or bisexual (LGB). The numbers and percentage of the queer population have been difficult to identify, and currently, there is no consensus. In a 2015 U.S. poll by YouGov, 31% of 18-29-year old adults identified as “not completely heterosexual” (Moore, 2015, para. 1). In 2017, the United States Center for Disease Control (CDC, 2017) reported that 0.6% of the population identified as transgender, which was about 1.4 million people in the U.S. (Deschamps & Singer, 2017). According to the Oxford English Dictionary, transgender refers to “denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex” (Transgender, n.d.)

In 2015, Pew Research Center completed a randomized survey of 35,071 Americans and reported roughly 5% of the population identified as LGB (Deschamps & Singer, 2017). In 2012, Gates and Newport (2015), from UCLA School of Law, partnered with Gallup and completed the largest population survey about sexual orientation. Gates and Newport (2013) reported 6.4% of people between the age of 18 and 29 identified as LGBT, and 3.5% of those surveyed declined an answer. Gates and Newport (2013) stated the number of identifying LGBTQ people is vastly different from the number of people who have engaged in same-sex experiences, as 20 million Americans reported to have engaged in same-sex experiences. To date, an adolescent survey regarding sexual orientation has not been published (Gates, n.d.).

In a 2015 survey of more than 35,000 people in the United States, 5% of men and women identified as LGB; and bisexual women make up the largest segment of the queer community and are more likely to suffer abuse, rape, and other violence compared to any other women in the
United States (Deschamps & Singer, 2017). In addition, bisexual women are most likely to be closeted, have the fewest services, and experience the greatest discrimination in the queer community (Deschamps & Singer, 2017). In 2017, the Human Rights Campaign (HRC, n.d.) reported half of bisexual women have been raped, with the first occurrence happening from ages 11-17. According to HRC (n.d.), bisexual adolescents are not as visible as queer peers and need a greater number of services due to the higher risk of negative effects on emotional, physical, and mental health.

The narrow focus of scientific research on cisgender lesbian and gay individuals leads to the difficulty in the identification of, and services for, the broader queer population (Clarke, Ellis, Peel, & Riggs 2014). Cisgender (cis) is defined as “denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex” (“Cisgender,” n.d.). Current research primarily focuses on White, Western, middle-class, and able-bodied members of the queer community. Clarke et al. (2014) recommended additional intersectional research across multiple planes of minorities and various social categorizations within the queer community. In addition to being outdated, the current research focus is primarily on the negative aspects and difficulties of queer youths’ lives (Savin-Williams, 2001). Savin-Williams posited that this research practice fails to display the resilience and positive aspects of queer adolescents. With support from parents, teachers, peers, schools, and medical and mental health professionals, adolescents have a better chance to survive and thrive in adulthood.

The development of sexual and gender identity is usually expressed during adolescence and is a crucial time for needed support. According to the American Psychological Association (2012), there are many reasons sexual and gender orientation develops, and sexual orientation is typically determined by individuals at an early age. Often, society (and specifically families) are
looking for reasons a child or adolescent falls outside the norm. The American Psychiatric Association (2013) stated that "to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality. Similarly, no specific psychosocial or family dynamic cause for homosexuality has been identified, including histories of childhood sexual abuse” (p. 14). To date, a current, definitive agreement does not exist regarding the development of homosexuality as a genetic or prenatal determination.

**Challenges for Queer Adolescents**

According to Erickson (1974), adolescence is a crucial time for the formation of identity and is a key development task. Clarke et al. (2014) described identity as a major concern for an adolescent, and for a queer teen identifying, exploring, and sharing sexual and/or gender identity, it is typically more difficult. Queer adolescents are hyper-attuned to their social climate and keenly aware of discrimination and threat. Clarke et al. (2014) stated adolescents encounter many risks associated with “coming out” or stating gender or sexual orientation. Culture, religion, race, class, ability, location (rural vs. urban), and a host of other factors affect the adolescent’s safety after coming out (i.e., sharing identity with peers and family). According to the Oxford Dictionary, *microaggressions* are “a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group” (“Microaggressions,” n.d.). Subtle negative inferences such as microaggressions and a lack of public accommodation play another role in the adolescent’s perception of safety (Clarke et al., 2014). Microaggressions can be psychologically harmful as people begin to understand and form their identity during adolescence.

Many adolescents choose to hide their orientation due to the very real threat of bullying, harassment, abuse, and violence (D’Augelli, 1992). Adolescents who come out in high school
(or earlier) have greater risk for short-term and long-term negative impact on their physical and emotional well-being compared to when they come out as adults or college-age students (D’Augelli, 2009). Negative outcomes can include risky sexual and self-destructive behaviors, academic failure and struggles, substance abuse, violence, and mental health problems.

According to the CDC (2016a), LGB youth are at high risk for bullying. Bullying can include harassment, harmful teasing, physical intimidation, and physical violence. According to a national Youth Risk Behavior Study conducted by the CDC in 2015, 10% of LGB adolescents had been threatened with a weapon, 34% had been bullied on school property, and 18% of students had been raped at some point in their lives (CDC, 2016a). Bullying often results in missing school and has been linked to poor academic performance and low graduation rates (CDC, 2016a). Bullying can also lead to long-term negative effects for adolescents and create a greater risk for suicide, depression, and drug use (Elliot & Kilpatrick, 1994); however, support from home, and other adult support, can positively influence an adolescent’s mental health and survival. Negative experiences from a hostile school environment can be mitigated by parental support and teacher or school counselor intervention (Elliot & Kilpatrick, 1994).

Hate crimes against the queer community are a common occurrence, and a definitive number is difficult to identify because hate crimes are significantly under reported (Peel, 1999). According to the U. S. Federal Bureau of Investigations (2016), law enforcement officials reported 1,218 hate crime offenses based on sexual-orientation bias. Hate crimes most often lead to psychological trauma and ongoing problems such as depression, anxiety, PTSD, and feelings of anger and worthlessness (Herek, Gillis, & Cogan, 1999). In addition, hate crimes committed against a queer individual are more likely to have symptoms of psychological distress than crimes against a non-queer individual.
Compared to their heterosexual or cisgendered peers, queer adolescents often struggle with interpersonal and romantic relationships and other developmental and social tasks (Clarke et al., 2014). Clarke et al. (2014) reported that hate crimes against the queer population are a result of public displays of affection (e.g., holding hands) between queer individuals. In such an environment, queer youth explore their sexuality in isolation or in secret and often put health and safety at risk. For instance, LGB adolescents are at greater risk for sexually transmitted diseases (STDs), and 8 out of 10 adolescents with an HIV diagnosis are gay and bisexual males (CDC, 2016a). Queer adolescents might experience a negative view of the self as a result of discrimination, and this negative perception could lead to self-hatred, depression, anxiety, and shame, which could quickly progress to suicide or self-harm (The Trevor Project, 2017). Self-esteem, relational issues, family struggles, and day-to-day living can be affected as a result of a negative view of the self.

In the United States, the second highest cause of death for queer youth is suicide and suicidal ideation (The Trevor Project, 2017). Nearly half of transgender and non-binary gendered people experience suicidal ideation in their lifetime. Grossman and D’Augelli (2007), reported that “nearly half of transgender adolescents and pre-teens seriously thought about taking their lives, and one quarter report having made a suicide attempt” (p. 527). This statistic is significantly higher than that of heterosexual cisgender youth.

**Gender Identity**

For queer adolescents, the challenges of uncovering, exploring, and expressing gender identity is increasingly complex, because adolescents have the highest number of self-driven gender identity changes (Burns, 2013). For instance, some adolescents do not identify in a binary specific category (i.e., male or female) and are often misunderstood by therapists and
other adults when they may identify as non-binary or genderfluid (Clarke et al., 2014). Gender and sexuality are often used interchangeably but are separate and require therapeutic skills on the part of the clinician to understand the differences. Cover (2013) suggested that when people feel different from the gender they were assigned at birth, they can experience great personal strife and short- and long-term emotional and mental illness. Transgender, gender-fluid, and intersex individuals can experience discrimination and be socially marginalized within the LGB community by being grouped together. According to the Oxford English Dictionary intersex is “relating to or denoting a person or animal that has both male and female sex organs or other sexual characteristics” (“Intersex,” n.d.). In 2016, Deschamps and Singer (2017) reported that 0.6% of the U.S. population identified as transgender (i.e., approximately 1.4 million Americans); however, there are no specific reportable numbers on the population of transgender youth.

Transgender people are at a higher risk of inequality, discrimination, verbal harassment, violence and assault (Whittle, Turner, & Al-Alami, 2007). According to the 2015 U.S. Transgender Survey by the National Center for Transgender Equality (NCTE; 2016), 47% of transgender people have been sexually assaulted in their lifetime, and people of color are the majority of those victims. Of the 27,715 U.S. citizens interviewed by the NCTE, 8% of transgender individuals were kicked out of their homes as adolescents, and 17% of transgender individuals were sexually assaulted when they stayed at a shelter. One in 5 sexual assaults in prison or juvenile facilities occurred because the person identified as transgender (NCTE, 2016). As a result, transgender individuals are at a higher risk for trauma and health concerns during incarceration.
An individual who is intersex, or an individual who has/had intersex or sex-variant traits, can face additional personal and public gender identity issues. According to the United Nations Free and Equal (2018), it is estimated that 1.7% of the population is born with sex characteristics that do not fit male or female definitions, “a figure roughly equivalent to the number of redheads” (p.6). According to Morland (2014), “sometimes individuals are born with genital, genetic, or hormonal characteristics that some people find confusing” (p. 111), and frequently, these people undergo forced or coerced operations to obtain binary bodies. Jones (2016) found that the primary focus of studies and journal articles by medical professionals are related to the physical treatment of intersex people (e.g., medical rape, unwanted or forced surgeries, parent and doctor coercion, and life-threatening treatments) rather than mental health issues.

In a recent study of non-binary gendered people in Australia, Jones (2016) found the majority of the participants stated they were mentally and emotionally healthy adults, but 60% of the participants reported suicidal ideation, and 19% had attempted suicide. Jones (2016) found the non-binary population had high rates of poverty, mental illness, suicidal ideation, disabilities, and bullying during adolescence. In comparison, 3% of the total Australian population reported suicidal ideation (Jones, 2016).

Queer adolescents do not fit into a binary sexual or gender identification category and require increased care and support from family and other adults to successfully cope with the associated challenges (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Often, queer adolescents have unresolved trauma ranging from medical to sexual trauma sustained from a variety of places and people and have a higher rate of PTSD and other mental health problems than straight and cisgendered counterparts (Russel & Fish, 2016). Numbers of queer adolescents seeking services for gender identity issues are rapidly increasing (Riittakerttu, Bergman,
Art therapy is a proven safe and effective approach to explore feelings and expressions of gender to address and heal unresolved trauma (Campbell, Decker, Kruk, & Deaver, 2016).

**Trauma and Art Therapy**

Traumatic events are prevalent in most cultures and societies, and traumatic events for children frequently result in mental disorders and physical diseases due to the trauma (van der Kolk, 2003). Kessler (1995) stated that 15% of the U.S. population reported they have been physically attacked, raped, molested, or involved in combat in military action. Of the victims of violence in the U.S., half are under the age of 25, and 29% of victims of forcible rape are under the age of 11 (Kessler 1995). Kilpatrick et al. (2000) found that, “among U.S. adolescents aged 12 to 17, 8% are estimated to have been victims of serious sexual assault; 17% victims of serious physical assault; and 40% have witnessed serious violence” (as cited in van der Kolk, 2003, p. 170). As a result of the traumatic experiences, Kessler (1995) stated individuals who seek help are most often diagnosed with PTSD.

Trauma, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2013) is an event or series of events that overwhelms the person’s ability to cope. Traumatic events can be experienced or witnessed firsthand and can be of an emotional nature and include shaming or chronic neglect, physical, and/or sexual abuse. Trauma experienced by adults, adolescents, and children can result in PTSD. Roy et al. (2012) extensively studied PTSD combat veterans and found untreated PTSD can lead to serious physical, behavioral, and psychological disorders. Emotional distress from social stress and conflict-based interactions are, according to Song (2017), future “robust psychosocial predictors of physical health” (p.100). Problems can include inflammation of the joints and organs, chronic
sleep issues, and behavioral habits such as substance abuse, smoking, or feeding problems that contribute to other physical diseases (Song, 2017).

Post-traumatic stress disorder can also result in a variety of long-lasting psychological problems that require emotional healing. These psychological effects can include dissociation, anxiety, depression, aggression, self-harm, compulsive behaviors, and a predisposition to become an abuser (van der Kolk, 2000). It can be difficult for adolescents with PTSD to maintain attention at school, process pain, develop language and sensory-motor skills, and regulate emotions. Additionally, adolescents with PTSD struggle with relationships, school, family, peers, and feelings of isolation when alone or in a crowd. Other PTSD symptoms can include feelings of fear or anxiety, sleeplessness, intense startle reactions, feeding problems and other physical disturbances even if the individual is in safe environment (van der Kolk, 2003).

The Adverse Childhood Experiences study (ACEs), is a widely researched and accurate measurement predictor of how trauma before the age of 18 affects physical disease later in life (CDC, 2016b). The ACEs aims to identify a client’s trauma history and its impact on physical health, treatment, and recovery. The higher the incidence of trauma before the age of 18, the greater the risk for developing negative health consequences later in the life. Additionally, people with PTSD are at a greater risk for chronic pain, diseases, and other health problems that can include, but are not limited to, cancer, heart and/or liver disease, chronic lung problems, stroke, hepatitis, and more (Felitti et al., 1998).

The CDC confirmed the connection of childhood trauma with physical disease and promotes the use of the ACEs test in hospitals and communities in the U.S. (CDC, 2016b). The ACEs, and similar studies, reveal a connection between mental and emotional health and trauma and physical health. According to ACEs, childhood trauma and family dysfunction is the leading
cause of early death (CDC, 2016b). At a time when adolescents learn to regulate emotions, make healthy choices, process feelings, and express and create personal, sexual, and gender identity, trauma and PTSD can increase adolescent vulnerability and decrease the potential for healthy adulthood. Early childhood trauma before the age of 18 affects neurodevelopmental delays, other areas of brain development, and health in adulthood (CDC, 2016b).

**Trauma and Brain Development**

Perry and Szalavitz (2008) posited that early childhood trauma has a direct connection with brain formation. A developing brain is vulnerable to stressors, especially significant stress, and adapts accordingly. The neurological brain development with chemical and hormone production affects the way humans deal with stress, and consequently, how they heal from illness and disease (Perry & Szalavitz, 2008). Neurons are sensitive to the environment and can change quickly and easily, and the brain’s plasticity lends itself to adapting to its environment. At times of significant stress, the brain will change in a maladaptive way.

Brain scans of people suffering from trauma show increased activity in the amygdala and other parts of the brain (Perry & Szalavitz, 2008). Additionally, brain scans reveal hormone shifts in stimuli responses (e.g., an increase in cortisol production). Increased amygdala activity and hormone shifts occur as a result of trauma and can result in mood dysregulation, problems in the parasympathetic nervous system, and unhealthy cravings for substances as the body attempts to regulate the system. It is difficult for people who have PTSD to calm the “fight, flight, or freeze” response to outside stimulus within the body (Levine, 2015). When people struggle with PTSD, it becomes difficult to calm the fight, flight, or freeze response even when individuals are not in danger.
Post-traumatic stressors in adolescence and childhood, when the brain is still forming and at its most sensitive developmental psychological period, can lead to hypervigilance, anxiety, lack of motivation, impulse control, various relationship issues, and an inability to modulate emotional responses (Ford, 2011). In an attempt to soothe a parasympathetic nervous system response to stressors, adolescents frequently engage in harmful, temporary means to obtain relief. Harmful coping behaviors can include substances, dangerous thrill seeking, risky sexual behaviors, or self-harm, which can continue into adulthood (Ford & Hawke, 2016).

Adolescents who do not receive appropriate treatment for PTSD can develop a psychological disorder in adulthood including, but not limited to, bipolar disorder, conduct disorder, and various dissociative disorders and psychotic disorders (Ford, 2011). Adolescent trauma can be particularly harmful because adolescents are attempting to process emotion and express and form gender identity (Ford, 2011). Social environment, interpersonal relationships, and life events have an effect on healthy gender expression.

**Gender Development**

Riittakerttu et al. (2018) stated gender is influenced by a multiplicity of sources and life experiences. Gender experiences can be interpreted, experienced, or felt in various ways, is interpreted differently throughout the lifespan, and is defined by “the way one understands, describes and expresses oneself and the reflection of those entities to others” (Riittakerttu et al., 2018, p. 32). Many factors contribute to the development of gender such as social environment, culture and nationality, racial identity, a caregiver’s view of gender, religious and political beliefs, climate, and socialization. At a biological level, hormones and brain development, genes, pre- and postnatal hormones, puberty, and neural circuitry have an impact on gender development (Heins et al., 2011). In addition, trauma may have an effect on gender
development. For instance, trauma may delay gender development or cause an adolescent or child to hide thoughts and feelings.

Many believe gender is created at conception and is one of two options—a binary system of either male or female (Clarke et al., 2014). Socially, one of two genders are usually assigned at birth based on external genitalia. If a baby does not fit into one of the two categories, gender is often forcibly assigned by parents and/or doctors at birth or early childhood (e.g., as with intersex individuals). The decision between male and female is made for the child based on surgically changing the child’s genitals to best fit the act of heterosexual intercourse (Clarke et al., 2014). Many intersex individuals mature without the knowledge of their gender birth story and never feel that they “fit” their assigned gender. Some adolescents and adults who felt their assigned gender misaligned with their gender identity have later discovered their parents and/or doctor forcibly assigned a gender to them when they were born or as young children (Horlacher, 2016).

Usually by age 2 or 3, a child is socialized into a binary-gender system, and at this age, gender-variance is acutely noticed by the adults and children (Tuerk, Menvielle, & Perrin, 2005). Gender-variance is a behavior or gender expression that does not fit into the assigned birth category or the social binary gender system (Clarke et al., 2014). For some children and adolescents, parents and caregivers are supportive and allow children to express themselves and explore their gender experience as it is forming in the brain. Often, a child displaying gender-variant behaviors or preferences is suppressed, and the suppression causes problems and mental health issues into adolescence and adulthood (Clarke et al., 2014). This suppression can take the form of bullying, shaming, harmful inferences, and blatant discrimination, which classifies as early childhood trauma.
Gender and sexual orientation are not influenced by a parent’s gender or sexual identity. Parental orientation is associated with how the child or adolescent views or feels about gender and sexuality as a whole but does not influence whether or not a child will identify as queer (Sumontha, Far, & Patterson, 2017). Parental gender and sexual orientation do not establish a child’s gender development. That is, queer and heterosexual adolescents experience the same process of gender development regardless of parental orientation (Sumontha et al., 2017).

Personal gender identity evolution can bring feelings of emptiness, loss, isolation, and ultimately, depression (Clarke et al., 2014). Greater difficulty arises if the feelings of dysphoria or personal struggle exist over a long period of time. In some cases, depression and gender interact with each other. Gender can be all encompassing for an individual, especially if a person feels complications associated with gender.

**Art Therapy and Trauma**

Art therapy has been effective in mitigating the effects of childhood trauma (Gantt & Tripp, 2016) and fosters healthy expression in LGBTQIA+ youth (Takemoto, 2016). Considering how damaging childhood trauma is in the long-term, these findings validate the need for psychological and holistic care. Appropriate therapy can help an adolescent with a trauma history increase coping skills and emotional development (Klorer, 2016).

Talking about trauma can be retraumatizing and cause a client to disassociate as they “relive” the painful memory (Gantt & Tripp, 2016). Children and adolescents often have trouble tolerating the memory, and often PTSD sufferers will relive the memory as though they were currently experiencing it (van der Kolk, 1989). Trauma-informed therapists often use an approach that is both conscientious of this potential for retraumatizing along with a non-
cognitive approach. A nonverbal approach, such as art therapy, is well suited to processing developmental trauma (Gantt & Tripp, 2016).

Because traumatic memories are both visual and physical, cognitive and language-based approaches may be ineffective, even though trauma can have a great impact on cognitive functions (van der Kolk, 2006). Someone who has PTSD is often unable to fully experience the world and their bodies and have what van der Kolk (2006) referred to as a “physical immobilization” or a chronic state of reactive helplessness (p. 283). Those with PTSD may be suspended in such a state of overwhelm that feelings and sensations created by the brain and body are disrupted and cut off. There is a loss of self and lack of awareness in the body that makes internal feelings unrecognizable.

According to van der Kolk, (2006), healing PTSD is not accomplished through cognitive therapies, but through experienced-based and sensory approaches. Art therapy is inherently visual, sensory, feeling, and body-oriented, which makes it an ideal approach for healing PTSD. Art therapy can be effective at reducing many symptoms that are associated with the traumatic experience or memory and can lead to post-traumatic growth and brain development (Lusebrink & Heinz, 2016). Traumatic memories are often fragmented and located in different parts of the brain in non-narrative, disjointed segments (Lusebrink & Hinz, 2016). These memories and imagery can be processed, integrated, and reorganized through art making with a trained art therapist.

In art therapy, metaphor is often used in storytelling and in non-verbal art making. The use of metaphor is powerful; it is complex by nature and uses many parts of the brain (Stepney, 2010). Metaphor is also used by music, psychodrama, and play therapists and is particularly effective with adolescents who are already steeped in stories of the self or others. Often, rich
stories and memories arise when working in art therapy, giving insight to both the client and the therapist. Mcnamee (2004) stated, “Drawing sometimes provides a way for other parts of the brain, the nonverbal parts, to tell their story” (p. 138).

**Art Therapy**

From the earliest recorded history, visual and other expressive arts have been used to express the human experience, communicate ideas, promote healing, process thoughts, emotions, and a wide variety of experiences. Art transcends language and offers insight to personal and collective history. In an often difficult and challenging world, the art-making process can promote health, wellness, insight, community activism, personal growth, and enjoyment.

Art therapy was introduced as a treatment modality by Margaret Naumburg in the 1940s and became a growing therapeutic field in the 1950s, combining art-making and psychology (Malchiodi, 2006). Art therapy draws on ancient and modern forms of artistic and creative expression that developed in conjunction with psychological therapeutic processes over the past 80 years.

Art therapists are master-level clinicians with a dual degree in psychotherapy and art therapy, and are held to the same ethical standards as all therapists (American Art Therapy Association [AATA], 2018). Art therapists have been clinically trained in psychotherapy, diagnosis, human development, clinical practice, spiritual and multicultural artistic traditions, the use of art materials, non-verbal symbols, and metaphors that are often expressed through the creative process. Art therapists honor individual values, orientations, and beliefs and can work with people who are challenged with medical and mental health problems. Additionally, art therapists work with individuals seeking emotional, creative, and spiritual growth (AATA,
To date, the American Art Therapy Association (2018) estimates more than 5,000 practicing art-therapy professionals in the United States.

Using various art materials and media, trained art therapists help clients create artwork that can revolutionize self-understanding, bring comfort and personal insight, support positive neurological changes, and express feelings and thoughts in a safe environment (Malchiodi, 2006). The creative process allows an individual to express unique inner and outer experiences, identity, emotional processes, style of life, development, goals, and strengths. By using art materials with an art therapist’s support, a client can increase coping skills and self-esteem, find a new way to self-understanding, and reduce a host of symptoms including anxiety and depression (Malchiodi, 2006).

When compared to non-queer youth, it is more likely that a queer youth has sustained trauma and will have symptoms of psychological distress (Herek et al., 1999). Art therapy is effective in mitigating the effects of childhood trauma (King, 2016) and fosters healthy expression in queer adolescents (Takemoto, 2016). Recent neurobiology research supports art therapy, and other non-verbal expressive approaches, as an effective and safe way to process early developmental trauma and negative experiences (Gantt & Tripp, 2016; Malchiodi, 2012).

There is abundant neuroscientific data that supports the use of art therapy to significantly increase brain function (Gantt & Tripp, 2016). The increase in brain function leads to increased flexibility and the ability to adapt to the environment, regulate emotions, and heal trauma. Art therapists work with activity patterns in the brain devoted to art-making and scientific discovery, which helps the brain process information and develop healthy brain connections. Brain scans show increased blood flow and activity when an individual is involved in a creative activity.
(Malchiodi & Crenshaw, 2014). In addition, creative activity increases serotonin, which is a chemical found in the brain that raises mood and reduces stress and feelings of depression.

Art therapists help clients cope with painful thoughts, feelings, and memories of the past by providing a means to reprocess memories in a safe way (Moon, 2002). Often in art therapy, the work results in replacing painful feelings and memories with peaceful, loving, and resolved feelings. The verbal retelling of memories is naturally flawed, and the human ability to verbally tell personal stories from the past is fraught with untruths (Gazzainga, 1998). The flaws associated with verbal storytelling are a result of the left brain attempting to make sense of the memory and create narrative cohesion.

When using creative non-verbal techniques in therapy, art therapists and clients access a part of the painful memory that contains more accurate information than during verbal processes which can then be used by the therapist and client to make changes (Moon, 2002). Art therapy is ideal for processing trauma with an adolescent, and an art therapist is trained to be aware and safeguard against re-traumatization, which can be damaging to the psyche (Gantt & Tripp, 2016). This non-verbal process can bring great healing and is directed by the client who can move at a personal, unique, and healthy pace to access deeper feelings, and consequently, deeper healing (Moon, 2002).

Art therapists use the *expressive therapies continuum* (ETC) as a framework for understanding a client’s state, to make decisions, and to design a therapeutic approach for a client’s treatment (Hinz, 2009). The ETC integrates various types of media and artistic processes along a measured continuum for classifying complex creative outcomes. The ETC functions as a comprehensive visual structure to guide an art therapist. The ETC outlines a measurable developmental hierarchy, which includes the following four states: *kinesthetic/sensory,*
perceptual/affective, cognitive/symbolic, and creative expression (Hinz, 2009). The kinesthetic/sensory is in the earliest developmental hierarchy during the sensorimotor stage. The focus of someone working in this stage would be a kinesthetic experience rather than visual outcome of the art. The perceptual/affective state includes using personal metaphor and symbols to make meaning of the world around the client. This state would include emotions, responses, and perceptions. The cognitive/symbolic level of the ETC includes sophisticated expression more complex than the previous levels. The person is able to express ideas and thoughts outside of their normal experience and demonstrates an understanding of action and consequences. The creative level of the ECT can exist at all previous stages. The creative level references the value and joy in making art used to express the self and experience emotions and sensations.

By identifying how a client is using materials, what materials they are using, and the outcome of the art itself, the ETC framework can be used to identify whether the client is using right or left-brain functions and how the client is processing information (Hinz, 2009). A person can make art on any or all of the ECT in any order, and the current level does not define the ability or value of the experience (Hinz, 2009).

Further developed by Kagin and Lusebrink (1978), the ETC is a widely-used conceptual model used to understand the complex expression in art-making. The ETC is used in a variety of settings and populations and is an effective tool for the trained art therapist to help clients understand themselves and effectively communicate through art-making (Malchiodi, 2005). Frequently, adolescents will create art in the cognitive/symbolic or creative expression but will move across the spectrum outlined in the ECT when supported by an art therapist. By moving across the ETC, the art therapist can help the adolescent experience new ways of processing and adapting to prevalent changes in an adolescent’s stage of life (Malchiodi, 2005).
Metaphor and Adolescents

Through metaphor and other modes of self-expression, art therapists strive to allow the client to express themselves in accurate and meaningful ways. Developing personal symbols and metaphors can have great meaning for adolescents (Moon, 2007), and symbols and metaphors work with the cognitive and symbolic levels of the ETC (Hinz, 2009). Hinz (2009) stated that metaphor is effective in reinforcing feelings and thoughts as well as making positive action and movement occur in the client’s life.

Metaphor originates directly from the right side of the brain and is a powerful tool frequently used in art therapy practice (Webb, 2003). Personal metaphors are creatively developed and used to tell a story that often cannot be easily articulated or articulated with very much clarity, by the left, or rational side, of the brain. The creative use of metaphor and personal themes is specifically effective with those struggling with attachment disorders or children who have experienced deep loss or traumatic events. In a study of children experiencing grief, Webb (2003) wrote that expressive therapies “provide children with an opportunity to communicate feelings about and reactions to their bereavement experiences in symbolic form” (p.1).

Metaphor is also regularly used by psychodrama, music, and play therapists and is particularly effective with adolescents who are already deeply involved in their story (Webb, 2003).

Adolescents and Art Therapy

Art therapy for adolescents is key to telling personal stories, processing past trauma, coping with family problems, feelings, and changes in the young person’s life (Moldovan & Năstasă, 2015). Art therapy can be particularly effective when helping a young person safely explore their feelings of sexuality and gender in a supportive and non-judgmental environment. Moldovan and Năstasă (2015) stated, “creative-expressive techniques help children to
understand themselves, set themselves free from the accumulated anxieties, and loosen the process of elaborating strategies in solving conflicts and developing personal skills” (p. 39).

Edith Kramer, an early practitioner of art therapy stated, "art therapy is conceived primarily as a means of supporting the ego, fostering the development of a sense of identity, and promoting maturation in general" (Babyatsky-Grayson, 2014, p. 18). That is, the use of art therapy with adolescents allows for freedom of expression during the growing and self-preparing process as adolescents move toward adulthood.

Non-verbal therapies provide young people the opportunity to communicate and process in a way that is natural to them because their ability to speak and explain feelings is limited at this stage of life (Webb, 2003). Webb suggested that speaking directly to a young person about a complex topic (e.g., grief) could include the risk of re-traumatizing the youth. Re-traumatization could occur because the discussion is directed by the adult clinician who has developed verbal skills to process difficult conversations, and the adolescent has not yet fully developed such skills. Expressive therapies offer adolescents a chance to tell a story in a self-directed pace required to facilitate healing (Webb, 2003). As a result, the therapist learns about the adolescent’s current emotional state and is better able to assist the client. Art therapy helps distinguish between what adults and peers think about the adolescent and the adolescent’s personal identity (Riley, 1999).

**Art Therapy with Queer Adolescents**

Adolescents are in the process of becoming adults, and this includes identifying gender and sexual identity. When adolescents actively question gender or sexual identity, they are at greater risk of mental health problems than heterosexual or LGB youth (Espelage, Basile, Rue, & Hamburger, 2014). Open-ended art therapy projects allow an adolescent self-expression that is
not defined by societal norms (Riley, 1999). Open-ended art therapy projects must include diverse materials and inclusive images. For instance, art therapists offer diverse racial, cultural, gender, and sexual identity images that represent various beliefs and lifestyles to support an accepting environment.

Art therapy is a modality used to support a growing healthy identity and can be used as a resource for queer adolescents in the coming-out process or for identity disclosure to friends, family, and peers (Moon, 2007). Coming out offers personal validation, identity development, community connections, and honesty in close relationships, which is necessary for mental health (Pelton-Sweet & Sherry, 2008) and takes an incredible amount of courage and support. Clients are at various stages in this process and need to come out at an individualized pace. Pelton-Sweet and Sherry (2008) believed coming out is an important part of working with the adolescent population; however, therapists must remember that coming out is a personal decision and may not be healthy or safe depending on the adolescent’s situation.

As a high-risk population, queer adolescents are at an even greater risk while in the process of coming out to themselves and others (Cole, Kemeny, Taylor, & Visscher, 1996; Halpin & Allen, 2004; Vincke & Bolton, 1994). The process of coming out can cause a significant decrease in physical and emotional well-being (Pelton-Sweet & Sherry, 2008). During the process of coming out, self-esteem and happiness can decrease, and loneliness and isolation can increase (Halpin & Allen, 2004). During the process of coming out, art therapy for a queer adolescent can alleviate a variety of symptoms, assist with the avoidance of pitfalls, and provide an opportunity to “try on” an identity within the safety of the art therapist’s office.
Art Therapy Programming

An art therapy space with plenty of materials allows adolescents to feel safe and be well resourced to express themselves. Diverse and regularly held art therapy groups allow queer adolescents to attend safe social gatherings and heal struggles. Moon (2002) stated it is highly effective for adolescents to speak in a group with their peers, because a group can provide a level of support within a new social system.

With art therapy practices that include art therapy groups and one-on-one counseling, queer adolescents can learn how to process and talk about their complicated feelings, build resiliency, grow community, and foster personal growth (Riley, 1999). Linesch (1988) stated, "since the very struggles of the adolescent revolves around self-expression and peer interaction … a combination of art and group therapy techniques will be particularly effective with this population" (p. 135). Art therapy can be an effective tool to help a young person safely explore feelings of sexuality and gender in a supportive and non-judgmental environment.

Art therapy directives. Art directives are open-ended project prompts used by art therapists to allow clients an opportunity to create something unique and highly personal (Malchiodi, 2012). The clients can discuss feelings about the potential projects before or after the end of the project. The art therapist is on hand to assist as needed in the physical creation of the project, to offer encouragement, and to discuss ideas or potential forms of expression. Riley (1999) suggested the trained art therapist is keenly aware of the client’s mood and emotional state during the creation and discussion of the art piece and will redirect should the client become unsettled and outside the window of tolerance (i.e., triggered). Upon completion of the project, the client is invited to discuss the meaning of the project with the therapist or the group. This
discussion can be an emotional process for some clients and extra care should be taken in group settings.

**Mask-making.** Using a mask as metaphor, the client creates from scratch a life-size mask of their own design with plaster wrap, other 3D materials, collage materials, paint, or markers (Stepney, 2010). The directive is to create an external face to symbolically represent the face they show to the world (i.e., their persona). The inside of the mask is meant to symbolize the internal experience the client had or is having (i.e., the private self). Walker, Kaimal, Gonzaga, Myers-Coffman, and DeGraba (2017) reported that mask-making is a very effective art therapy directive when working with survivors and PTSD. This mask-making art directive offers a visual display to support adolescents and facilitate recovery when they question gender and/or sexuality, gender transitions, conflicted feelings, coming out, or feelings about community, family, and society. Mask-making can help the adolescent explore and define emotions, self-image, and feelings of self-evaluation, support vulnerability for revealing internal feelings, and promotes healthy feedback in a group setting (Stepney, 2010).

**Art journal.** A personal art journal is an opportunity for story telling using metaphor and personal narrative in a private way (Stepney, 2010). This art directive is particularly effective within a group setting due to the inherent privacy offered from the use of a book that can be opened or closed within a group setting. Using a repurposed book, a created book, or store-bought book, a client can create their world and a place to express deep feelings and ideas (Malchiodi, 2006). This art journal directive is ideal for processing or chronicling hurtful or painful memories as the book can be closed and made private. The book can hold secrets, goals, emotions, ideas through stories, writings, poetry, drawings or paintings, and is an approachable project well suited for group work due to the private nature of a self-contained book (e.g., the
client can choose who views the work; Stepney, 2010). Directives can be given to a client or a group to process a feeling, current or past situation, or a symptom or struggle. Vela, Ikonomopoulos, Dell'Aquila, & Vela (2016) stated art journals are effective when used to raise self-esteem, process painful memories, and decrease PTSD symptoms of trauma survivors.

**Self-portrait.** Self-portraits have a long history in art-making practices and have been widely used by artists, school children, adolescents, and clients to express identity in art therapy settings (Muri, 2007). The self-portrait can range from a figure to an abstract representation and can be deeply personal in nature and highly powerful. Creating a self-portrait can take a wide range of time (e.g., 30 minutes to many weeks or months), which makes this a versatile project in the art therapy practice. By creating the image of the self, a person identifies and expresses elements of themselves that are often a combination of what others see, what the client sees, and what the client feels internally that is hidden from others (McGann, 2006). Clients who are more withdrawn or quiet often feel more comfortable expressing their identities through a metaphor that can represent the part of themselves they are not yet ready to share (Makin, 2000).

Self-portraits can be confrontational by nature, and clients frequently feel vulnerable as they create and share the self-portrait (Makin, 2000). For instance, a self-portrait provides an opportunity to allow the interior world of the client to be expressed on the outside for viewers to experience (McGann, 2006). That is, to see and be seen is a vulnerable act. This self-portrait directive is well matched for adolescents who are exploring and forming their identity, self-concepts, and ability to express themselves to others and society at large. The client has an opportunity to express what they see or want to see in themselves, and/or what others might see, which will give the art therapist insight into the client’s current state of mind, relation to personal culture, gender, race and society, body image, mental health, and emotional development.
Individual Psychology

Individual Psychology was pioneered by Alfred Adler in the early 1900s and is also referred to as Adlerian theory. The core of Adlerian theory includes a focus on positive lifestyle, contributing to one’s community, encouragement, striving to complete life tasks, self-worth, significance, forming healthy relationships, confidence, and social interest (Ansbacher & Ansbacher, 1964). Adler believed that community feeling leads to positive mental health, and everyone has a right to experience health, personal growth, and improvement (Ansbacher & Ansbacher, 1964). The Adlerian concepts included in this project are encouragement, lifestyle, striving and feelings of inferiority, and community feeling.

Adlerian theory is humanistic and holistic, and therefore, a great fit for the queer adolescent population (Seligman, 2004). Adler stated that adolescence is ripe with fear of failure and discouragement as the lifestyle of the youth is revealed (Dreikurs, 1973). Feelings of inferiority or discouragement are prevalent for queer youth due to their unique challenges. Adolescence is a crucial time of life where the encouragement from an adult, such as a caregiver, teacher, or therapist, can help to create a positive outcome and style of life for the adolescent. Queer youth can have difficulty expressing themselves and connecting to others because of the pressures to conform to societal norms and culture.

Encouragement

According to Adler, encouragement relates to the willingness to participate with courage in healthy behavior and tackle the problems in life (Griffith & Powers, 2007). The lack of encouragement can cause an adolescent to feel discouraged, worthless, and lacking in courage. When combined with family and social pressures, these feelings can lead to mental health problems (Griffith & Powers, 2007). A clinician that accepts a queer client with unconditional
positive regard in initial and subsequent sessions can bring great personal change to the client while strengthening the therapeutic relationship. The therapeutic relationship can create a feeling of acceptance and belonging, possibly for the first time in the client’s life. A clinician can become a role model to support queer youth to find courage, creative power, community connection, and foster adaptability, encouragement, and cooperation with others (Kottman & Lingg, 1995).

Lifestyle

According to Ansbacher and Ansbacher (1964), lifestyle refers to the way people move through the world in their own unique style. For example, Griffith and Powers (2007) stated an adolescent’s style of life is based on attitudes, experiences, influences, personal convictions, and mistaken goals (i.e., goals demonstrated by wanting attention, power, revenge, or feeling inadequate). Many lifestyles can mimic a set of values and could include the desire to be perfect or fit within the accepted cultural norms. Many people value difference and the ability to be the true self. For example, Harrison (1994) found that the way people feel about personal gender, as well as the gender of others, relates deeply to personal lifestyle.

Lifestyle contributes to how a person who identifies in the LGBTQIA+ spectrum moves through the world. Early influences from society contribute to mistaken beliefs about identity and the self. For instance, if an adolescent was told that they should be a certain gender or sexuality, this would affect their lifestyle. This is especially true if the adolescent discovers they have a different identity. A mistaken belief may be that this individual may view a transgender person as wrong, or that perhaps their identity was bad and should be hidden. This negative view of self could lead to self-hatred, depression, anxiety, and shame, which could progress to suicide or self-harm (The Trevor Project, 2017).
Adolescence and Gender Norms

Gender guiding lines and sexual norms are prevalent in society and culture, including medical and psychological theory and practices. There is a limited amount of writing about the queer adolescent population in Adlerian literature, which offers great potential for growth in writing and research (Trail et al., 2008). Most Adlerian literature about sexuality and gender norms is focused on cis-gendered gay and lesbian identified individuals, with almost no mention of transgender, gender non-conforming, and genderqueer individuals (Sperry, Carlson, Sauerheber, & Sperry, 2015).

While Adlerian concepts contain guidelines for healthy individuals, Adler was born in Europe in 1870 and died in 1937 (Ansbacher & Ansbacher, 1964), and his era greatly influenced Individual Psychology on the topics of gender and sexuality. During Adler’s adult life in the early 1900s, non-normative sexuality in Europe was a punishable crime and this would not be overturned in Austria until 1971 (Carroll, 2016). Adler was not a supporter of punishment for homosexuality and did not view homosexuality as a crime (Ansbacher & Ansbacher, 1964).

Adler himself was a minority, he was of Jewish heritage and had suffered from a physical disability as a child due to illness. Adler was a forward thinker for his time compared to his peers, colleagues, and society at large, and his clinics in Austria were closed due to being from a Jewish family. One could hypothesize that if Adler were alive today, he would have progressive views of gender and sexuality and his level of understanding of gender and sexual minorities would be inclusive, non-hetero-normative, and clinically helpful to the queer adolescent community. Adler believed all people have inherent worth and value and should have access to positive mental health (Ansbacher & Ansbacher, 1964).
While Adler was a believer in equality and feminism, like many of his contemporaries, Adler stated that non-normative sexuality was an unhealthy adaptation or perversion in need of correction (Griffith & Powers, 2007). Adler was progressive for his time; however, he followed the popular medical model of his era that while homosexuality is not a crime, it should be considered an illness (Ansbacher & Ansbacher, 1964). Adler stated a normal lifestyle would include a heterosexual partner and cis-gender expressions in relationships and self-identity. 

According to Griffith and Powers (2007), Adler was observed by a colleague when working with a man who identified himself as homosexual. Adler stated that if the man was happy, he should be left alone. Leaving the man alone might suggest that if a client saw no problem with their personal identification or sexuality, Adler would have considered their orientation a non-issue. Adler was progressive for his time in thoughts and opinions of equality for women and children and considering the lack of medical and psychological research about the queer population and the prevalent homophobic social opinions in Adler’s era, it is probable that Adler would adopt an inclusive approach to treating and supporting the queer population if he were alive today.

Adler described love and marriage as a relationship between a man and a woman (Griffith & Powers, 2007). Furthermore, Adler considered gender guidelines as something to be taught and dictated by a child’s parents (i.e., a woman and a man). Adler also believed that a lack of clarity regarding gender identity creates problems and distress later in life. Contrary to Adler’s statements, one could argue that it is not the fault of an individual, but rather, the stress and difficulties for a queer individual within a heteronormative culture that furthers a lack of belonging and creates pervasive inequalities that create dissonance.

**Striving and Feelings of Inferiority**
For queer youth, societal norms and striving for perfection can have a detrimental effect not limited to suicide, suicidal ideation, and self-harm (Clarke et al., 2014; Croake, 1982). Adolescent depression and low self-esteem can be related to Adlerian concepts such as feelings of inadequacy, struggles with independence, anger, overambition, competition, power struggles, and superiority (Croake, 1982). Low self-esteem, relational issues, family struggles, housing, and day-to-day living can be negatively affected as queer adolescents often feel inferior to cisgender and heterosexual peers. Often queer youth feel imperfect and are viewed as imperfect due to being different from the majority of their peers in their immediate community. The way individuals view perfection is deeply linked to religious, societal, and nurture-based affiliations (Thorne, 1955). For instance, humans strive to connect with others, and perfectionism is linked to feeling inferior, inadequate, and imperfect and can affect the way an adolescent connects with others.

Along with a strong desire to connect and belong, people inadvertently associate belonging with perfection, and perfection with sameness (Thorne, 1955). Mistaken beliefs influence lifestyle, which can have a direct correlation to mental health and survival (Rasmussen, 2003). Embracing the courage to be imperfect, rather than striving for perfection while examining personal mistaken beliefs, can have a liberating effect on an individual. The power of having the courage to be imperfect, combined with lifestyle examination, can release inner strife and help an individual move toward contentment, the ability to support the community, and ultimately, create community feeling.

Perfection in the United States is based on norms. That is, in order to be good and perfect people assimilate to the prevailing thoughts about how they should live their lives (Thorne, 1955). Applying this concept to gender identity in the US, one could surmise that perfection and
norms need not be an identified goal. For individuals who feel different from the gender they were born with, or the identity around that gender as set by cultural norms, gender can cause great personal strife and often emotional and mental illness (Cover, 2013).

**Adlerian Art Therapy**

Adler discussed social interest as the highest among artists and writers (as cited in Ansbacher & Ansbacher, 1964). Adler stated that artists and writers contribute to society more than other groups because of their creative ability to uniquely observe and then teach others how to see the world and observe personal experiences. According to Ansbacher and Ansbacher (1964), Adler believed the creative class is responsible for being the “friends and leaders of mankind” (p. 153). Art therapy, where anyone can use and grow their creative abilities to help themselves and others, is an Adlerian technique used to promote community feeling, empathy toward the self and others, and to create a sense of belonging and healing.

**Adlerian Views on Adolescents**

Adler believed adolescents are at a crucial point in the development of identity and are especially sensitive to outside criticism and a perceived lack of safety to express individuality (Ansbacher & Ansbacher, 1964). Adolescents often begin to express, or repress, gender and sexuality depending on the nature of the environment. An adolescent that has been raised with safety, significance, and a sense of belonging will have increased potential to be courageous and healthy. A sense of belonging can decrease feelings of inferiority and increase the motivation and desire to connect with community (Griffith & Powers, 2007).

**Community Feeling**

Community is especially vital for a queer individual’s health and well-being. Community is the birthplace of social justice, encouragement and empowerment, a sense of
belonging, and mental and emotional health (Ansbacher & Ansbacher, 1964). Alfred Adler believed that connection with community, also known as social interest and community feeling, could decrease many problems that can lead to emotional and mental illness (Ansbacher & Ansbacher, 1964). Mosak and Maniacci (1999) described community feelings as "the individual's sense of feeling at home in the world at large and responsible for the welfare of people in general" (p. 113).

The more developed adolescents’ sense of community feeling, the more likely they are able to combat difficulties they face in themselves and within their lives. Connecting with community can decrease mental health symptoms and increase belonging, health, empowerment, courage, and optimism (Ansbacher & Ansbacher, 1964). This need for community feeling continues throughout life.

**Special Interest Groups and Events**

According to Ansbacher and Ansbacher (1964), Adler believed feeling at home in the world and one’s community is essential for health. This is especially difficult when individuals perceive themselves as an “other” or as different from their family or communities. For most of history, queer people have been discriminated against and made to feel as outsiders in their community of origin, resulting in a divided community that went underground (Brooks, 2015). The 1970s offered a turning point and launched the queer rights movement (Carter, 2004).

In 1970, Pride celebrations began in the US to honor the collective resistance and rebellion against police harassment at the Stonewall Inn, a national landmark gay bar in New York City. The Stonewall Inn Rebellion and related riots took place in June and July of 1969 and was a turning point for the LGBTQIA+ rights movement. In 1969 homosexual relations were illegal in New York, and the queer community was regularly discriminated against, and
physically and verbally harassed (Stonewall Riots, 2018). Queer bars and gathering places were perpetually raided by the police (Stonewall Riots, 2018). Spearheaded by several transgender women of color, more than 400 outraged members of the queer community rioted against the police after a raid at Stonewall Inn (Carter, 2004). While there were other protests occurring in the late 1960s, the Stonewall Resistance was the first time members from different orientations within the queer community united against oppression (Stonewall Riots, 2018). The uprising at Stonewall Inn launched a social movement that resulted in the formation of social justice, LGBTQIA+ organizations, and Pride gatherings all over the world. Pride marches, community days, and festivals around the world offer a collective gathering, a sense of community feeling, and a way for adolescents, adults, and families to express themselves in a safe environment surrounded by community. Since the 1970s, the Pride gatherings foster awareness, support the queer community, and increase a sense of belonging.

In 2016, more than 400 Pride celebrations took place around the world (Deschamps & Singer, 2017). In 2018, more than 2 million people participated in the Pride march in New York City, one of the largest gatherings of this population in the world (NYC Pride Sponsors, 2018). There are other special interest groups that support LGBTQ+ minorities. For example, in 1990, Black Pride celebrations began in Washington, DC, and currently, more than 30 Black Pride celebrations take place annually around the world (Deschamps & Singer, 2017). In 2017, more than 300,000 people attended the annual Pride celebration in Minneapolis, Minnesota (Twin Cities Pride, 2018).

Community Organizations

There are a number of national non-governmental organizations in the United States that advocate for queer rights. All of these organizations work to create community feeling, safety,
significance, and belonging. Community, safety, significance, and belonging contribute to mental health (Ansbacher & Ansbacher, 1964). The Human Rights Campaign (HRC) has more than 3 million supporters (HRC, 2018) and is the largest organization for queer civil rights working toward equality. Gay and Lesbian Alliance Against Defamation, now referred to as GLADD, is a media monitoring organization founded in 1985 (GLADD, n.d.). Employees and members of GLADD monitor news outlets for defamatory language and educate inclusive and accepting language about LGBTIQ+ topics.

The American Civil Liberties Union (ACLU) has a substantial branch working toward equal rights for the queer population and has been active since 1936 (ACLU, 2018). The ACLU brings more legal cases and advocacy to queer rights than any other organization. The Federation of Parents and Friends of Lesbian and Gays, Inc. (now referred to as PFLAG) is an activist organization of parents of queer individuals (PFLAG, 2018). Since 1972, PFLAG seeks to support parents who struggle with a child’s identity and associated family dynamics. In addition, PFLAG advocates for safe education and medical treatment. Members of PFLAG produced research about the damaging effects of conversion therapies, parental rejection, and bullying and harassment at schools, business, and hospitals.

The National LGBTQ Task Force (2018) is the oldest queer rights advocacy group in the United States. The National LGBTQ Task Force works with discrimination issues endured by the queer population including housing, healthcare, employment, retirement, marriage equality, and other basic human rights. The Trevor Project is an organization that produces key research for the clinical field and provides a 24-hour crisis line, programming, and other services for queer youth. The National Center for Transgender Equality (2016) is a social justice and advocacy organization working toward equality of transgender individuals.
In 2015, there were 379 for-profit businesses and corporations that openly supported queer rights for their employees by supporting marriage equality (Kaufman, 2015). Google, Amazon, Apple, Goldman Sachs, Coca-Cola Company, and Morgan Stanley, and several sports teams were listed as some of many corporations in support of marriage equality. The global law firm, Morgan Lewis, stated marriage equality raises morale, productivity, and improves the lives of employees (Kaufman, 2015).

While most Minnesota-based organizations serve queer adults, there are a few that offer services specifically for queer adolescents. There are limited organizations and facilities in Minnesota that offer queer-focused services or branches within their organizational structure. RECLAIM is an organization that works to increase access to mental health and offers other services for queer adolescents and young adults. The LGBT Therapists of Minnesota network is a volunteer-based network of queer-affirming or identifying clinicians working in Minnesota. The LGBT Therapists of Minnesota network offers a searchable database for individuals looking for mental health support and provides relevant education and networking for clinicians.

Transforming Families Minnesota in a volunteer-based network that provides a monthly meeting space for transgender, gender non-conforming, and questioning youth and their families. The Minnesota Transgender Alliance provides resources and support to the transgender community. Avenues for Homeless Youth, The Bridge for Youth, the GLBT Host Home Program, and ConneQT Host Home Program provide services for queer adolescents and young adults experiencing homelessness. These organizations offer crucial emergency services and mental health support for queer adolescents (RECLAIM, n.d.).

National organizations, foundations, and events offer affirmation, increased visibility, resources and connection for the queer community. With increasing support and acceptance, and
increased legislation for queer rights, safe opportunities will increase for the collective self-expression and community feeling for queer adolescents.

**Discussion**

An art therapy center for queer adolescents would allow adolescents at a crucial time in their lives to safely explore sexuality and gender, connect with peers, receive support from educated therapists and adults, and participate in their community. This support can lower negative mental health symptoms while increasing self-esteem, safety, a sense of belonging, and significance, which is essential to becoming healthy young adults.

Minnesota does not have adequate resources for queer adolescents and does not have a dedicated therapy or community center for this underserved population. There is a rising need for specialized services and new modalities of therapy designed for the needs of queer youth. Creating an art therapy center would help queer adolescents receive the support, counseling, and community they need while learning to help others and engage their social interest.

Implementing art therapy with adolescents would allow them to process trauma and talk about their complicated feelings, build resiliency, and a foster a healthy identity. Art therapy could foster personal growth and have a positive impact on the mental health of queer adolescents. Art therapy directives guided by the ETC (Hinz, 2009) will offer adolescents a variety of ways to express themselves in a group or individual therapeutic setting.

**Implications for Practice**

Based on Adler’s theory of social interest, Dreikurs encouraged people to make useful and active contributions to society and their communities (Griffith, & Powers, 2007). Adler’s concept of community feeling and social interest would play a large role in the proposed art therapy center. Through the use of a *clubhouse model*, queer adolescents would contribute in an
age-appropriate leadership role. Adolescents would be invited to become active members of the center. Active membership would ensure connection with community and a sense of belonging through actively engaging social interest based on individual strengths. To further engagement, the center would establish a governing board with youth members who would help make decisions about the center, suggest programming concepts, and identify needs. These age-appropriate roles offer adolescents leadership within the community they are attempting to build. Being an active part of a safe and empowering community creates a sense of belonging and significance for queer adolescents, which supports a healthy transition to adulthood. Expansion of the center could include partnering with the aforementioned local and national organizations to include social services, safe housing and transportation, health and wellness, mentorship, school advocacy, career and college support, family and group art therapy, initiatives, alternative therapy modalities, education, and community events and activities.

Clarke et al. (2014) suggested it can be a common occurrence in the field of psychotherapy to have gender and sexuality issues be outside the scope of practice for clinicians. The lack of education and research creates many issues for clients, families, and clinicians, and as a result, mental health workers can unknowingly cause harm to clients. Treating queer clients as a minority is part of having a culturally competent and ethical practice (Hogan, 2003). There are societal taboos in the US about mental health, and within the mental health sector, taboos exist about non-normative gender and sexuality.

Clinicians will benefit from learning how to ethically support the vast demographics within the queer community. While sexuality and gender might not be the forefront of concern for adolescents seeking therapy, many complex factors are at play when working with a queer individual. Areas of therapeutic focus should include self-empowerment, family interactions,
coming out to self or others, and insight on personal client goals (Burns, 2013). Various specialized concerns and problems for the queer adolescent population might include, but are not limited to, infant gender reassignment surgery, adolescent gender change surgery, hormone therapy, sex with a partner, polyamory, alternate partnership and parenting styles, open dialogue about sex organs, family of origin issues, and trauma relating to gender and sexuality.

Gender and sexuality-affirming clinicians practice with the use of proper and current terms and take an interest in understanding a client’s self-identification and pronouns. Correct use of pronouns validates identity and fosters connection in the therapeutic relationship. Gender and sexual identity and preference should not be presumed, and to do so can cause harm to the client or make the clinician appear uninformed or unaccepting of the client’s identity. Clinicians must review their personal feelings and understand their limitations and biases. Additionally, it would be beneficial for mental health organizations to identify areas of hetero and gender-normativity. For example, offering intake paperwork that allows a client to use preferred gender options and an inclusive office environment with inclusivity markers (i.e., a queer affirmative symbol) can help a client feel comfortable and respected. Guidelines and community education tools are widely available for therapists to educate themselves and remain current with changes related to serving queer clients and the queer community.

**Recommendations for Future Research**

Recommendations for further research include identifying an accurate number of queer individuals in the United States through thoughtfully designed census questions that gather data about the queer community and diverse groups within the queer community, including adolescents. The resulting data could support education, grants, funding, research, initiatives, and resources for queer individuals. There is a great need for gender-related research including,
but not limited to, intersex, gender variance, gender queer, and a transgender individual’s biological history and needs. There is a lack of research knowledge related to physical health needs, trauma and mental health, and ethical practices when working with queer adolescents (Fisher & Mustanski, 2014). Such research might assist in overcoming discrimination, taboos, harmful legislation, funding issues, and current systematic and biased beliefs about queerness and queer adolescents.

As a unique modality, art therapy requires additional research related to its effectiveness, empirical evidence of its success, and its relation to trauma. Art therapy research about adolescents, and especially queer adolescents and adults, needs expansion. Additionally, Adlerian theory is lacking in both literature and treatment related to the specialized needs and experiences of queer individuals. As the concept of queerness is ever evolving and expanding to become inclusive, future research is necessary to identify mental health needs, inform mental health treatment, improve therapeutic practices and the outlook for queer adolescents.

Conclusion

Queer adolescents commonly suffer from a variety of difficult and traumatizing circumstances stemming from discrimination based on their sexual or gender orientation. Difficult circumstances often result in symptoms related to mental illness and mental health due to traumatizing events at a crucial point in the development of their identity (Clark et al., 2014). Art therapy is well poised to help queer adolescents process trauma and develop a healthy identity (Riley, 1999), and Adlerian theory supports the need to belong to a strong community for health and well-being (Ansbacher & Ansbacher, 1964). Limited local and national and resources exist to build and support a healthy community for queer youth. An art therapy center for queer adolescents would allow this underserved minority population to begin healing at a
crucial point in their development, express themselves through art therapy, and create a community of peers to foster a healthy identity, increased mental health, and a sense of wellbeing.
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