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Heteronormativity: How Dance Movement Therapy Can Change the Narrative Around the
Societal Norms and Expectations Created Around Sexuality and Gender

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Abstract

Heteronormativity, defined as the societal norms and expectations around sexuality and gender has an immense impact on individuals who do not identify with the norms set in place.

Heteronormativity is enforced from early childhood where eventually individuals who do not identify as “straight” or cisgender develop several mental health disorders due to feelings such as exclusion and invalidation. Both medical and mental health care becomes a barrier for these individuals because health care providers do not have the skills or tools necessary to treat LGBTQ individuals. The stigma created by society around the LGBTQ community has enforced a need to find ways to bridge the gap between the heterosexual cisgender community and LGBTQ individuals. The field of dance/movement therapy becomes important as one of the ways to address this gap that includes cultivating values of empathy, openness, understanding in the therapeutic space.

Keywords: heteronormativity, transgender, non-binary, gender identity, sexual identity, dance/movement therapy

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History of Sexuality and Gender

Sexuality and gender are ideas that have evolved throughout history. Homosexuality is an idea and a construct that has existed throughout history, in all types of society, among different classes and people. What separates societies from one another is the way people perceive the word homosexuality and the connotations or meaning around the word (Weeks, 1972, as cited in Jagose, 1996). This has changed over time. In the early Victorian era, specific feelings were thought of as either male or female in the same way that a penis or clitoris was specific to one sex (Katz et al., 1995). It was a binary way of thinking where anatomy equaled psychology, or sex physiology determined the sex of feelings (Katz et al., 1995). In 1862, Ulrichs coined the terms “dioning” and “urning” (Katz et al., 1995). Uurning was a term used to define a man who loved another man, and dioning referred to a man who loved another woman (Katz et al., 1995). In 1869, Kertbeny first used the terms “homosexual” and “heterosexual” (Stryker, 2008). Ulrichs and Kertbeny considered these terms to be physical and inborn, and represented early activism where being labeled as gay or transgender were simply different kinds of people equally entitled to full participation in society (Stryker, 2008). Throughout the latter half of the nineteenth century, medical professionals began to identify specific practices as “abnormal sexuality” and began putting labels to the objects of their concerns (Katz et al., 1995). Labels such as “contrary sexual feeling”, and “sexual inversion” were used which began a tradition of labeling heterosexuality as the norm. This demonstrates the influence people in power have on society, and the ease with which heteronormative values have been set. Medical professionals had and still have the power to determine who is sick or healthy, sane or insane – and thus, have the potential to transform neutral forms of human difference into unjust and oppressive social hierarchies (Stryker, 2008). It is a scary concept to process because we end up becoming the

product of our own demise. Stigmas, discrimination, and prejudice develop prominence in societies because of choices made in defining “normal”.

Throughout the first half of the twentieth century, homosexuality and gender variance were often closely associated. One common way to think about homosexuality was that a man who was attracted to men was thought to be acting like a woman, and a woman who was attracted to women was thought to be acting like a man (Stryker, 2008). Freud argued that all humans were naturally bisexual. Although Freud did not consider homosexuality to be the natural outcome of psychosexual development, he also did not believe it was a mental illness (Herek, 2010). Prior to World War II, different labels were used for individuals who identify as homosexual such as “fairies” for effeminate men, “queers” for individuals interested in same-sex sex, and “trade” for heterosexual men who accepted sexual relationships with the “fairies” or “queers” (Chauncey, 1994, as cited in Nardi, 2000, p. 3). The term “gay” emerged in the 1930’s and 1940’s as the dominant label which was applied to any man who had sexual experiences with other men, gradually replacing the category “trade” (Nardi, 2000). By the 1940’s, American psychoanalysis determined that homosexuality represented a phobic response to members of the other sex, and that humans are naturally heterosexual (Herek, 2010). Psychology played an important role in permitting people to be categorized according to their sexual and romantic attractions; however, it created a new dichotomy in which heterosexuality became the norm and homosexuality was seen as a disease (Herek, 2010). Once homosexuality was seen as a disease, gay and lesbian citizens began to experience more direct persecution. These individuals were regularly charged with offenses such as disorderly conduct, public lewdness, and solicitation (Herek, 2010). Many states passed sexual psychopath laws that put homosexuals in the same category as child molesters and rapists, and they were put in psychiatric institutions until

declared “cured” (Herek, 2010). It became difficult for gay and lesbian individuals to obtain jobs that required professional licensure, and thousands lost their jobs as government, hospital, and state workers (Herek, 2010). At its peak, the discrimination against queer individuals was intense and irrational and, again, demonstrates the power the leaders of society have on the people. One perspective to examine this is the power and authority create these normative values specifically around sexuality and anything outside of that norm was considered a disease.

Heteronormativity

There is most likely no arena in modern life where a norm does not exist, where it is a privilege to be seen as natural (Davis, 1995, as cited in Robinett, 2014). The norm is perceived as being the most common, so it is often assumed to be what is most natural (Robinett, 2014). It then becomes an inherent privilege in being perceived as normal. We are born into a world full of pre-existing ideologies that we conform to, such as learning which restrooms we are supposed to use, how to look, and how to behave. We learn what it means to be “normal” and learn what may happen for those who are not (Robinett, 2014). A spectrum slowly develops on what actions may be perceived as more normal than others (Robinett, 2014). The more “normal” an individual acts, the less they are questioned by society (Robinett, 2014). For example, an individual who is not easily identifiable as male or female may get questioned or stared at for not meeting the “normal” expectation. One of the foundational definitions of heteronormativity is the idea that there are two and only two biologically determined sexes that naturally behave differently and desire each other (Blank, 2012, as cited in Robinett, 2014). According to this perspective, there are distinct and meaningful differences between individuals identifying as male or female (Robinett, 2014). This creates a binary in regard to gender and sexual orientation (Robinett, 2014). Bodies and behaviors do not inherently contain meanings; instead, meanings have been

attached by Western society (Butler, 1993, cited in Robinett, 2014). Heteronormativity has created a language that is “straight”, meaning Western culture has learned how to see straight, read straight, and to think straight (Sumara & Davis, 1999).

Robinson (2005) argues that enforcement of heteronormativity begins from early childhood, specifically in early education. From the moment they are born, powerless and voiceless, children are at the hands of adults for their survival and wellbeing (Robinson, 2005). According to Robinson, children are born innocent and pure: asexual and immature with little to no control over their bodies, and over time, the powerlessness and voicelessness become reinforced (Robinson, 2005). Sexuality is seen as an “adult” issue and an aspect children are vulnerable to and in need of protection from (Robinson, 2005). Sexuality as an identity is not something that children have the space to explore, instead, sexuality is seen more as a physical act (Robinson, 2005). Children grow up with very little knowledge of sex and sexuality, and the taboo nature of it all results in them becoming fearful of talking about sexuality issues with adults (Robinson, 2005). The ironic nature of it all is that these children who are well looked after and protected, are the children who become a victim to this binary between the adult and child (Robinson, 2005). There is a fear present in adults when a young male child chooses to dress in women’s clothes or when educators discourage young children’s desire for same-sex relations (Robinson, 2005). For example, a young boy in early childhood may express his wishes to “marry” the person they love the most, who is most often their male best friend (Wallis & Van Every, 2000, as cited in Robinson, 2005). Adults or educators do not question certain activities played out by children such as mock weddings, mothers and fathers, or girlfriends and boyfriends (Robinson, 2005). Activities like this are not thought of as a contributor to heteronormativity or heterosexual desires, they are seeing as a natural part of growing up

(Robinson, 2005). Stereotypes around gender will influence how an individual views their sexuality. For example, boys may be seen as tough, loud, and physically active whereas girls may be seen as quiet and soft-spoken. As a result, the process of forming a gender identity happens simultaneously with developing a sexual identity (Robinson, 2005). When examining gender, it is the repetition of the performance of masculinities and femininities that constructs and reconstructs the masculine and feminine identities (Butler, 1994, as cited in Robinson, 2005). Children continuously attempt to “do it right” in front of their peers and others and it is through this practice that the feminine and masculine identities become defined and constructed (Butler, 1994, as cited in Robinson, 2005).

Queer theory seeks to interrupt and re-narrate the construction and narratives supporting heterosexuality (Sumara & Davis, 1999). By better understanding what queer theory is, there is more of a capacity to see the effects heteronormativity has on Western culture. One of the ways is understanding the meaning of the word “Queer”. In this context, “queer” is not meant as a term used to represent gay, lesbian, bisexual, and transgendered individuals; however, “queer” is a term used as a marker to refuse the heterosexual bribe – meaning the rewards given by society for a heterosexual identity (Sumara & Davis, 1999). It is calling into question conventional understandings of sexual and gender identity by deconstructing the categories and oppositions that sustain them (Hennesy, 1994, as cited in Jagose, 1996). The word’s primary motive is to break down the heteronormative motives society has created (Jagose, 1996). It suggests a whole range of sexual possibilities, and challenges the familiar distinction between normal and pathological, straight and gay, masculine and feminine (Jagose, 1996). Queer aims to change up the categories that permit sexual normativity, while avoiding the previous delusion that its motive is to invent a free, natural, and primordial sexuality (Jagose, 1996). By seeing

this, the capacity held for knowledge is broadened, not just about sexuality, but how forms of desire are inextricable from processes of perception, cognition, and interpretation (Sumara & Davis, 1999). Rather than defining queer identities based on particular bodily acts and quirky lifestyles, queer theory asks to broaden the possibilities by challenging the continued narrative supporting heterosexuality (Sumara & Davis, 1999).

Fernandez and Castro presented a study, contextualized in the framework of Queer Theory, that analyzed student's perceptions of bullying situations, and ways in which intelligible masculinity and femininities are performed through violence (Fernandez & Castro, 2018). Fernandez and Castro explained how societies have fixed practices of otherness to help maintain an illusion of a fixed, stable self that has no plasticity (Fernandez & Castro, 2018). Strict gender norms created by society achieve their normality through their opposition to more unintelligible genders (Fernandez & Castro, 2018). This was a qualitative study using 12 focus groups consisting of 93 Spanish adolescents who attended four compulsory secondary education schools in Spain (Fernandez & Castro, 2018). Focus groups were used in this study to create a safe environment in which participants could share their opinions and experiences (Fernandez & Castro, 2018). Each session started with a general question regarding better understanding the relationships between adolescent boys and girls, particularly with situations that make students feel bad (Fernandez & Castro, 2018). The results of the study demonstrated that bullying is a strongly gendered phenomenon caused by heteronormative values created by society (Fernandez & Castro, 2018). Fernandez and Castro (2018) argued that bullying involves imitating and reproducing gender norms while punishing those who do not conform to these norms. This study demonstrates that bullying is one of many practices of otherness that has caused marginalization against individuals who do not conform to gender and sexuality norms. Along with this, it goes

to show the complex nature of heteronormativity and the effect it has on a spectrum of social justice issues.

Another study done by Kostas (2022) regarding gender zones in school playgrounds in Athens, Greece, further examines the effect heteronormativity has on early childhood. The study analyzed the ways in which boys would dominate the playgrounds both spatially and symbolically, specifically through the sport football (Kostas, 2022). Playing football allowed the boys to show off their heteronormative masculinity, showing off qualities such as their football skills, fitness, aggression, and physical and emotion strength (Kostas, 2022). A hetero-masculine embodiment was created where kids attempted to show off masculine qualities; however not all boys identified with this embodiment. When they did not personify these characteristics, they would be put in a lower status in the playgrounds (Kostas, 2022). The absence of characteristics such as football skills or physical strength, and the lack of interest in “masculine” sports invoked charges of sassiness or gayness (Kostas, 2022). Kostas observed verbal homophobic bullying serving the purpose of policing masculinity and heterosexuality (Kostas, 2022). Kostas explains that sexuality and gender are important factors in understanding bullying throughout early childhood. For girls, different performances of femininity co-existed in the playgrounds. Most girls enacted what Kostas described as “girly femininity” which was constructed around heterosexuality, emotionality, and lack of physicality, all assumed characteristics of women (Kostas, 2022). There were a few girls who identified with more sporty femininity or tomboyism and refused to conform to ideals of “girly” femininity. However, these girls were not seen as outsiders compared to less masculine boys as they openly practiced heterosexual relations, forming romantic relations with boys and friend relations with girls while maintaining a feminine physique (Kostas, 2022). Overall, this study highlights the heteronormative nature of early

childhood, especially in the school setting. The playground is a setting for children to rigidly establish and police gender boundaries, forming a specific identity regarding femininity and masculinity (Kostas, 2022). This is enforced by the rise of homophobic bullying, specifically with boys who do not identify with the masculine norm.

Adolescence is a time where young men routinely practice heteronormative masculinity (Korobov, 2005). As boys practice this during adolescence, they become more aware of the antinormative aspects of masculinity, and may begin to resist obvious displays of affiliation with certain features of hegemonic masculinity (Korobov, 2005). Heteronormativity “governs” both gender and sexuality and operates through multiple dimensions of social life (Jackson, 2006 as cited in Martin, 2009). Parenting advice about gender raises parents’ fear that non-normative gender behavior is a sign of homosexuality, especially with heterosexual fathers (Martin, 2009). When children are sexually abused, fathers will use homophobia to “fix” a son’s masculinity after the abuse (McGuffey, 2005, as cited in Martin, 2009). Socialization can be understood as a process through which children make meaning from a variety of pieces of culture that they absorb (Martin, 2009). Children’s questions, actions, and reactions shape what parents say and do with children (Martin, 2009). A survey study done by Martin (2009), explored the heteronormative environment children potentially grow up in. Using open- and close-ended questions, the survey asked mothers what they say and do not say to their children regarding sexuality (Martin, 2009). In this study, 74 percent of mothers reported they have never wondered if their child may be gay or lesbian (Martin, 2009). If a mother did question specifically a boy’s sexuality, it was due to non-normative gender behavior they were observing in their child (Martin, 2009). These statistics suggest that most mothers understand their children as heterosexual, often times not even questioning or wondering if their child may identify as gay

(Martin, 2009). The culture children grow up in has a large impact in forming their heteronormative views, as love in Western culture is widely expressed in a heterosexual way (Martin, 2009). When children get introduced to romantic love, it is often in the context of heterosexuality (Martin, 2009). By assuming a child's heterosexuality, heteronormativity gets reinforced by erasing gays and lesbians from the children's social world (Martin, 2009). In this study, 62 percent of mothers said nothing to their children about gays or lesbians, not even something negative (Martin, 2009).

Older queer identifying adults have significantly higher psychological distress compared to their heterosexual counterparts (Hoy-Ellis et al., 2016). When the Diagnostic and Statistical Manual of Psychiatric Disorders first came out in 1952, it described homosexuality as a psychiatric disorder. This persisted until its removal in 1973 (Hoy-Ellis et al., 2016). Gender dysphoria – experiencing extreme discomfort with one's assigned birth gender, is still considered a psychiatric disorder today (Hoy-Ellis et al., 2016). In most recent years, the LGBTQIA+ population has seen increased recognition and inclusion, although LGBTQ older adults continue to fear, expect, and experience discrimination (Hoy-Ellis et al., 2016).

LGBTQ older adults have a rich history that must be taken account when exploring mental health needs for these individuals (Hoy-Ellis et al., 2016). A lot of them do not seek help due to a fear of being seen as “crazy” due to a result of decades of inadequate or abusive treatment (Hoy-Ellis et al., 2016). Many LGBTQ older adults deal with loneliness due to a number of factors, including the fact that they are less likely to have kids compared to their heterosexual counterpart, resulting in an increase in social isolation and loneliness (Hoy-Ellis et al., 2016).

A study done by the American Academy of Pediatrics regarding mental health issues around transfeminine and transmasculine children and adolescents shows the amount of mental health issues the gender nonconforming population faces (Becerra-Culqui et al., 2018). The study examined electronic medical records in integrated health care systems in California and Georgia (Becerra-Culqui et al., 2018). A total of 2,154 candidates three to 17 years of age were identified through the medical records, 1,333 of whom identified as transgender or gender nonconforming (Becerra-Culqui et al., 2018). Five hundred eighty-eight of the individuals identified as transfeminine and 745 identified as transmasculine (Becerra-Culqui et al., 2018). The most common diagnosis among children three to nine years of age was attention deficit disorder and anxiety disorders (Becerra-Culqui et al., 2018). Among transfeminine children, 5% had an autism spectrum diagnosis. In the adolescent group, attention deficit disorder and anxiety disorders remained common; however, depressive disorders had the highest prevalence amongst this group (Becerra-Culqui et al., 2018). Self-inflicted injuries and suicidal ideation amongst transfeminine adolescents ages 10 to 17 were 2.6% and 7.5% respectively, slightly higher than their cisgender counterpart. Amongst transmasculine adolescents ages 10 to 17, the rates for self-inflicted injuries and suicidal ideation were 8.2% and 10.4% respectively, this time significantly higher than their cisgender counterpart (Becerra-Culqui et al., 2018). The gender ratio in this cohort studied revealed that transfeminine youth may present earlier in age than transmasculine youth (Becerra-Culqui et al., 2018). This may pose a challenge when attempting to identify mental health needs in transmasculine youth (Becerra-Culqui et al., 2018). One of the most important results of this study is the high prevalence of suicidal ideations and self-infliction among gender nonconforming individuals, specifically transmasculine youth, compared to their

cisgender counterpart (Becerra-Culqui et al., 2018). This study shows the immediate support Queer identifying individuals may need, especially at a young age (Becerra-Culqui et al., 2018).

Johnson et al. (2020) examined the ways in which non-binary adolescents experience minority stress and how it influences their mental health and well-being (Johnson et al., 2020). In this study, 14 ethnically diverse non-binary adolescents between ages 16 and 20 residing in New York City and San Francisco were interviewed using Lifeline methodology and photo elicitation (Johnson et al., 2020). Lifelines are a visual depiction of an individual's life history where their experiences or events are displayed in chronological order (Gramling & Carr, 2004, as cited in Johnson et al., 2020). At the end of these lifeline interviews, individuals were asked to take photos related to prompts about psychosocial resources (Johnson et al., 2020). Participants returned a few weeks later with their photos which were then used to guide a second lifeline interview. The interviews were intentionally set up to trigger feelings of invalidation, where the interviewer refused to acknowledge the individuals gender identity (Johnson et al., 2020). This intentional invalidation is a form of minority stress, which is the predominant framework used to explain mental health disparities among sexual and gender minority populations (Johnson et al., 2020). Minority stress theory explains how these individuals experience unique minority stressors such as identity invalidation stemming from society's stigmatization of their identities (Johnson et al., 2020). The lifelong accumulation of minority stresses can lead to poor mental health outcomes; however, receiving the right amount of support may diminish the effects of minority stress on mental health (Johnson et al., 2020). A big minority stressor that has an effect on transgender/non-conforming individuals is "non-affirmation of gender identity" which is defined as a phenomenon that occurs when an individual's gender identity is not supported or recognized by others. According to Johnson et al. (2020), more frequent gender identity non-

affirmation was positively associated with higher levels of depressive and social anxiety symptoms. The results of this study show identity invalidation as the main form of minority stress non-binary individuals face (Johnson et al., 2020). Invalidation was tied to feelings of self-doubt, confusion, increased rumination, and internalized shame (Johnson et al., 2020). Participants reported consistent experiences where their identities were perceived as fake, fabricated, or a phase that they will grow out of (Johnson et al., 2020). Part of the issue non-binary individuals face is they have to conceptualize their own gender identity; they do not have specific individuals they can look up to for guidance (Johnson et al., 2020). In result, they may experience a profound sense of confusion and self-doubt during the beginning stages of their exploration and beyond (Johnson et al., 2020). On top of this, adults they look up to may dismiss their gender identity, resulting in this double burden of identity invalidation (Johnson et al., 2020). Several participants reported their identity invalidation is related to internalized stress processes such as identity concealment and self-shame (Johnson et al., 2020). The anticipation of having to disclose and educate others on their identity often resulted in concealment or allowing others to make an assumption on their identity (Johnson et al., 2020). While this may be protective, concealing one's identity can lead to intense psychological distress (Johnson et al., 2020). Another aspect that cannot be ignored is the emotional labor non-binary individuals face in the binary world, as it takes a lot of effort for non-binary individuals to be vigilant about anticipatory stressors that most likely have a negative effect on their mental health (Johnson et al., 2020). The anticipation of correcting someone when a non-binary individual gets misgendered or not having their gender accepted as a part of society can take a large emotional toll on the non-binary community.

Identity misclassification is a large part of gender nonconforming individuals negative mental health experience. When misclassification occurs, a part of an individual's personal or social identity is not verified by others (McLemore, 2015). Confirming one's self view satisfies a psychological need for coherence, providing knowledge of the self, and allowing for social interactions to occur in a smoother way (McLemore, 2015). When self-views are not acknowledged, people experience negative outcomes that include a variety of mental health issues (McLemore, 2015). Identity control theory explains that individuals simply want to be seen as members of the group they belong in (McLemore, 2015). For example, queer identifying individuals will most likely experience more positive interactions with other queer identifying individuals and when people question or misinterpret an individual's "queerness", the outcome may be deleterious. Identity control theory then becomes an issue when individuals identify as members of stigmatized groups such as the queer community (McLemore, 2015). These stigmatized groups are less able to maintain situations in which their social identity is verified by others (McLemore, 2015). In the case of transgender individuals, there is an immense stigma to be explored as this specific group challenges the gender binary which goes completely against the normative view society has created (McLemore, 2015). Misgendering is a subtle form of stigma this group faces that has the potential to make a negative impact on their mental health, as it has the potential to shape how they feel and how they view their self-worth or identity (McLemore, 2015).

Two online studies done by McLemore (2015) explore the effect misgendering can have on the transgender community. In the first study, 115 transgender spectrum individuals reported how frequently they got misgendered and how devalued these experiences made them feel (McLemore, 2015). The second study was an extension of the first study but this time

introducing measures of shame, verification, and enhancement striving, evaluation of the self as a transgender person, and evaluations of non-transgender individuals (McLemore, 2015). The second study included 134 transgender spectrum individuals, representing a new set of participants. The results of the first study showed frequency of misgendering did not associate with a negative affect; however, feeling stigmatized when getting misgendered was associated with a negative affect. Individuals who felt more stigmatized when misgendered reported feeling less favorable about their appearance and a negative association with self-esteem (McLemore, 2015). Identity importance was important for individuals with frequent misgendering experiences, but had less of a capacity with identity strength (McLemore, 2015). Frequency of misgendering was not associated with transgender felt stigma, however, feeling stigmatized when misgendered was positively associated with transgender felt stigma (McLemore, 2015). The second study showed participants who experienced frequent misgendering reported a greater striving for identity verification (e.g., wanting to be seen as a specific gender) (McLemore, 2015). Participants who felt stigmatized when misgendered reported a striving for self-enhancement (e.g., wanting to be seen in a positive way by others) (McLemore, 2015). Participants who had more frequent experiences with misgendering and felt more stigmatized when misgendered reported less positive views toward non-transgender individuals (McLemore, 2015). Feeling stigmatized when misgendered, but not being misgendered more frequently, was associated with more feelings of shame (McLemore, 2015). This study shows that more frequent experiences with misgendering increases an individual's desire for identity appraisal, whereas when feeling stigmatized when misgendered increases an individual's desire to be seen in a more favorable manner (McLemore, 2015).

When seeking mental health care, transgender individuals are at risk of encountering structural and interpersonal forms of stigma that spread throughout society (Goldberg et al., 2019). This may lead them to fear stigma and avoid seeking help altogether, further impacting the existing mental health issues among the queer population (Goldberg et al., 2019).

Transgender individuals may encounter therapists who make an effort to enforce a specific gender binary, encourage them to come out as a specific gender, or have narrow definitions of what it means to identify as transgender (Goldberg et al., 2019). On the other side of the spectrum, transgender individuals may have a positive experience with their therapists (Goldberg et al., 2019). They may be more satisfied with the therapeutic process related to personal growth and gender-related issues (Goldberg et al., 2019). Providers who are empathetic and approach the therapeutic relationship with an open mind help facilitate self-acceptance and hope for the individual (Goldberg et al., 2019). When examining transgender experiences in the health care setting, according to the 2015 U.S. Transgender Survey, one third of respondents who saw a health care provider in the past year reported at least one negative experience related to being transgender (Goldberg et al., 2019). Some of the experiences include getting harassed or having to teach providers what it means to identify as transgender (Goldberg et al., 2019). One quarter did not see a doctor when they needed one because of a fear of being mistreated due to their gender identity (Goldberg et al., 2019). These results show the immense stigma against trans individuals and the lack of training in health care setting surrounding gender identity (Goldberg et al. 2019).

A mixed method study done by (Goldberg et al., 2019) explored the mental health and health care experiences of transgender students in higher education using survey data from 506 transgender students. The first two approaches were qualitative approaches where they explored

the students understanding of their mental health and examining student's experiences with mental health care (Goldberg et al., 2019). The third approach utilized quantitative methods to decipher which personal characteristics are related to their perceptions of more affirming treatment by campus counseling and reports of misgendering from campus therapists and healthcare providers (Goldberg et al., 2019). Three hundred and eighty (75.1%) of the participants identified as non-binary and 24.9% identified as binary, showing this was a predominantly non-binary study (Goldberg et al., 2019). Only 75 out of the 506 participants reported to not be dealing with any mental health issues with the rest either reporting a mental health diagnosis or struggled with mental health concerns (Goldberg et al., 2019). The majority of the participants reported various mood disorders and anxiety disorders, with ADHD, eating disorders, personality disorders, autism, and schizoaffective among the smaller percentages of diagnosed disorders (Goldberg et al., 2019). Two-thirds of the participants, specifically those who reported anxiety, depression, and eating disorders, commented on how their difficulties stemmed from structural and interpersonal sources of stigma (Goldberg et al., 2019). This stigma includes the stress that is present by living in a highly gendered society that stigmatizes transgender people (Goldberg et al., 2019). One-fourth of the participants attributed their mental health challenges to society's response to transgender people and the fear and violence they have experienced (Goldberg et al., 2019). Some students reported getting physically or sexually assaulted based on their gender, and experienced acts to get them to "erase" their gender (Goldberg et al., 2019). An added stress for some students is not only their fear of transphobia but other discrimination or violence related to other parts of their marginalized identity such as the color of their skin (Goldberg et al., 2019). Transphobia, sexism, homophobia, classism, and racism are all interconnected and can have an amplified effect on an individual who identifies

with multiple marginalized identities (Goldberg et al., 2019). One-third of the participants identified the lack of family support as a major contributor to their mental health issues (Goldberg et al., 2019). Some students reported that their family had attempted to send them to conversion therapy or to a therapist known for “curing” transgender people or their “gender disorder” (Goldberg et al., 2019). Along with this, feelings of invalidation related to their gender identity, particularly with non-binary individuals, were felt by more than half the students (Goldberg et al., 2019). They noted and understood that their non-binary identity does not fit with societal expectations and remain in an uphill battle to fight for their identity with a fear of being told that what they are feeling is not real (Goldberg et al., 2019). When looking at experiences with health care providers, slightly over one-third of students described only negative experiences of therapy, and less than one-third shared only positive experiences (Goldberg et al., 2019). Most of the negative experiences included explicit invalidation of their gender identity, with the therapist denying their transgender experience, especially with non-binary identities (Goldberg et al., 2019). Some therapists would fail to use a student’s preferred name and pronouns and even misgender them after a multitude of sessions where they would remind the therapists of the correct language (Goldberg et al., 2019). Other therapists would center their gender identity as the root to all of their problems (Goldberg et al., 2019). Although they were being sensitive to their gender, they were making it their defining aspect of who they are and assuming a negative connotation to identifying as transgender or non-binary (Goldberg et al., 2019). These therapists treated transgender individuals as if their gender is what is causing their mental health issues when that may not even be the case at all, or it is just part of the mental health issues they are experiencing. However, not all therapists were insensitive to the participants, as some therapists were able to use their correct name and pronouns which were

praised and appreciated (Goldberg et al., 2019). Several of the binary transgender students reported how grateful they were to have therapeutic guidance throughout their gender transition (Goldberg et al., 2019). In experiences with health care providers, one-third of the participants reported challenges or concerns when receiving health care (Goldberg et al., 2019). Some encountered similar issues as with therapists where they had to educate providers with information about their gender, even when they came in for problems not related to their gender (Goldberg et al., 2019). Some health providers did not track or ask about their pronouns and even made assumptions of their gender, which was invalidating (Goldberg et al., 2019). Others voiced frustrations surrounding the absence of campus providers who were able to provide transition related medical care (Goldberg et al., 2019). This entire study highlights the experience of invalidation and invisibility transgender individuals face in both mental health care as well as health care (Goldberg et al., 2019).

A review of various published literature or studies regarding the mental health of transgender youth was completed to get more clarity in the mental health issues transgender youth experiences (Connolly et al., 2016). The study was done by searching the databases PubMed and Ovid Medline for any studies done from January 2011 to March 2016 (Connolly et al., 2016). The combined search of various gender queer terms produced 654 articles; the resulting abstracts went through a tiered elimination system, resulting in 15 articles getting chosen for the study (Connolly et al., 2016). The results show that transgender youth have an increased rate of depression, suicidality and self-harm, and eating disorders (Connolly et al., 2016). However, reports show when transgender youth have access to appropriate medical treatment, there is an increase in psychological functioning (Connolly et al., 2016).

A survey done by Rieger and Savin-Williams (2012) explored the relationship of psychological well-being with gender nonconformance and sexual orientation (Rieger & Savin-Williams, 2012). The survey consisted of 230 female and 245 male high school seniors ranging from ages 16 to 20 years old (Rieger & Savin-Williams, 2012). Same-sex sexual orientation and gender nonconformity have been linked to poorer well-being, however, results in this study show that gender nonconformity related more negatively to well-being than sexual orientation (Rieger & Savin-Williams, 2012). The study also suggests it is less about sexual orientation that is driving same-sex oriented people to report poorer well-being, and more about the gender nonconforming behaviors, feelings, activities, and interests (Rieger & Savin-Williams, 2012). Another way to look at this is that not all gay, lesbian, or bisexual individuals are gender nonconforming; however, those who are show a significant decrease in well-being (Rieger & Savin-Williams, 2012). This may be due to more experienced discrimination and societal stigma which are all components of the minority stress model (Rieger & Savin-Williams, 2012). The social environment has a lot to do with the decrease in well-being specifically related to how individuals portray their gender and less about their sexual orientation (Rieger & Savin-Williams, 2012).

Dance/Movement Therapy

According to Chaiklin (2016), dance/movement therapy is defined as the use of dance and movement as a psychotherapeutic or healing tool, rooted in the idea that the body and the mind are inseparable (Chaiklin, 2016). Its basic premise is that body movement reflects inner emotional states and that changes in movement behavior can lead to changes in the psyche, thus promoting health and growth (Chaiklin, 2016). One of the basic theories and core concepts of dance/movement therapy is this idea that the human being is a unity of body-mind and

dance/movement is its manifestation (Chaiklin, 2016). Moreover, gesture, posture and movement express the person and allow for self-knowledge and therapeutic change (Chaiklin, 2016). Last but not least, dance and movement is utilized as a way to enter into the unconscious (Chaiklin, 2016). One of dance/movement therapy's main goals is to revitalize the body, reestablishing connections that may have been blocked (Chaiklin, 2016). The dance therapist gives an individual the opportunity to facilitate the self-development of a client when the process has been interrupted (Chaiklin, 2016). Chaiklin explains this idea of the self, or the awareness of our own existence is not there from the very beginning (Chaiklin, 2016). The self is a lifelong construction resulting from the development of intersubjective experiences (Chaiklin, 2016). The core sense of the self is the foundation of other, more elaborate domains such as the awareness of our own subjectivity and others (Chaiklin, 2016).

Kinesthetic empathy is another core concept of dance/movement that has a possibility to address heteronormativity (Chaiklin, 2016). Empathy is defined as the ability of one person to understand another; an individual attempts to experience somebody else's inner life and implies knowing what the other person is feeling (Chaiklin, 2016). An example of kinesthetic empathy is empathetic mirroring. Marian Chace, an early practitioner of dance/movement therapy in the United States, let her patients know that she was available and interested in their feelings, movements, and thoughts (Chaiklin, 2016). By making the movements of the patients her own, acceptance or empathy was shown in her body (Chaiklin, 2016). Another dance/movement therapy practitioner, Mary Whitehouse, allowed her body to be moved by the experience of others by becoming a special witness to her patient's processes (Chaiklin, 2016). These ideas of mirroring and resonating are tools used by dance/movement therapists to deeply understand an individual's experience. Through movement, perception, understanding, and intervention,

dance/movement therapists understand that empathy enables vulnerability and human closeness (Chaiklin, 2016). One of the basic goals of dance/movement therapy is to expand the movement repertoire, leading to a wide variety of experiences which allow individuals to accept, respect, and understand different human feelings and ways of living in the world (Chaiklin, 2016).

Whitehouse valued understanding the endless possibilities the world has to offer (Pallaro, 2007). Whitehouse believed in a humanistic growth model where providing empathy, trust, and a safe environment were key to relationship (Pallaro, 2007). She believed in this innate capacity for an individual to change and grow and that growth comes from within (Pallaro, 2007). She expressed that an individual can connect with the unconscious through movement and that this process itself has inherent healing value (Pallaro, 2007). When an individual is aware of spontaneous movements as a reflection of themselves, that person is on the road to consciousness (Pallaro, 2007). An individual's inner connection is of the utmost importance and giving conscious awareness to the movement experience allows for deeper levels of the individual to unfold (Pallaro, 2007). The individual then gives themselves opportunity for self-discovery and this causes innate changes in everyday life and behaviors (Pallaro, 2007).

Whitehouse is seen as the founder and creator of authentic movement, a movement practice utilized as a form of therapy to allow individuals to explore the self through the body (Pallaro, 2007). Whitehouse was interested in exploring the inner experience of the mover, she utilized dance improvisation in her own work by providing images and directions as well as encouraging individuals to find their own spontaneous responses (Pallaro, 2007). There is a direct connection between what we are like and how we move, and authentic movement is utilized to make these connections (Pallaro, 2007). Whitehouse called these inner experiences movement-in-depth. It was another dance/movement therapist, her student, Janet Adler, who

formalized a set practice now called Authentic Movement. Central to this practice is the development of an inner witness or an awareness of what one is doing, even while attempting to move from the unconscious (Pallaro, 2007). Along with this, the core of the work is a belief in the wisdom of the body, that through the body we can find insight, inspiration, and healing (Pallaro, 2007). No movement is inherently unacceptable, and the practice allows for unusually broad freedom of movement possibilities, all aspects important for an increased awareness of the self and others. Authentic Movement provides a secure space to explore all that may impede others from growth and wholeness as well as serve to heal wounds, bring individuals to balance, and transform inner relationships (Pallaro, 2007). All participants are assumed equal, valuing the diverse experiences and perspectives of each individual, all while observing the self and the unconscious self (Pallaro, 2007). Understanding does not only come through self-awareness, but also through the act of nonjudgmental seeing by a witness, who may express this through the use of mirroring both verbally and nonverbally (Pallaro, 2007). There is a witness role in Authentic Movement where this individual sits and observes as the mover moves their bodies and explores their bodily experiences. The witness's role is to accept the mover without critical analysis and to speak only when the mover asks for a response; they are practicing the art of seeing (Pallaro, 2007). The witness learns how to contain their own experience and biases, allowing for more new information to enter their bodies (Pallaro, 2007).

Dance/movement therapy can be a great entry point in allowing more individuals to feel more comfortable sitting with this idea that society is more than the heteronormative ideals it has created. Caldwell and Leighton (2018) explained how somatic theories and practices can be used to interrogate body norms. One way to do that is to look inward into the body and notice bodily sensations, emotions, and images when practicing a bodily norm such as removing the hair from

a particular area of the body or taking medication for acne (Caldwell & Leighton, 2018). By questioning body norms, individuals give themselves the chance to make them less unconscious, less involuntary, and more available for possible change (Caldwell & Leighton, 2018). In this way, new information is introduced into the consciousness that was not available previously, information that may shift the understanding of bodily behaviors, preferences, and assumptions (Caldwell & Leighton, 2018). This practice is not about collecting body-centered evidence in support of predetermined change, but to enhance an individual's awareness of self and others (Caldwell & Leighton, 2018). Simply giving ourselves the opportunity to immerse in sensations without judgment is in itself a liberatory experience (Caldwell & Leighton, 2018). The way Caldwell and Leighton explains "querying the body" can be directly related to the problem society faces with heteronormativity. When an individual faces a situation where the heteronormative ideal is challenged, change may happen if they look inward into the body and notice any bodily sensations or emotions that arise. By questioning the bodily reactions, an individual may give themselves the opportunity to bring any unconscious feelings to the surface. New information is then introduced that may increase their awareness of themselves and others, which then may shift their understanding of the gender or sexual binary.

Johnson explained a class exercise they conducted with their graduate students asking them to "read" their body for indicators of their social identifications and positions (Caldwell & Leighton, 2018). The students paid attention to Johnson's posture, gait, gestures, clothes, grooming, and facial expressions and from these observations made inferences about their gender identity, social class, sexual orientation, ethnicity, age, and religion (Caldwell & Leighton, 2018). This exercise highlights the degree to which we compare observed bodily indicators with various cultural identifiers and that we pay attention to the identifiers that are

most important to us (Caldwell & Leighton, 2018). Once an individual is comfortable with the idea of body reading as ubiquitous and spontaneous, the next step is understanding that these readings have judgments attached and we assess people's social worth based on the degree to which their bodies meet the norms society or we have internalized (Caldwell & Leighton, 2018). Rather than taking a visceral reaction to someone's body as an invitation to reject them from society, we can use it as an invitation to explore our own cultural and historical relationship with the norm that body seems to transgress (Caldwell & Leighton, 2018). Noticing our own judgments in the way Johnson has explained can all be related to heteronormativity. In fact, body norms and the oppression of the body are all related to heteronormativity as the body norms that are created come from this heteronormative view on society. The heterosexual assumption and gender binary that exists makes an impact on the body choices an individual makes. Moreover, one of the main aspects of dance/movement therapy, according to Whitehouse (Pallaro, 2010) is looking inward as a means to self-discover, and one of the ways Johnson explains breaking down this heteronormative norm is by looking inward to question and further explore where our judgments come from (Pallaro, 2010).

Societal body norms are another factor to examine when looking at the impact heteronormative culture has on Western society. Caldwell and Leighton (2018) state, "One way to enact oppression against members of a particular social group is to characterize them as bodily objects rather than intelligent and sentient subjects, and to simultaneously depict those bodies as uncivilized, crude, ugly, or distasteful" (Caldwell & Leighton, 2018 p. 97). Caldwell and Leighton are expressing this human desire or tendency to undermine particular social groups who do not fit in with the norm. Almost no one is exempt from the countless expectations to present our bodies in a particular way, especially those whose bodies fall outside the dominant

norm or whose social position does not allow them the privilege of refusing to conform (Caldwell & Leighton, 2018). The body choices we make are our own choices we choose to make, however, it is impossible to ignore the external messages about body images we absorb from the media, our family members, peer groups, and social institutions (Caldwell & Leighton, 2018). Internalized racism, homophobia, and misogyny shape our bodily desires in ways that are hard to distinguish from our own preferences (Caldwell & Leighton, 2018). What is important to note is body norms are not inherently harmful. Norms establish an organized set of expectations about our roles as members of particular social groups that can enhance feelings of group membership, support group cohesion, and signal behaviors that might threaten the stability of the group (Caldwell & Leighton, 2018). However, they become harmful when we begin to prohibit benign differences, stifle individual creative expression, and induce shame, resentment, and inequality amongst various social groups (Caldwell & Leighton, 2018).

Discussion

Cultivating empathy, openness, and understanding in the therapeutic space are major components in creating a safe environment where individuals are not at risk for judgement and bullying. If all possible, I would like for the LGBTQIA+ community to coexist in the same therapeutic space as the cisgender heterosexual community, an intersection of social groups. This way there is a chance for an intersection of social groups to be fostered in a safe space. Individuals will have the chance to express themselves in the most authentic way possible with little to no judgment, and if there is judgment it is addressed in the space. Difficult conversations are where the most growth occurs and there is no better space than a dance/movement therapy space where both movement and verbal processing can be used as a way to express who we are. Movement can be vulnerable as well as empowering, and to be seen while moving adds an extra

layer that gives others the chance to see an individual for who they really are. It is difficult for an individual to mask themselves through movement, and a witness can most likely notice when the authenticity is not quite there. By allowing ourselves to move from a place that feels real and raw, we give ourselves the opportunity to experience vulnerability in our own bodies as well as from being witnessed by others. This process not only promotes self-growth but empathy as well. When there is more capacity for empathy, individuals have more space in their bodies to let the uncomfortable ideas and emotions in. Difficult conversations may not feel so difficult anymore and ideas that made an individual feel uncomfortable before, may now have a little more space to lie in their bodies. By allowing for different social groups to intersect in a dance movement therapy space, there is a major opportunity to foster empathy where individuals feel accepted enough to express (as much as possible) their authentic self.

A specific dance/movement intervention within this intersection of social groups is the practice of mirroring in a circle. In this intervention, the group members and the therapist will form a circle and within this circle a dance will be created by the group. The therapist will prompt the group members to show a specific movement that embodies their sexual or gender identity. Each group member will have a chance to express their movement to the group. As each group member expresses their sexual or gender embodiment, the rest of the group will mirror what the group member expresses. A dance will slowly form as each group member will add on to the movement created by the previous member, again mirroring each member as they express their movement. There are multiple therapeutic goals happening in this intervention such as an increased capacity for empathy, vulnerability, connection, and community. As explained, mirroring is a great way to develop kinesthetic empathy, not only between the therapist and client but between other clients as well. By mirroring each other's movement choices, the group

member is not only getting seen and witnessed by others, but the other group members are allowing another member's movement expression to sit in their bodies where there is an opportunity for an increase in empathy as group members are sharing from a personal place. Vulnerability is another therapeutic value cultivating in the group as there is inherent vulnerability in forming a circle. In a circle, each and every individual is getting seen with little to opportunity to hide from the group. Connection and community is also forming in the group as the group is making meaningful connections through the body by mirroring each other and seeing each other for who they are. Community is formed by the creation of the circle as well as dancing and moving with each other to music. With mirroring comes synchrony and to move together to music creates a supportive community where meaningful connections are able to form.

Another dance/movement intervention that addresses heteronormativity in this intersection of social groups, is utilizing rhythm in a circle. In this intervention, the therapist will bring in various instruments and have group members create rhythms together where eventually a music score will be created. As an entry point into the experience one group member will start with whatever rhythm comes naturally to their body, and then slowly one by one, each group member will add a rhythm until a music score is created. Once a flow is created, group members have the option to explore the music score as there is no limit to what they can or cannot do. Group members can change up their own rhythm or even mirror or find a contrast in another member's rhythm. This experience will be done in circle where group members will have the opportunity to witness each other and make meaningful connections through the use of rhythm. Rhythm allows for group members to find themselves in a profound synchrony where everyone is united in the joy of sharing, in the enthusiasm for repetition allowing the flow of energy to

increase (Schott-Billmann, 2015). Sharing rhythm enables a commonality amongst individuals by taking pleasure together in feeling of being alive (Schott-Billmann, 2015). In this intervention group members are cultivating connections through forming community and with that comes an increased capacity for empathy and understanding. Each group member puts their own self into the space that allows for more comfortability amongst each member to express who they are as authentically as possible.

One specific way to hold space in this intersection of social groups is through authentic movement. As explained, in authentic movement there are movers and witnesses. The witnesses sit at the outer edges of the room while the movers are moving in the center. The dance movement therapist is the person to keep track of the amount of time a mover moves and to hold the entirety of the space. In this specific space it is important for there to be a mix of LGBTQUIA+ individuals and cisgender heterosexual individuals as both movers and witnesses. The movers do the best they can in the moment to move their bodies in whatever way feels real to them. There is no limit to what they can or cannot do in the space, while the witnesses will observe the movers with as much empathy and open mindedness as possible. The entire space is a vulnerable and sensitive one as both movers and witnesses are exploring from a deep place in their bodies that may have been suppressed for a long time. The goal for the mover is to move from a place that feels as authentic to them as possible and through that, possible unconscious thoughts and emotions may arise. The mover also has a chance to express who they are in front of other people, an opportunity for them to be seen for who they are. The goal of the witness is to observe the mover with as much empathy as possible. The witness is doing their best not to not judge the mover, and, if they do, then noticing in their bodies where that discomfort is coming from and doing their best to move past it or simply allow it to lay in their bodies. By doing this

they are increasing their capacity for empathy by acknowledging the uncomfortableness and making a choice to not let it consume their bodies in a way that masks their perception of reality. The mover and witness get to experience both roles and, at the end, everyone gets together in a circle to comment on what they observed as both a mover and a witness. The end is a conversation where there is a shift to a more verbal aspect of dance/movement therapy as both nonverbal and verbal communication is an important part of the practice.

This practice of intersecting social groups is a process and a practice that takes time to cultivate. There needs to be a trust that builds not only between each individual but with the therapist as well which makes this practice a difficult one to aspire for. To consistently hold space for a group of diverse individuals where trust can form takes a lot of time and effort from each individual. Commitment is required from each person to show up as fully as possible each and every session, which is not always attainable. Every person goes through their own trials and tribulations and that very well may come up during these sessions. It is the job of the dance/movement therapist to continue to cultivate empathy, openness, and understanding in the space regardless of what may come up, as well as showing up as fully as possible for each individual.

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