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Perspectives on Queer Music Therapy: A Qualitative Analysis of Music Therapists' Reactions to Radically Inclusive Practice

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Background: *The queer music therapy model was designed by Bain, Grzanka, and Crowe in 2016 as a novel therapeutic approach to affirm and empower LGBTQ+ identity through music. No data have been generated on how this model might actually be implemented, or the strengths and limitations of the model according to music therapy professionals.*
Objective: *The purpose of this study was to build on Bain and colleagues' work by collecting music therapists' perspectives on queer music therapy and using these data to critically evaluate the model.*
Methods: *Semi-structured qualitative interviews were conducted with twelve music therapists who identify as LGBTQ+ or have experience working with LGBTQ+ clients. Participants were prompted to discuss their music therapy backgrounds, experiences with LGBTQ+ clients, and reactions to the queer music therapy model. Interviews were analyzed using a critical discourse analysis approach.*
Results: *The qualitative findings revealed major strengths of the queer music therapy model and ways in which it could be improved by attending to: (a) the structural limitations of the music therapy discipline, including the demographic composition of the field and lack of critical*

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perspectives in music therapy training; and (b) intersectional considerations of ageism and ableism within diverse LGBTQ+ populations.
Conclusions: *Queer music therapy has positive implications for future work with LGBTQ+ individuals, but it must more substantively integrate intersectionality theory to serve a diverse range of LGBTQ+ clients. Further, it must critically attend to the structural limitations of the music therapy discipline itself.*

Keywords: *LGBTQ+; queer music therapy; intersectionality; critical discourse analysis; mental health*

Introduction

In 2016, Bain, Grzanka, and Crowe proposed a novel model of music therapy specifically designed to affirm and empower LGBTQ+ identity. Since its publication, Bain and colleagues' model, known formally as queer music therapy, has generated much positive attention in the music therapy community for its future implications; however, no data have been generated on how this model might actually be implemented, or the strengths and limitations of the model according to the professionals who might attempt to implement it. The purpose of the present study was to build on Bain and colleagues' work by collecting music therapists' perspectives on queer music therapy and using these data to critically evaluate the model. In order to gain uniquely qualified music therapy perspectives for this study, we chose to interview LGBTQ+-identified and -allied music therapists who have experience working with LGBTQ+ clients. Specifically, the present study involved conducting semi-structured, in-depth interviews with music therapists in order to identify the model's perceived strengths and weaknesses and potential areas for improvement.

Background & Relevant Literature

Central to the exigency of the queer music therapy model is the lack of music therapy literature on LGBTQ+ individuals, much less substantive engagement with critical theories (e.g., Critical Race Theory, intersectionality) that might challenge music therapists' basic conceptualizations of therapeutic work with this diverse

population (Whitehead-Pleaux et al., 2013; Hardy & Whitehead-Pleaux, 2017). The queer music therapy model is the first to assert that truly inclusive and affirming music therapy practice with LGBTQ+ individuals is more complex than simply inviting them into an existing therapeutic framework with a cissexist and heterosexist history (Bain et al., 2016; Grzanka & Miles, 2016). Queer music therapy rejects this kind of superficial effort toward inclusivity and instead calls for an approach that challenges the concepts of normal and fixed identity by wholly affirming the diversity and fluidity of sexual orientation and gender identity (Bain et al., 2016). The idea of challenging the concepts of normal and fixed identity and emphasizing fluidity is a fundamental principle of queer theory, which was used to inform the model's design. In the context of both Bain et al.'s work and the present study, the term "queer" should be taken to mean "(a) individuals who identify as any non-conforming sexual or gender identity (including lesbian, gay, bisexual, transgender, transsexual, asexual, pansexual, etc.), or (b) individuals, and theoretical perspectives, that reject heteronormative sexual and gender politics" (p. 22).

The queer music therapy model was designed as a community-based music therapy approach for LGBTQ+ adolescents in the formative stages of their identity development. Bain and colleagues (2016) lay the foundation for their model by reviewing relevant literature that stresses the societal and cultural roots of LGBTQ+ issues, citing the ways in which heterosexism and cisgenderism create an environment that threatens the physical and mental health of LGBTQ+ youth (Cover, 2012b; Waidzunas, 2012) and interferes with positive identity development without adequate resources for coping and support (Fassinger & Arseneau, 2007). Despite the oppressive challenges facing LGBTQ+ youth and their at-risk status as a population, Bain et al. (2016) utilize queer theory to inform a therapeutic approach that gives LGBTQ+ youth the opportunity to "develop empowered queer identity through music instead of focusing on their implied vulnerability" (p. 23). They cite evidence to support music's powerful influence on adolescent identity development (Hodges & Sebald, 2011) and ability to connect individuals with stigmatized identity (Bennett, 2000), suggesting music therapy as a unique and advantageous medium through which to empower queer identity.

Further, the work of Grzanka and Miles (2016) interrogates the degree to which diversity, LGBTQ+ identities, and intersectionality are often involved in contemporary psychotherapy discourse, but may not reflect critical attention to how systems of inequality—and not just intersecting identities—affect the lives of all clients (see also Moradi, 2017). Grzanka and Miles underscore how simply incorporating LGBTQ+ people into counseling paradigms is not the same as reconsidering the heterosexism and cisgenderism immanent to dominant approaches to counseling and psychotherapy (see also Ansara & Hegarty, 2012). Queer music therapy possesses the potential to address some of their concerns and facilitate a kind of fundamental reconsideration of how we create what Bain et al. (2016) call "radically inclusive" therapy.

According to Bain et al. (2016), the major aims of radically inclusive queer music therapy are to "(1) offer a safe space for clients to musically express their LGBTQ identities openly, (2) embrace differences, rather than emphasize sameness, (3) acknowledge systemic oppression, rather than minimize or disregard the reality of LGBTQ marginalization, and (4) celebrate their individuality and group identities" (p. 29). Bain and colleagues lay out specific music therapy interventions to accomplish these aims, which include: musical autobiography assessment, gender-bending song parody and performance, music and creative arts, critical lyric analysis, and group anthem writing. Similar to the way that this research conceptualizes the term "queer" as reclaimed language that rejects heteronormative sexual and gender politics, we intentionally utilize the term "intervention" to signal queer music therapy's aim to intervene in the systems of heterosexism and cisgenderism. The queer music therapy interventions in no way function to come between a hypothetical client and their imagined pathology; instead, these interventions foreground and interrupt dominant narratives that position LGBTQ+ identity with "sickness" or "deviation" from an oppressive norm (Grzanka and Miles, 2016; Waidzunas, 2015). Because the queer music therapy interventions will be referenced throughout the present study, please find a brief description of each intervention below:

> *Musical autobiography assessment:* A variation on song (music) communication (Bruscia, 2014) in which clients are asked to create a musical autobiography of songs that

represent their past, present, and expected future, with consideration of their sexual orientation and gender identity. Clients bring their musical autobiographies back to the group to listen and reflect on how one of their chosen songs connects to their experiences of oppression and stigmatized identity.

Gender-bending song parody and performance: A form of song transformation (Bruscia, 2014) in which clients parody a song by rewriting the lyrics to reflect themes in their therapeutic process. Clients may choose to change the gender pronouns in the original lyrics to accurately represent and perform their sexual orientation or gender identity.

Music and creative arts: This is a variation on projective drawing to music (Bruscia, 2014). Clients receive three sheets of cardstock that represent their past, present, and expected future. While a music therapist plays music to guide the activity, clients are prompted to create visual art that reflects their past, present, and future in relation to their queer identity.

Critical lyric analysis: A music therapist facilitates a group dialogue in which clients critically analyze song lyrics related to LGBTQ+ issues. This intervention is similar to Bruscia's song (lyric) discussion (2014), but is more structured in its aim to facilitate dialogue and critique on the representation of LGBTQ+ identity in various cultural arenas (i.e., media outlets, pop culture, politics, etc.).

Group anthem writing: Clients are prompted to engage in group composition and write a group anthem that can be performed before the start of each session. The group anthem should acknowledge diversity within the group, while also stressing inclusivity and group empowerment. This intervention is closely aligned with Bruscia's (2014) emphasis on "re-creative experiences that help clients to 'live through' and own their own feelings, while also sharing and identifying with the experiences and feelings of others" (p. 134).

Given that our anecdotal evidence gathered at conferences, on social media, and through our professional network suggests that there is enthusiasm for the proposed model, the present study

represents an attempt to systematically gather information from practicing music therapists on the strengths and weaknesses of the model. Accordingly, the research questions driving our project were as follows:

> *RQ1.* To what extent do music therapists think this model represents a potentially effective way to work with LGBTQ+ clients? How does queer music therapy complement, extend, and/or challenge existing approaches?
> *RQ2.* Have any music therapists implemented any elements of the model in their practice, and if so, what were their experiences with the model?
> *RQ3.* What are the perceived strengths and weaknesses of the model? Specifically, are there elements of the model that may inhibit implementation, and how might these elements be modified to make queer music therapy more accessible and practical?

Method

For the execution of this study, we used in-depth, semi-structured qualitative interviews with board-certified music therapists and music therapists in training to explore their perspectives on Bain et al.'s (2016) proposed model. We recruited participants through a Facebook network of LGBTQ+ and allied music therapists after receiving permission to post information about our study from one of the group's administrators. In total, eleven board-certified music therapists, as well as one music therapist in training, agreed to participate in the study, which was approved by the Institutional Review Board of the University of Tennessee–Knoxville. To protect the confidentiality of our participants and the clients that they serve, we use pseudonyms when reporting findings from our analysis.

In advance of scheduled interviews, respondents received electronic copies of the Bain et al. manuscript, informed consent form, and interview questions. The first author conducted all interviews with respondents via Skype and FaceTime and met regularly with the second author to discuss the interviews and emergent issues in the qualitative data. After the interview process was complete, a third party transcribed and de-identified all of the completed interviews for subsequent analysis.

During the analysis phase, the third author, who was working with de-identified interview data to reduce potential bias, realized they would be able to identify several of our respondents. The third author then consulted with the second author, an established psychotherapy researcher, on potential issues of bias and concluded that their previous relationships with some participants would not inhibit their ability to participate in analysis of interview transcripts and to audit the first two authors' conclusions.

After the completion of the interview process, we employed a critical discourse analysis approach to data analysis, which foregrounded power dynamics and sites of silence in the data (Clarke, 2005). Our research questions guided this interpretive approach, which emphasized complexity and contradiction rather than consensus, as opposed to the orientation of Consensual Qualitative Research (Hill, 2012). We drew upon the second author's extensive qualitative research experience using team-based critical discourse analysis and engaged in an interactive process of analysis and dialogue to generate the structure of our argument, which we explain below. Finally, three outside faculty with no prior knowledge of the queer music therapy model served in an auditing capacity of a near-final version of this manuscript.

Results

Strengths of the Queer Music Therapy Model

Participants reflected that Bain and colleagues' queer music therapy model is innovative in the way that it employs the principles of queer theory to inform praxis. Queer music therapy reconstructs our understanding of LGBTQ+ identity by challenging the concepts of heteronormativity and fixed identity and acknowledging the systems of power that oppress sexual and gender minorities (Bain et al., 2016). Study participant Jamie identifies the principle of identity fluidity in queer theory as a major strength of the queer music therapy model when she states:

> Queer theory should absolutely be incorporated into music therapy, and in understanding people, because we're not all born into one of two boxes. There are spectrums of how we can exist and identify...If we're going to be working with people as they are forming their identities, and we're not

> there to support them fully, we're actually counteracting [identity development] and creating environments where they don't feel safe to engage in music therapy.

Queer theory also requires us to address societal power imbalances and oppression based on LGBTQ+ identity, as these systemic injustices are inextricably linked to the personal struggles of gender and sexual minorities (Baines, 2013). Several study participants commented on queer music therapy's crucial engagement with larger systems that create social inequity and minority stress for LGBTQ+ individuals:

> Jamie: "If we work to create changes in our clients, but we don't work to change the communities and systems around them—all the way up to the top of our government—we're doing a huge disservice."
> Alex: "I've done a lot outside of my role as a music therapist, in my role as just a member of the community. I've done a lot of facilitating support groups and interacting with LGBT-identified youth in community settings. I feel like that has strengthened my ability to interact and to understand the needs of the community."

As Alex and Jamie's comments reflect, music therapists ultimately do a disservice to the LGBTQ+ population when they ignore or disengage with systemic issues facing the community outside a therapy session (see also Grzanka & Miles, 2016; Moradi, 2017). Understanding social stigma, oppression, and minority stress helps music therapists understand LGBTQ+ clients, their needs, and the personal struggles they bring into therapy more fully.

As Bain et al. (2016) also posited, queer theory critically examines the way the medicalizing and pathologizing of LGBTQ+ identities produces a systemic power imbalance between therapists and their clients. With a historical awareness of the designation of homosexuality as non-normative and its former classification as a mental disorder, Foucault (1978) warns against the establishment of a therapeutic relationship in which the therapist acts as an "observer" and the LGBTQ+ client acts as the "observed." Alternatively, Grzanka and Miles (2016) described this as the pathologizing logic of earlier approaches to psychotherapy with sexual and gender minorities, which was organized around concepts such as sickness,

deviance, and repair (see also Waidzunas, 2015). This kind of pathologizing dynamic between clients and therapists threatens to perpetuate oppressive messages about LGBTQ+ identity within the therapeutic relationship. Queer music therapy emphatically rejects the medical, pathologizing model of LGBTQ+ issues and places a focus on identity affirmation and empowerment. Study participant Allison speaks to the importance of resisting medicalization in her music therapy practice:

> The medicalization of queer identity can be dangerous. Especially if you go in as a therapist and your typical model is that the locus of the problem is within the client and the locus of the solution is within you. I'm really resistant to that in any of my practice...I always start my sessions by saying, "I'm a music therapist. The therapist in my job title is not what therapist usually means. I'm not here to fix you. I don't think anything's wrong with you. Music therapist just means we're using music as a way to experience community and be expressive together."

Another strength of the queer music therapy model identified by participants is its design for use in a group setting. Several music therapists who have previous experience working with groups focused on LGBTQ+ identity offered their insights on working with this heterogeneous population. Each of their perspectives highlight the power of the group setting in creating a positive atmosphere for identity empowerment, including its potential to counteract negative social messages that clients receive about their identity outside the group.

> Reed: "We have a client in our community group who is a transgender man. In group, we use he/him pronouns…and he openly talks about his girlfriend. He openly feels like that's his space to talk about it, and I don't think he gets that outside of the group."
> Henry: "At the end of my LGBTQ+ group, I noticed changes in people's openness, what they were comfortable sharing about themselves, and also the way that they would so kindly treat one another with such respect. We were sitting around a table in one group, and a client said he felt like we were sitting down for a family dinner."

Additionally, as one of the first music therapists to our knowledge that has implemented queer music therapy interventions in her practice, Allison spoke to her experience of implementing the critical lyric analysis intervention in her LGBTQ+ student group. When discussing her group's response to this intervention, Allison reflected that through lyric analysis, her clients opened conversations about their own coming-out processes, bisexual erasure (i.e., the systematic and everyday ways in which bisexual identities are ignored or invalidated; Nelson & Hawley, 2009), and anti-LGBTQ+ political ideologies. Ultimately, their discussion of personal experiences helped deepen the conversation about cultural misconceptions, stigma, and struggles facing LGBTQ+ individuals.

A final strength of the queer music therapy model that participants describe is its focus on common cause versus commonality. LGBTQ+ clients may share the common cause of identity empowerment and resisting harmful sources of LGBTQ+ oppression, but Bain et al. (2016) note that it is critical to keep in mind that they are "just as heterogeneous a group as cisgender heterosexual individuals" (Bain et al., 2016, p. 27). For example, Henry spoke about the importance of acknowledging and affirming difference within the LGBTQ+ population when he stated:

> When working in groups, you have to emphasize that we all have differences, but our common denominator is that we are here to support one another, to respect one another, and to connect through music together.

In addition, Allison offered an important perspective on acknowledging individual differences between queer people in her work with an indigenous population when she stated: "There's a lot of inherent harm [in a therapeutic relationship] when I, as a white queer person, try to talk to a member of an indigenous community who might have a two-spirit identity, and act like we are having the same experience." This reflection points to the concept of intersectionality, which is an integral piece of the common cause versus commonality emphasis in queer music therapy. Although the queer music therapy model asserts the need to acknowledge and affirm differences within the LGBTQ+ population, it misses a crucial critique of the structural limitations of the music therapy discipline and considerations of ageism and ableism, which we elaborate below.

Structural Limitations of the Music Therapy Discipline

Over the past 25 years, psychological and sociological research has emphasized the importance of understanding individuals through an intersectional lens—that is, a lens that acknowledges an individual's interconnected social and cultural categorizations of race, ethnicity, class, sexual orientation, gender identity, ability, and age that contribute to lived experiences of privilege and oppression (Cho, Crenshaw, & McCall, 2013; Cole, 2009; Grzanka, 2014). In the context of a therapeutic relationship, we utilize this framework to assess a client holistically, without making assumptions, stereotyping, or flattening their experiences or identity. An intersectional framework also calls us to attend to the social context and larger systems that may contribute to a client's experience of oppression and minority stress (Grzanka & Miles, 2016; Chun, Lipsitz, & Shin, 2013; Meyer, 2003; Moradi & Grzanka, 2017). Furthermore, we become aware of the distinct cultural backgrounds that both therapist and client bring into a therapy session, and we become sensitive to how these cultures will interact and impact the relationship. If we are not careful to attend to these multicultural dimensions, we run the risk of "unintentional cultural disregard or disrespect," which can ultimately damage the therapeutic relationship (Lee & Park, 2013; Hadley & Norris, 2016). In prompting study participants about intersectionality and the inclusion of multicultural issues in their music therapy training, data on the structural limitations of the music therapy discipline itself emerged from their responses. These structural limitations are evident in the demographic makeup of the music therapy field and in the inadequacy of multicultural education in the degree programs themselves.

When prompted to consider the ways in which music therapy can holistically address the intersectional identities of clients, several study participants made emphatic statements about the barriers facing a more intersectional approach to music therapy:

> Dana: "Music therapy can absolutely address intersectionality, but the barriers to doing so are ourselves and our deficits in training. We need to become aware of intersectionality and work out the ways to acknowledge it professionally through our training programs."

Although there has been a trend toward attending to multicultural issues within music therapy over the past 50 years (Hadley & Norris, 2016), Dana's response calls attention to a glaring structural limitation that restricts conversations of intersectionality in music therapy to superficial discussions about diversity and inclusion (Ahmed, 2012; Grzanka & Miles, 2016). Furthermore, participant Allison insisted in her comments that until the music therapy field is representative of the diverse clientele it serves, intersectionality can only be explored academically. On the whole, the music therapy field consists of individuals that hold positions of significant privilege; it is primarily dominated by music therapists who are women, white, cisgender, heterosexual, temporarily able-bodied, Christian, middle class, and university educated (Hadley, 2013). In accounting for this homogeneity of professionals in the field, study participant Jamie pointed to critical structural barriers in music therapy training programs required for professional certification:

> [Our field] is a mess because we do not reflect our clients in any way. It's partly because you have to go through college and have some money to do that, but it's also because we follow Western rules around music education. Almost every program is based in classical music, and that's mainly a European American, White tradition…Luckily, there are programs like Berklee that are very diverse in the music that they teach, but we don't have nearly enough. We're not drawing from people that could bring diversity to our field.

In addition to the clear monetary barrier music therapy training poses for those aspiring to the career, the above reflection underscores Hadley and Norris's (2016) argument, which asserted that the academic privileging of Western classical music as the "pinnacle of musical attainment" has alienated music therapists who could make great contributions to the field. Several of our participants confirm that conservatory-based music programs tend to isolate and erase students who might have strong backgrounds in music traditions not based in Western classical music—for instance, students with backgrounds in rap, electronic, or indigenous music. Furthermore, any additional training music therapy students may receive apart from their classical training is likely to be music that

is "centered on palatable Western contemporary music styles" (Hadley & Norris, 2016). Study participant Reed's description of his music therapy training illustrates this implicit cultural bias:

> I felt I brought a lot of diversity in my musical tastes...In my music classes when we had to bring in music to share, I always had something that people either didn't know or something that was more on the urban side. I was very much not a Beatles person. I was not a Bob Dylan person, but that's the music we were given to learn, because that's the music that the clients we worked with in that area liked. I felt that my program lacked in this respect.

Reed's reflection not only emphasizes a cultural music bias, but also speaks to the way that this bias restricts opportunities for multicultural knowledge to be spread organically through the interactions of a diverse student population with unique musical and cultural traditions. In reflecting on music and intersectional identity, Allison poignantly stated that:

> I think the benefit of music is that it isn't easily categorized, like we aren't easily categorized. We can create music that has layers and that reflects our different identities…We can look at existing songs and talk about how the identity of the artist comes through, or how the identity of the client comes through in their response to the music.

This reflection illuminates the power of sharing identity through musical preferences and traditions. If formal music training programs fail to attract and admit diverse cohorts of students with multicultural identities and musical backgrounds, they create a foundational barrier to diversifying the music therapy profession.

Notably, the majority of our study participants shared Reed's sentiment that their music therapy programs lacked a substantial multicultural component. Out of 12 total study participants, only one participant felt that she received adequate and comprehensive multicultural competency training in her degree program—training that went beyond merely studying the music of other cultures and actually included coursework on power, privilege, oppression, and intersectionality. The rest of our participants, on the other hand, reported that they received or are receiving no formal education

in LGBTQ+ issues or cultural humility (e.g., Hook, Davis, Owen, & DeBlaere, 2017). Several of the participants attributed the lack of multicultural training to the fact that there is so little time in the undergraduate music therapy program to cover all of the necessary coursework, and they stated that multicultural-focused training is more available at the graduate level; however, because a graduate degree is not required for board certification and is not accessible to every music therapist, our qualitative findings suggest that any person eligible to work as a music therapist should be receiving training in cultural humility before entering the field:

> Jamie: "I'm involved [with music therapy education], and I see that there is a lot to teach, and it's hard to get all of that in within the short time you have…But we can't let this go by the wayside...The message it gives me as a member of a couple minorities is that I don't matter."
> Sara: "Before we get into goals and objectives, we have to talk about the person that is sitting in front of you... What are your experiences of that person, and how can you immediately challenge all of the assumptions and experiences that you've just thin sliced onto [a client]?... [Multicultural training in music therapy] not only needs to be its own course, but it needs to be woven into every single course that's taken."

As Sara indicates above, multicultural training is much larger than the inclusion of a single course on the music of other cultures. The work necessary for a therapist to strive toward cultural humility is a continual process of self-examination, respectful curiosity about identities and cultures that differ from one's own, and a commitment to address the ways that our differences impact our positions in the world.

Attending to ageism

The music therapy interventions that Bain et al. (2016) propose are primarily geared toward LGBTQ+ youth with the goal of fostering empowered queer identity development. One consideration that Bain and colleagues do not specifically address in their work is how radically inclusive queer music therapy might apply in populations of elderly LGBTQ+ individuals. According to the American

Psychological Association (Keita, 2014), age is a critical aspect of identity that is often neglected in conversations of multicultural competencies; in failing to attend to this critical aspect of diversity, researchers and clinicians run the risk of perpetuating ageism and preventing the elderly from receiving care that meets their specific needs. Although the qualitative data gathered from our interviews posits that the elderly LGBTQ+ population can benefit from aspects of the queer music therapy model, it also calls us to attend to differences in their population needs, stage of identity development, and the tone that queer music therapy takes with elderly clients.

Study participants Tovah and Parker offered their perspectives and important reflections about working with elderly populations of queer individuals in nursing home and palliative care settings. In their responses to Bain et al.'s (2016) queer music therapy, both Tovah and Parker spoke to the elderly LGBTQ+ population's need for safety, LGBTQ+-affirming care, and music therapists who understand them in the context of their generation and acknowledge their involvement in the progression of queer history. With regard to safe spaces and LGBTQ+-affirming care, Tovah stated:

> I'm working primarily with older adults. It's not about identity development for them, so much as managing LGBT stigma within nursing home situations…They are all of the sudden having to receive care from outside agencies that are not always friendly to who they are.

From the above remark, we understand that managing LGBTQ+ stigma is a more salient issue for elderly LGBTQ+ individuals in nursing homes than a focus on forming empowered queer identity. This is not to say that LGBTQ+ youth do not need support in managing stigma or that identity empowerment is entirely irrelevant for elderly populations; what is important to highlight here is that elderly LGBTQ+ populations within nursing home settings are completely vulnerable and dependent upon their care providers. If a care provider has not been properly educated on LGBTQ+ issues and interacts with a resident in insensitive or discriminatory ways, the resident does not have the same agency that a young person may have in defending themselves or disengaging with the care provider. As Tovah expressed, "They really don't feel

safe. They've lost their vitality...They've lost their ability to just leave the situation, flip somebody off, and walk out the door…They're completely vulnerable."

Furthermore, Tovah emphasized that music therapists can play a vital role in helping elderly LGBTQ+ clients feel understood, seen, and respected for their place in queer history, the struggles they faced, and the groundwork they laid for current and future generations of queer people to build upon:

> What they feel mostly is misunderstood, I think, and either forgotten or looked down upon because they're not as out there or radical...I think they all need their therapists to understand that they grew up in a very different era, and that their experiences as LGBT people led them to make very different decisions...They want to know that their history is appreciated.

From this important finding, we gain perspective for adjusting queer music therapy interventions to meet this particular client need. For example, music therapists might utilize era-specific music for critical lyric analysis related to the struggles facing earlier generations of LGBTQ+ people. Another adjustment might be to shift the focus of musical autobiography assessment toward life reflection and paying tribute to the contributions, both small and large, that elderly LGBTQ+ individuals made toward moving queer history forward.

A second important difference to consider within elderly queer populations is the status of identity development near the end of life versus the formative years of adolescence. Notably, a focus on youth and emerging adulthood is undoubtedly a bias of much of the academic research on LGBTQ+ mental health (Cover, 2012a; Grzanka & Mann, 2014; Waidzunas, 2012). From Parker's perspective, working as a music therapist in palliative care, his interview responses offer important insights regarding elderly LGBTQ+ identity near the end of life:

> ...in regards to the diversification with my elderly people, [therapy] is about their memory, their past exploration, and finding closure. With LGBT youth it's about growing, and with my elderly people, with my dying people, it's about closing.

With regard to the queer music therapy interventions of musical autobiography assessment and creative arts, each of which ask the client to engage with their past, present, and expected future, Parker's insight about elderly LGBTQ+ identity indicates that these interventions might be more effective as life reflection opportunities. Additionally, these could be opportunities to find closure for experiences related to their queer identity that they may not have been afforded due to LGBTQ+ stigma, lack of identity empowerment, or risk of physical and emotional harm.

Keeping the historical hardships of LGBTQ+ individuals in mind, Parker's interview also draws attention to the change in tone that certain queer music therapy interventions take when applied in an older population. In response to utilizing the group anthem writing intervention within his own practice, Parker noted that "when discussing difficult topics at the end of life versus the beginning of life, it could possibly be a bit more somber. [A group anthem] might not be a power anthem; it might be a somber ballad about missed opportunities." Furthermore, this kind of group song might not be an empowering anthem that elderly LGBTQ+ individuals will want to perform before every session, as the Bain et al. (2016) article suggests.

In addition to group anthem writing, queer music therapy interventions that emphasize past, present, and future—musical autobiography assessment and creative arts—will also present a potential shift in tone for elderly clients. Facilitating these interventions with healthy adolescents who can reflect on their lives many years into the future will be markedly different than with an elderly individual on hospice care who may only be able to reflect on the next few months of their life. In reflecting on past, present, and future, individuals in palliative care might confront difficult questions such as "What are the implications of me never being able to have top surgery?" or "How do I reconcile that I wasn't able to marry the person I actually loved?" Parker suggests the addition of a fourth reflection to these interventions that addresses how one hopes to be remembered. This added reflection could serve to help clients walk through difficult emotions and gain a sense of closure. Ultimately, a somber tone shift in interventions can certainly be beneficial and appropriate in processing difficult emotions near the end of life, but music therapists should be prepared to help elderly LGBTQ+ clients sit with these difficult emotions and avoid the desire to rescue.

Attending to ableism

Another consideration that study participants identify as absent from Bain and colleagues' model is how queer music therapy might be implemented in populations of LGBTQ+ clients with disabilities. The proposed queer music therapy interventions assume that clients engaging in the therapy will be temporarily able-bodied individuals. By excluding individuals with mental, physical, and developmental disabilities from our considerations of queer populations who could potentially benefit from queer music therapy, we risk perpetuating ableism—a term denoting the prejudice and discrimination against individuals with physical, mental, and developmental disabilities based on the belief that they cannot function and participate fully in society (Castañeda & Peters, 2000). Ableism is informed by dominant societal attitudes that situate disability with abnormality and defectiveness instead of conceptualizing it as "a dimension of difference" (Smith, Foley, & Chaney, 2008). The qualitative data we collected from music therapists on working with individuals with disability calls for a queer music therapy that attends to issues surrounding the intersection of disability and sexuality, and ultimately emphasizes the need to generate more research on how the interventions can be adapted for this population.

Participants emphasized how important it is that the queer music therapy model attends to stigma at the intersection of sexuality and disability. Stemming from the ableist assumption of "defectiveness" so often attached to disability, our society has historically ignored, minimized, and denied the sexuality of individuals with disabilities (Holland-Hall & Quint, 2017). Further, if the sexuality of individuals with disabilities is acknowledged, it is likely assumed to be heterosexual (Noonan & Taylor-Gomez, 2011). The stigma surrounding sexuality and disability has restricted persons with disabilities from receiving adequate education on sexuality and prevents professionals and caretakers who work with this population from learning how to help them foster healthy sexuality (Holland-Hall & Quint, 2017). It should be preemptively noted that the music therapists who spoke about disability in our study work primarily with individuals who have intellectual and developmental disabilities. For this reason, our qualitative data is skewed in its focus on these particular types of

disability, and more research needs to be done to generate perspectives on implementing queer music therapy in populations of individuals with physical disabilities. Study participant Tovah reflected on her experience working with queer clients with intellectual disabilities and stated:

> People assume that LGBT identity is about sex, and about having sex…Adults, typical adults, deny young people with special needs the fact that they are sexual at all. To have them identify as LGBT is just horrifying, because it means that my son or daughter is a sexual person.

Tovah's comment not only reflects the issue of denial of sexuality for individuals with disability but also touches on the risk of engaging with queer identity for individuals with disability that are dependent on caretakers who may not welcome queer sexuality. This issue is reflected in Tovah's later comments when she stated:

> My clients who were intellectually disabled had a lot to consider in terms of how far they were going to take their identity disclosure...It's not like I could encourage them to come out. That really wouldn't have been responsible of me without really understanding how their parents would respond. They don't even have the capacity to wait until they're independent [to come out]. They were not going to be independent.

The above insights suggest that before a model like queer music therapy could safely and successfully be implemented within a population of LGBTQ+ clients with disabilities, our attention and efforts must focus primarily on combatting the stigma surrounding sexuality and disability and the structural issues affecting clients' multidimensional lives.

In critiquing the queer music therapy model, study participant Jordan also spoke from their perspective of working with persons who have intellectual disabilities. Jordan's discussion of disability highlights the need for queer music therapy to attend to cognitive differences in clients with intellectual disabilities and opportunities to empower the population's uniquely inherent sense of sexual and gender fluidity:

> In terms of the [special needs populations] that I work with, I'm always thinking, cognitively could we get there with [queer music therapy]?...There's a freedom that you see represented in their sexuality. If they developmentally get to a maturity of sexuality, which is not always the case... Socially and emotionally, they just might not ever get there. Their bodies might get there, but the concept of having a crush on someone or being sexually attracted to someone may never come. It really depends [on their individual experience of disability].

Jordan's insights pose a fundamental question of how we will adapt queer music therapy for individuals with intellectual and developmental disability who may not manifest the same level of sexual and gender identity as traditionally developing individuals with normative cognitive functioning. In order to serve this population, queer music therapy will have to find avenues to meet these clients where they are in their sexual and gender identity development. Further, engaging in complex cognitive activities like critical lyric analysis or creating and reflecting on a musical autobiography might not be accessible activities for clients with intellectual and developmental disabilities. One potential adaptation for queer music therapy that might address this issue could be to include interventions that incorporate more nonverbal activity, like rhythmic drumming and improvisation.

Another notable piece of data that emerged from Jordan's reflection is their experience of clients with intellectual and developmental disabilities being markedly fluid in their gender and sexual identities when given the chance to express themselves in this way:

> The sexual fluidity and also gender fluidity in this population, if they are allowed to express themselves, is fabulous and has less constraints than other populations. This might stem from being less aware of social restraints [that stigmatize gender and sexual fluidity].

Due to the emphasis queer music therapy places on affirming fluidity and diversity with LGBTQ+ identity, it could certainly be a tool for empowering the fluidity Jordan describes within populations of individuals with intellectual and developmental disabilities. In fact, Jordan even mentions using gender-bending song

performance within their practice to affirm clients who express interest in exploring gender identity. Although allowing space to explore sexual identity fluidity is a potential beneficial element of the existing model, considerations and adaptations must be made to address the issues of combatting stigma, ensuring safety, and considering cognitive and physical limitations.

Overall, the qualitative data gathered in this study on attending to disability underscores unequivocal silences in music therapy (as a discipline) with regard to addressing ableism and the intersections of disability, sexuality, and gender identity. More research is needed to gain an understanding of how we might better conceptualize and co-create affirmative and radically inclusive therapeutic spaces for LGBTQ+ individuals with disabilities. Finally, as we explore below, these findings about disability further underscore the need to foreground intersectionality in any discussion of comprehensive inclusivity.

Is Therapy Political?

Bain and colleagues (2016) identify their queer music therapy model as a "radically inclusive" approach to music therapy practice. They invoke "radical" as a way of aligning the model with anti-oppressive, social justice–based approaches to music therapy. Because anti-oppressive therapy practice centers itself around (1) acknowledging the connection between oppressive social systems and the personal struggles of individuals with stigmatized identities; and (2) empowering clients to resist these oppressive social systems, the act of engaging in anti-oppressive therapy can be viewed as a political act. Furthermore, Bain et al. assert that their proposed music therapy interventions are avenues for LGBTQ+ clients to engage in "subtle acts of political empowerment and resistance to heteronormativity" (p. 27). Due to the inherently political nature of such a form of therapy, one of our interview questions sought to identify music therapists' perspectives on the political implications, if any, of their current music therapy practices.

The open-ended interview question posed to study participants regarding the intersection of politics and therapy was: "Do you conceptualize your current work as having political implications?" The responses to this question revealed a substantial disparity in participants' interpretation of the term "political" and its application

in their professional practice. Half of the participants responded emphatically that all aspects of their lives are political, while others emphasized that their *work* has political implications or expressed that they strive to keep their political beliefs out of their practice in order to maintain appropriate therapeutic boundaries.

Out of 12 total participants, six participants responded to this question with an emphatic "yes" and a statement that "the personal is political." This phrase, "the personal is political," originated in the second-wave feminist movement of the 1960s and, in the context of therapeutic professions, became an integral component in the feminist approach to psychotherapy (Brown, 2004; Maine, 2004). Among these six respondents, we identified a theme in their interpretation of "politics" as the system of societal power arrangements that affect all aspects of our lives. Study participant Callie encapsulates this theme in her response when she states:

> I feel an overwhelming yes to that question. I conceptualize my life as being political...you know, the personal is political. There are different ways of thinking about influencing political systems. You can think "top down," like legislation down to individuals. But more recently, I'm starting to think of it from the bottom up. First, yourself… doing all of your own personal work, and then thinking about the ways we interact with individuals in our community to help build them up. I think when we work to strengthen our communities around us, that is political inherently.

Another notable theme that emerged from the affirmative responses to this question was the idea that LGBTQ+ visibility and living authentically are inherently political acts. Participants Jamie and Sara bring this theme to light in their responses.

> Jamie: "It took years to get to the point where I can stand up and speak out as openly as I do now [about LGBTQ+ issues]. This is who I am. I'm not putting on some sort of act for anybody…and that's helped me to gain more power within our organization."
> Sara: "I think the personal is political and vice versa. Even my visibility [as a queer person] and working towards changing policies in my hospital [is political]. I definitely say yes."

Alternatively, several music therapists expressed some hesitation when initially confronted with this question and weighed the importance of maintaining therapeutic boundaries and holding their clients in unconditional positive regard. Their responses also reveal a pattern of interpreting "politics" as an individual's particular political orientation or affiliation with a certain party (e.g., liberal, conservative, Republican, Democrat). This pattern is exemplified by Reed's and Alex's initial responses to the question:

> Reed: "Oh...That's a tough question. I myself try not to be a very political person. I keep up with things to an extent, but I try not to let it bleed over into my work. I can remember when the election was still happening, and I would have clients that would say, 'I'm voting for Hillary' or 'I'm voting for Trump.' I'd just have to sit there and be impartial and say, 'Mm-hmm. You are entitled to that vote,' whether I agreed with them or not."
> Alex: "Let me think about that...That's a really hard question for some reason. I would say in my day-to-day clinical work...no. When I'm interacting with a patient, I work really hard to be present in the moment with that patient and their needs...I don't want the political climate or my own personal perspective to affect that."

With its origins in psychodynamic theory, the concept of establishing therapeutic boundaries has been adopted by many health practitioners as a means to ensure a safe and ethical practice (Medcalf, 2016). Therapists typically make professional considerations about the setting of therapy sessions, client confidentiality, privacy, and how much they will disclose to clients about themselves when working to establish boundaries in their practice (Medcalf, 2016). Alex and Reed's above comments highlight the discomfort some participants faced when processing how politicizing their work might directly conflict with their professional commitment to therapeutic boundaries, as well as how much they are willing to self-disclose to clients. Because speaking about political issues can be a sensitive and divisive topic for many people, it makes sense that a therapist would want to refrain from personally engaging with these topics in a professional setting. Additionally, Reed's comments touch on the professional commitment of a therapist

to hold clients in unconditional positive regard, even when a client expresses opinions that may differ from one's own (i.e., listening to a client's political perspectives impartially, even if the therapist personally disagrees).

Notably, in processing their thoughts on whether or not their work is political, every participant who initially said "no" also acknowledged some level of uncertainty about whether their political beliefs and values could be totally separated from their clinical work.

> Reed: "No, I don't really think a lot of my political views come in, *at least verbally they don't come in.* In how I come across, that would take some self-awareness and reflection on my part."
> Zarina: "Regardless of where I work, I have very strong political, social activism thoughts and beliefs. I have to be very careful in my role working at a private hospital...but *I don't think I could completely disregard or completely separate them from myself* [my political and social activism beliefs]."

In interpreting the uncertainty these participants expressed, we are compelled to think critically about therapeutic boundaries and their involvement in a therapeutic framework like queer music therapy, which is political and self-reflective by design. This means that while queer music therapy might be implemented by a therapist who identifies as heterosexual, Bain et al.'s model does appear to mandate a kind of self-disclosure/self-situating praxis in which clients and therapists work together to better understand each other's social locations and places in what Collins (2000) identified as the "matrix of domination," that is, a way of conceptualizing individuals' and groups' relationships to multiple systems of inequality. Study participants' concern that perhaps they cannot totally extricate their personal political orientation from their work points to research that challenges the traditional idea of rigid therapeutic boundaries. In her work on the use of self in therapy training and practice, Watts-Jones (2016) expounds upon the "postmodern era [of therapy practice], which ushered in the paradigm that the personal is always present in our observations and knowledge" (p. 12). As queer music therapy exemplifies this so-called postmodern paradigm, Bain et al.'s work underscores the notion that both

self-disclosure and politics (broadly construed) are crucial elements in truly affirming and empowering clients with stigmatized identities.

Discussion

The accumulated insight from queer and allied music therapists collected in this study generated qualitative data on the strengths of queer music therapy and considerations for improving its future implementations. Music therapists identified queer music therapy's foundation in queer theory, rejection of pathologizing LGBTQ+ identity, design for use in a group setting, and focus on common cause versus commonality as major strengths of the model. Music therapists' perspectives on the potential challenges and weaknesses of the queer music therapy model brought forth crucial considerations of the lack of diversity within the music therapy profession, inherent privilege and structural barriers of music training programs, and the inadequacy of multicultural training in the core curriculum of undergraduate degree programs in music therapy. Our data also revealed silences in the queer music therapy model's attendance to intersectional queer identity, specifically emphasizing the need for adaptations that accommodate age and ability status within the LGBTQ+ population. Finally, a pattern of disparity emerged in study participants' conceptualizations of engaging in work with political implications—a finding that ultimately drew attention back to the inadequacy of multicultural training in many or most music therapy degree programs, especially at the undergraduate level.

The major implication of this study is that queer music therapy must more substantively integrate intersectionality theory to serve all LGBTQ+ clients, not just non-disabled LGBTQ+ adolescents. Furthermore, in working toward a more intersectional framework, queer music therapy must critically attend not only to the content of the therapy but also to the structure of the music therapy discipline itself (cf. Grzanka & Miles, 2016). Without a music therapy field that reflects the diverse clientele it serves, diversity and inclusion efforts will likely remain superficial and steeped in unaddressed privilege. Further exploration of representation and privilege within music therapy is needed to understand the ways in which the homogeneity of the field can be transformed and

reconstituted to support intersectional representation or what Bain et al. (2016) term radical inclusivity. A major piece of this exploration must include a critical evaluation of music therapy curriculum required for professional certification. In order to attract and support a diverse student population, music therapy curriculum must assess cultural bias within the Western classical music tradition and consider the ways it may limit and devalue students—and client populations—with multicultural music backgrounds. Aside from structural barriers that limit more diverse student populations from entering music therapy programs, the undergraduate curriculum does not include multicultural training outside the inclusion of a single multicultural music course (American Music Therapy Association, 2017). Learning about the music of other cultures without developing a sense of cultural sensitivity and an awareness of how personal cultural identities inevitably influence therapeutic practice is a prime example of the superficial and potentially harmful inclusivity efforts that the queer music therapy model rejects.

Although the present study presented qualitative data that expanded upon Bain et al.'s original work, the queer music therapy model is a theoretical framework that still lacks empirical data analyzing the actual outcomes of queer music therapy interventions on LGBTQ+ mental health. Keeping the present study's qualitative findings on moving toward an intersectional queer music therapy in mind, the next step in this research is to implement queer music therapy in a formal study designed to measure the outcomes for LGBTQ+ clients. But the data here also suggest continued possibilities for considering how queer music therapy may function as a social justice–oriented therapeutic intervention with implications for systems-level change (e.g., Mallinckrodt, Miles, & Levy, 2014). In this sense, by helping clients become critical of heteronormativity, cisgenderism, and intersectionality, queer music therapy may empower clients—and therapists—to cultivate identities as politically oriented agents of social transformation across their multiple roles.

As our data simultaneously point to some therapists' concerns over what they perceive to be the pitfalls of mixing politics with therapy, which others see as inextricable, future work should explore opportunities and obstacles to implementing music therapy with a systems or macro-level orientation (Grzanka & Miles, 2016).

Notably, in verbally processing feelings of hesitation, discomfort, and conflict surrounding self-disclosure and the political implications of their work, study participants actually engaged in the kind of critical and reflective self-evaluation that is integral to cultural humility training. Taking the time to deconstruct and evaluate how one's personal beliefs and values will inevitably influence their music therapy practice is something one would engage in with a multicultural training program. Although it is not a personal fault or flaw, it is important to recognize that some of the music therapists who responded to our questions about the political implications of therapy may not have been afforded the opportunity to make these critical self-evaluations in their music therapy training programs, pointing back to the structural limitations of the music therapy training. On the other hand, while we believe these data are rich and have helped us critique and expand Bain et al.'s proposed model, we also recognize that the artificial nature of the interview setting is a major limitation of our research design and may have led to consequential demand characteristics, including socially desirable responding and other interviewer effects. Future research may involve anonymous surveys so that more participants can both be included and feel comfortable voicing concerns without fear of judgment in the context of an in-depth interview.

Most importantly, collaborative research that centers clients' perspectives will undoubtedly improve any kind of music therapy with LGBTQ+ clients. From our perspective, the next step in moving toward a radically inclusive music therapy is participatory action-informed research with LGBTQ+ clients so these individuals can use their subjective experiences to co-create innovative approaches that best address the needs of LGBTQ+ clients.

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