Exploring Music Therapist's Experiences of Sharing Pronouns within Group Therapy

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A Thesis Submitted to

Slippery Rock University, Pennsylvania

in Partial Fulfillment of the Requirements for

the Degree of Master of Music Therapy, with an Endorsement in Counseling

August 2024

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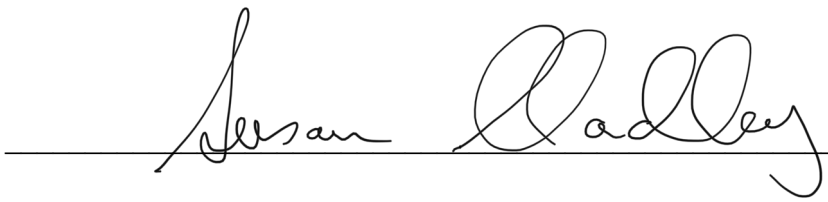
Slippery Rock University

Music Therapy Program



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Abstract

If music therapists are following the code of ethics, they should be striving to provide inclusive practices. This includes how gender, and its concepts are communicated by therapists. In context of clinical group work, promoting gender inclusivity can be cultivated through disclosure and musical choices. Additionally, there are contextual factors that influence clinical decisions made by the therapist. These factors can impact how gender identity is shared and explored by the therapist and clients in the group setting. There is growing research in the music therapy and counseling field regarding the impact of disclosing gender pronouns as well as how the therapeutic relationship is perceived to be impacted by the act of sharing pronouns with clients. However, minimal research has been curious towards how these decisions are made by the clinicians. This thesis aimed to explore the experiences of music therapists sharing or not sharing their pronouns within group settings, and how pronouns are considered when selecting songs for clinical experiences. Semi-structured interviews were conducted with five participants, who were recruited from social media postings. Through thematic analysis, four themes emerged from the data: 1) potential for harm, 2) culturally affirming practices, 3) context, and 4) musical considerations. The researcher hopes this research will be a useful addition to the growing literature exploring gender-inclusive music therapy practices.

Acknowledgements

I hold much gratitude for those who have helped me along this journey. It is hard to summarize the acts of kindness and support that I have received within just these past three years from my loved ones. I am incredibly fortunate and blessed to have so many wonderful people within my support system that encouraged me to keep going, even when I felt the most defeated. Before going into my specific thank yous, I believe it is important for me to acknowledge my held privileges that have allowed me to complete this thesis, my master's degree, and to be able to pursue music therapy. I recognize that my whiteness and gender identity have provided me with opportunities that are withheld for BIPOC and people of marginalized and oppressed gender identities. I hope for a world where we can move towards having a plethora of equitable opportunity for marginalized communities.

A special thank you to my wild, but incredibly loving family. I use the word family here to describe the family that I have made, and the family I was privileged to be born with. The amount of love you have shown me within these past years has restored my faith in myself. You helped me survive some of the darkest chapters of my life thus far, and no amount of written thank you will demonstrate how much you all mean to me.

Thank you to my graduate colleagues for your resilience and patience. I have so much to learn from each one of you. There were times in my graduate education where I did not reciprocate the efforts and passion that you all brought into our class space. I own that and it is a huge regret of mine. I aspire to learn from my transgressions to be a better person not only professional, but in humanness. A special shout out to Carly and Maryrose who provided me with additional support in completing my thesis. You both are wonderful people.

Thank you to my readers Maevon and Natalie for your time and commitment towards this project. Your feedback was essential for this project to be the best version of itself and offered critical insight for me to consider. It was a privilege and pleasure having you on my committee.

Thank you Sue for being such a role model for what it means to be human. You demonstrate a fiery passion yet fight with so much humility and grace. Thank you for challenging me in new ways I have never experienced before. You are a beautiful person, and I am so appreciative of being able to learn from you and the other faculty you provide us with throughout this program.

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Introduction

Motivations for Research

Practicing in a group therapy setting is a novice experience for me and my music therapy career. I have spent the last three years at my current and first formal music therapy job challenging practices that I utilize with my school, drug and alcohol, and community music ensemble groups. Embarking on this journey in tangent with this graduate program has provided me with opportunities to critically analyze how my therapeutic actions either promote inclusive or harmful practices. Hadley (2017) argues that we are not separate from our personal selves, and our sociocultural identities permeate our professional identity as therapists working with clients. Narratives that we have internalized appear in different forms while interacting with clients, even when approaching practice with best intentions. A narrative that has been a focus point for me at the time of this research is gender identity. This research project was sparked by my experiences of introducing my gender identity when facilitating groups, which then seeded the curiosity of regarding how clinicians approach introducing gender identity within therapeutic spaces. This project provided me with failures, successes, and most importantly opportunities to further challenge my internalized beliefs specifically regarding gender.

As a white ciswoman it is critical that I acknowledge the power I hold as a human in and outside the therapeutic space. A part of that acknowledgement has been confronting my own missteps and ignorance to the role gender plays in everyone's life. Some of those questions included: How was I perpetuating harm as the clinician? How was I constructing this research in a way that pathologized gender expansive communities? What is my relationship with my gender identity? How was I failing to understand gender? It is essential that as I continue this journey that I pause to reflect on my failures, have ownership of my wrongdoing with humility, and learn

from my failures. I also call to question my motivations for wanting to pursue a project regarding gender as a cisgender clinician. At what points was my altruism demonstrating cissaviorism, and why was I truly interested in doing this work? The short answer I believe is that it is the right thing to do; utilizing my privileges that promotes equity. But I also recognize that there were instances where this urge of 'doing the right thing' led to me mitigating gender its relationship with people and systems. There is always work that needs to be done with unlearning oppression. Completing one thesis about communicating gender identity in therapy spaces does not mark the end of my journey. Instead, I view it as an important stop along the way. My hope is that this thesis will be an additional source of literature that can be utilized to assist with journeys of unlearning, as well as a piece towards challenging group therapeutic practices.

Review of Literature

Through a review of existing literature, I will provide the following: a brief overview of various dimensions of gender identity, an exploration of the importance of considering gender identity within healthcare and counseling contexts, and a review of music therapy research related to gender identity. Because language is ever-evolving, I will attempt to provide a brief understanding of some gender identity terms that are relevant to my research. I recognize that providing definitions for such terms is limiting and negates the idea of viewing gender on a fluid spectrum. These definitions are minimal, and I highly encourage the reader to expand their understandings of gender performance and expression by further exploring published works included in my review. A resource to consider is The Trans Language Primer.

Cisgender – a person who identifies with the gender they were assigned at birth

Cisheteronormative – the normalization of being cisgender and heterosexual; perpetuates the belief that any else is an abnormality

Cissexism – a system of oppression that results in degradation, isolation, stigmatization, and marginalization of transgender people and wider trans+ communities

Deadnaming – the harmful act of calling a person by a name that was assigned to them in the past that is not their current name

Gender – complex combination of roles and norms, expression, aesthetics, identities, performances, social interactions, and more that are assigned certain meanings by society; is self-defined and societally defined

Gender binary – pervasive social system constructed through colonialism that states there can only be presumably cisgender men and women, as well as no alternatives in terms of gender or expression

Gender identity – a person's internal sense of their own gender(s) or lack thereof, may or may not align with a person's birth assignment

Gender inclusive language – discourse that not only does not reflect discrimination against gender identity or sex of a person but invites many possibilities of gendered experience; example: mail carrier versus mailman, y'all versus "you guys," partner versus wife/husband, humankind versus mankind, opportunities to reflect gender outside of the so-called binary versus only man/woman/prefer not to say boxes on official forms

Gender non-conforming – a person who does not fully conform to societal expectations surrounding their gender regarding expression, roles, and other aspects

Gender expansive – gender that expands beyond typical boundaries of the gender binary or gender spectrum, people who consider themselves gender expansive may or may not transition dependent on their relationship with gender and their access to transitioning within their culture

Gender spectrum – an extension of the gender binary; the spectrum is a linear model with ranges of 100% man to 100% woman with various states existing in between

Gender galaxy – a model to assist with visualizing the diversity of gender identities and expression within humanity; used to demonstrate how gender is an overarching term that consists of diverse identities that can be expressed in an infinite amount of ways

Masking – actions used to conceal aspects of their identity such as gender; a strategy used to hide revealing parts of identity to blend in with surroundings to mitigate harmful experiences

Misgendering – the intentional or unintentional harmful act of attributing the wrong gender to a person

Pronouns – words that someone is referred to, the words a person uses does not necessarily denote a specific gender

Transgender – umbrella term for people whose gender does not match their birth assignment, some gender non-conforming people may identify as being transgender, however it is dependent on how a person identifies and relates to their gender

Gender Identity

Gender identity must be acknowledged as being a fluid spectrum, or as the Trans Language Primer encourages, to understand it as a 'galaxy'. Gender is often misconstrued as being a fixed identity instead of being an ever-evolving performance that changes over a lifetime. Embracing this perspective requires a paradigm shift for gender to be conceptualized as not a singular idea, but instead as dynamically intertwined with sociocultural lived experiences (Brady et al., 2022).

Colonial systems and practices reinforce gender as being a binary system (Robinson, 2019). The notion of a gender binary recognizes two genders and typically associates an individual's sex assigned at birth with their gender (which is also assigned at birth). The assumption is that they are congruent with one another. Alongside the gender binary, sex is also understood as a fixed binary. Intersex individuals who were born outside of this binary is often medically considered "abnormal," and Western medical practice has strongly encouraged or even enforced conformity with one of the two major sex categories. Thus, sex and gender are predominantly understood as natural, stable, binary categories, even though (a) sex exists along a continuum and (b) gender identity does not have to be synchronized with biological presentation.

Believing so negates the idea of a dynamic spectrum related to each. It is also important to understand colonialism's role that lead to the suppression and erasure of gender existing in communities such as Indigenous peoples (Robinson, 2019). This ultimately has impacted how gender systems are practiced and understood in societies today.

Butler (2004) suggests that gender is the apparatus where the deconstruction of masculine and feminine binary can occur. Butler conceptualizes gender as a spectrum free from associations of what constitutes femininity and masculinity. According to Butler, gender is a socially constructed vehicle of performance that can be influenced by sociocultural norms a person is regulated by. When gender expression veers away from what norms portray it as, this prompts dominant and authoritative powers to intervene and attempt to re-align expression to fit within a binary understanding (Butler, 2004). Additionally, Butler highlights how understanding gender to correlate with sexuality is reductive and should be understood as two tenets that can operate independently of one another.

Representation of the gender spectrum has increased in recent years through television, film and music but continues to be misconstrued in many of these portrayals. A study conducted by Bracco, Sczesny, and Sendén (2024) found that transgender females were represented more often than transgender men and gender diverse people by sampling 830 major news headlines from Italy, Sweden, and the United Kingdom. Their findings demonstrate a lack of media representation for transgender men and gender diverse people. This lack of visibility can further stigmatize and misrepresent the transgender and gender nonconforming community. Additionally, Terry (2014) reminds us that BIPOC trans women's contributions to the community and their advocacy efforts are often overlooked, particularly in print media.

It is also important to recognize how inaccurate gender representation can be harmful to all people, including ciswomen. Rolvsjord and Halstead's (2013) study demonstrates this by focusing on reinforced gender expectations of the female singing voice. The article describes the experience of a cisgender woman, Susanne, with a deeper, low voice pitch. Susanne reported feeling isolated because of her low singing voice. For her, the performance of her lower pitch did not match what is culturally expected of women and femininity. This led to a great deal of distress for Susanne. The researchers highlight how performance of voice is linked to gender stereotypes and expectations of one's culture. In the case of Susanne, she worked with the music therapist to participate in gender disruptions and gain empowerment through voice.

There is a lack of research regarding how harm is produced by inaccurate representation of transgender and gender nonconforming identities. However, we can observe examples of harm from misrepresentation by considering research focused on marginalized sexual identities and queer identities. Mainstream media sources continue to portray white cisgender males as being the majority of LGBTQ+ identity (Robinson & Oswanksi, 2021). This upholds the expectation as to what members of the LGBTQ+ community should represent, not what is represented. As a result, people with intersecting marginalized identities such as people of color, disabled people, and people who are gender non-conforming can feel impacted by an erasure of identity, or invalidations towards their gender experience. Additionally, it further creates stereotypes and misconceptions about gender identity.

Cissexism is intrinsically rooted within us and the systems we live in. Cissexism is harmful for people of all genders. Cissexism and transphobia As an example, we can observe the violence against Imane Khelif. Khelif, a ciswoman boxer in the 2024 Olympics, was attacked by transphobic rhetoric online following her opponent abandoning the fight (de la Ferrière, 2024).

Despite being cis, she was attacked based on her appearance; she did not fit into bioessentialist purity standards that promoted by cissexism (de la Ferrière, 2024). Instances of cissexism happen every day, however, such as being communicated through microaggressions. First coined by Chester Pierce (1970), microaggressions can be seen in everyday interactions in the form of non-malicious behavior, that evokes harm against a marginalized community. Gender microaggressions work to reinforce gender inequality and strip away power from people of marginalized gender identities (McSorley, 2020). When we fail to challenge microaggressions, it also works to uphold oppressive structures. Microaggressions can permeate any space and create a place of unsafety and risk for the targeted individual.

Masking becomes a necessary defense for people with marginalized gender identities and sexualities. Disclosure of gender identity can be dangerous. We can draw this conclusion not only based off the current rise in anti-LGBTQI and cisheterosexist political rhetoric, but also by drawing upon related research focused on marginalized sexual identities. Flores, Stotzer, Meyer, Langton, and Shah (2022) identified that violent hate crimes against LGBT people in the years 2017 through 2019 were primarily motivated by a person's presentation of gender identity or sexual orientation. The findings suggest that people with marginalized sexual and gender identities were more at risk for victimization when compared to cis-hetero people. It is important to note that this research fails to address how the intersectionality of other significant identities, such as race or disability, contributed to risk of experiencing violence. Also, we must consider how many sexual assaults are not reported to criminal justice officials (RAINN, 2024). So, the data collected for this study is most likely underrepresented. Additionally, the offenders screened were predominantly white, cis-male individuals.

In the summer of 2023, the Human Rights Campaign proclaimed a National State of Emergency for members of the LGBTQIA+ community as over 80 anti-LGBTQIA+ laws were passed taking away safety and equity (Human Rights Campaign, 2023). Specifically related to gender, these included discriminatory laws such as bathroom bans, forced unmasking student identity, and pronoun refusals. In some states such as Arizona, inhumane actions such as conversion therapy are "banned," but only on a state level (Human Rights Campaign, 2023). Many states have not effectively held legislative attacks accountable, as there are no federal protections in place for gender-based discrimination of the trans community (Blazina & Baronavski, 2022). Additionally, legislated protections do not necessarily translate to appropriate implementation of such protections in the workplace, in public interaction, or in healthcare. From the Pew Research Center, Blazina and Baronavski (2022) conducted a survey of slightly over ten thousand United States citizens. Their findings presented that most people were in favor of policies protecting transgender individuals, with 37% in strong favor of them. If inclusion and protections of all gender identities is to occur, change needs to occur at all system levels, including the individual. For clinicians, this includes implementing change within the healthcare and counseling systems.

Gender Identity within Healthcare

In recent years, there has been slow movement towards institutional change regarding how gender identity is recognized, understood, and reflected in healthcare. However, there is much more work to be done on all levels of the healthcare system, specifically counseling and therapeutic services. Fields such as psychology have failed to serve people of all gender identities with ethical and adequate care. There continues to be a lack of attention and understanding regarding the gender spectrum from professionals and in academic literature

(Ghorbanian, Aiello, & Staples, 2022; Hostetter, Call, Gerke, Holloway, Walls, & Greenfield, 2022; Smith, Shin, & Officer, 2021). These practices fail to be challenged by many providers of care, perpetuating a cycle of harm for people with marginalized gender identities seeking out healthcare. Healthcare services are built upon cisnormative structures that reinforce binaries of sex and gender (Boe et al., 2020). It is important to acknowledge that this idea of being 'woman' or 'man' enough in accordance with cisnormative values is harmful for people of all genders. This can be analyzed by considering the ways illnesses are rooted within sex and gendered narratives (Boe et al., 2020). The way in which disorders and illnesses are gendered ultimately affects how healthcare providers interact and provide treatment to clients, as well as impacting how other pockets of communities are cared for (Boe et al., 2020).

There is a pressing need to provide adequate care for people of all gender identities, primarily in scope of people holding gender expansive identities. A systematic review by Nic Giolla Easpaig, Reynish, Hoang, Bridgman, Corvinus-Jones, and Auckland (2022) found that current literature supported two themes: (1) rural healthcare providers having insufficient knowledge regarding clients who hold gender expansive identities, and (2) these providers therefore offer inadequate medical care to members of gender expansive communities. Clients and patients reported having mostly negative experiences when interacting with healthcare providers, such as misgendering and gender microaggressions. Additionally, there were limited opportunities for participants to disclose their gender identity to providers; often, they were not asked at all. This raises concern about the quality of care received when seeking out health-related services. Furthermore, it shows how healthcare providers continue to fail to integrate gender inclusive practices with clients.

The ability to access healthcare is greatly dependent on sociocultural privileges. People with gender expansive identities are met with systemic barriers and challenges to accessing the care they deserve (Costa, 2023; Griffin, Casanova, Eldridge-Smith, & Stepleman, 2019; Hostetter et al., 2022; Joudeh et al., 2023). Access to care also hinges on the intersection of sociocultural identities such as race, class, age, and geographical. People who find themselves living in rural areas might have less access to healthcare facilities or find traveling to be prohibitive because of the far distance to reach the care they need (Hostetter et al., 2022). Research has shown that people living within the southern region of the US are less likely to be insured and have access of healthcare (Griffin et al, 2019). BIPOC gender expansive people face even greater risks of harm due to the impacts of medical institutional discrimination and racial health disparities in comparison to their white counterparts (Williams & Rucker, 2000; Yearby, 2020). Similarly, social class and economic privilege impacts access to care. Low to no insurance coverages as well as denials of care from providers can prevent obtaining gender affirming care for people of lower socioeconomic status (Griffin et al., 2019). Depending on a person's financial status, not being able to afford their healthcare needs becomes another barrier.

Costa's (2023) systematic review of sociology literature highlights multiple studies that demonstrate healthcare gatekeeping practices against transgender people. Thematic analysis revealed several obstacles individuals faced such as interpersonal, organizational, community, physical, political, systemic, structural, social, economic, and institutional barriers (Costa, 2023). The identified barriers pointed to three needs that must be addressed by healthcare systems. First is the structure of the physical healthcare space, which can look like bathroom access, healthcare filing systems, and gender-affirming paperwork. Second, social spaces were identified as needing attention drawn to how professional and interpersonal relationships were negatively

experienced by trans people. Third, difficulty with physically accessing care was commonly seen as a barrier as well, relating to costs of services and ability to receive gender affirming procedures. Currently, there is not an umbrella law protecting the treatment rights of transgender people, let alone other gender expansive identities, so providers can also refuse treatment, thereby making the cost for gender-affirming care expensive. Costa's (2023) findings also called upon healthcare professionals to engage in gender-affirming training and education. A system that is meant to help people with healthcare needs instead becomes a filter to deny care to those who face adversities. Navigating healthcare becomes a battleground and a fight for equitable treatment. To address these barriers, gender inclusivity must be implemented into all levels of the healthcare system.

People holding gender expansive identities are at higher risk for experiencing stress and anxiety when dealing with healthcare institutions. Minority stress refers to the increased health risks marginalized and oppressed communities face because of adverse and traumatic experiences related to their sociocultural status (Costa, 2023; Hendricks & Testa, 2012; Meyer, 1995). Violence, oppressive political climates, and transphobia are just some of the elements transgender and nonbinary individuals find themselves facing daily. These adverse experiences affect the physical, emotional, and mental health of trans or gender non-conforming people (Griffin et al., 2019). People with interlocking marginalized identities such as people of color and those of lower economic status face different risks for experiencing these stressors. Millar and Brooks (2021) reported findings of racial and ethnic intersectionality impacting the psychological stress experienced by transgender people within North America when seeking out mental health care. BIPOC individuals, specifically Black participants, reported higher psychological stress than that experienced by white participants. Persons who hold multiple

minoritized social statuses faced greater victimization and distress when seeking out care (Millar & Brooks, 2021). Miller and Brooks' findings also demonstrated that geographical location was another factor impacting stress experienced. Participants within the Pacific Northwestern region of North America reported the lowest levels of gender-based discrimination experienced.

Finding gender-affirming care is another hurdle for gender expansive communities. Non-affirming gender practices can consist of deadnaming, incorrect pronoun usage, misgendering, and a general lack of education regarding gender inclusive practices (Hostetter et al., 2022). The risk of harm is greatly increased while receiving care, and some might prevent seeking out treatment out of fear. Transgender and nonbinary people are greatly disadvantaged in finding safe, quality treatment. Additionally, people holding gender expansive identities are at greater risk for language-related stress, which ultimately creates another barrier to receiving care and can instill long-term negative effects in them (von der Warth, Metzner, Korner, & Farin-Glattacker, 2023).

To work towards inclusive care, healthcare providers must change how gender is understood, accepted, and acknowledged. A study the first of its kind, McKay & Watson (2020) surveyed the experiences of gender expansive adolescents sharing their gender identity to healthcare providers. Their findings reflected that two-thirds of their sample did not disclose their gender identity to healthcare providers, and less than one-tenth disclosed to all healthcare providers. The researchers note that concealment of gender identity was often done for safety. Additionally, anticipated stigma and environmental limitations such as assessed risk of harm compromise the choice of sharing gender identity (Levitt & Ippolito, 2014; Rossman, 2017). A final consideration for this study was age of the participants in the sample pool. The researchers found that adolescents of 13 and 14 years old disclosed their gender identities to fewer healthcare

providers when compared to older participants (McKay & Watson, 2020). This calls to question how age-related services differ amongst opportunities to disclose gender identity to healthcare providers.

Gender Identity and Therapy Services

Medical approaches aimed at "fixing" disorders are deeply engrained with most therapeutic education as the field of psychology and psychiatry has notoriously pathologized gender identities that do not align with cisgender experiences. Queer history recognizes the attempts to eradicate or fix queer people within mental health practices (Kunzel, 2017). The DSM has pathologized gender experiences, particularly gender expansive realities, for many decades (Sennott, 2011; Thomas-Castillo & Rush, 2023). Through its lifespan, editions of the DSM have defined "transsexualism," "gender identity disorder of childhood," "gender identity disorder," "gender dysphoria," as pathological disorders and there have been diagnostic categories of "sexual deviations," and "psychosexual disorders."

People holding gender expansive identities continue to face discrimination in counseling and therapeutic services. Institutions have begun addressing discriminatory treatment experienced by clients. In response to legislative attempts to block gender-affirming care, the American Psychology Association (2024) recently adopted a policy in support of affirming evidence-based care for gender expansive clients. However, this is merely a band-aid fix for a larger presenting problem. For therapists and counselors to truly reduce harm in their practice, they must be willing to engage in critical, reflexive thinking about their misconceptions, biases, and privileges.

Gender expansive people experience unique stressors and microaggressions related to their gender identity. Counselors and therapists must recognize these unique stressors when

conducting therapeutic services to minimize harm within treatment, and to approach working with clients in a way that acknowledges the injustices they face daily. In addition to being reflexive and engaging in anti-oppressive practices, therapists must recognize how gender identity impacts experiences outside of therapy. Clinicians are urged to utilize tools such as the Minority Stress Model (Meyer, 1995) to understand how clients holding gender expansive identities are subject to increased mental and physical health risks such as suicide, self-harm, and isolation (Hendricks & Testa, 2012; von de Warth et al., 2023). By implementing this model, clinicians can attempt reducing the risk of discrimination and victimization experienced by clients while in therapy. Scrine and Koike (2022) reinforce that often there is "little attention to who dictates safety, and for whom spaces are deemed safe" (p. 39). Additionally, facilities fail to acknowledge how sociocultural power hierarchies are reinforced by everyday clinical practices (Scrine and Koike, 2022). It becomes imperative, then, that clinicians conceptualize therapeutic discourse through an anti-oppressive lens.

Therapists should understand that discourse holds power in how clients experience therapy. What is communicated related to a therapist's sociocultural understanding is a major part of establishing the therapeutic space and relationship. That being said, it can be understood that discourse holds the power to either work towards creating a braver or dangerous place for clients. When engaging in discourse critique, therapists must acknowledge how psychology practice is rooted in Westernized beliefs, and how gender has been constructed to be a binary understanding (McGeorge et al., 2021; Smith, et al., 2021). The language that we use reflects how we interpret social power and privileges among people. Failure to question and be critically vigilant in what is communicated to clients either works to dismantle power structures or

reinforce them (Smith, et al., 2021). If therapists are to create an inclusive space, then there must be attention given to the way language is used in therapeutic discourse.

Gender-inclusive language should be adopted by clinicians to help mitigate harm experienced by clients. Mindful use of language can promote the dismantling of gendered language and model gender-inclusive practices. Recent trends through platforms such as social media have encouraged the normalization of sharing pronouns as a way of promoting gender-inclusive discourse. An Instagram profile, for example, has the option to share pronouns within a person's bio. Gender expansive people can utilize online communities to help foster positive connections with others and find support systems that combat unique mental health concerns (Mathur, 2023). This shift in social discourse has slowly been trickling into other domains such as mental healthcare, but many clinicians continue to use cissexist practices that reinforce the gender binary. Gender-inclusive language is a step many institutions can take toward creating a space for all genders to be validated. The lack of using gender-inclusive language can trigger feelings of invalidation, powerlessness, anxiety, depression, and isolation for clients (Biedka, 2022; Shelton & Delgado, 2011; Smith, et al., 2021). Furthermore, research has been conducted to consider the importance of correct pronoun usage within healthcare services (Sevelius et al., 2020). Transgender females were scored on a scale created by the researchers to measure the importance of pronouns for the clients [TW-IP scale]. Data and analysis demonstrated that correct pronoun usage was associated with retention and successful engagement with healthcare services. The researchers found that this supported how incorrect pronoun usage could deter people from seeking out healthcare services and highlights the importance of social affirmation and validation for transgender female clients.

Healthcare practitioners are ethically responsible for remaining educated in best practices. Best practice for the professional includes advocacy work, demonstrating efforts towards inclusion, and remaining educated to provide the best care for all clients and patients. The lack of competency regarding treatment with gender expansive and queer communities is harmful on multiple tiers (Smith et al., 2021; Hostetter et al., 2022; Shelton & Delgado-Romero, 2011). An example of this ignorance is observed through the lack of inclusive language within medicine and healthcare seen within intake forms, charts, and interactions with medical staff and professionals. Language within spaces like healthcare and medicine has historically served as a way of oppressing, barricading, and pathologizing individuals (Clements-Cortes & Jing Yee Yip, 2022). Only in the 1970s did Western psychology begin challenging the belief of "curing" gender expression and identity (Whitehead-Pleaux et al., 2012). Practitioners need to be knowledgeable of how diagnosis and symptoms are not always biological and individualistic. Instead, it should be acknowledged that these can be valid responses to social injustices and discrimination experienced. Failing to critically examine how we use language that is exclusive towards marginalized communities consequentially continues to perpetuate systemic oppression that marginalized people face (Clements-Cortes & Jing Yee Yip, 2022).

Illiteracy and ignorance towards gender-affirming care prevents people from seeking out the care they need (Hostetter et al., 2022). Mental health professionals need to demonstrate attention towards gender-affirming language and engage in reflections on their practice according to inclusivity. The language we use to communicate with clients is demonstrative of our attitudes, biases, and beliefs. Language can allude to critical thinking around the ways cissexism is promoted in clinical discourse (Smith et al., 2021). Therapists may examine how their cisgender privilege creates a power differential through examination of their use of cissexist

language that promotes a bio essentialist gender binary. Reflexive practices towards clinical language and its ability to inform power structures between client and therapist can also strengthen the authenticity and genuineness of the therapeutic relationship (Smith et al., 2021).

Most of the therapeutic research regarding pronoun usage centers around psychodynamic clinical alliances and the impact of using first person and third person pronouns with clients (Priest, 2013; Ryu et al., 2023; Van Staden & Fulford, 2004). In recent years the clinical psych field has produced literature to explore gender pronoun usage in relation to clinical rapport (Morris et al, 2020; Knutson et al., 2019). Knutson et al. (2019) propose that therapist utilize transparency, empathy, and receptive attitudes regarding pronoun use when working with clients. When misgendering happens, they encourage the clinician to remain "open, empathetic, and genuine", as well as "self-compassionate, appropriately apologetic, and receptive to feedback" (p. 219). This is like suggestions that Maeder et al. (2029) propose to therapists with integrating pronouns; to be transparent about our own pronouns, to not assume a person's pronouns based on presentation of the client and providing opportunities where people do not feel forced to share pronouns.

Morris et al. (2020) study provides data and findings that demonstrate how microaggressions such as incorrect pronoun use impact clients seeking out therapeutic services, and ultimately aspects of the therapeutic relationship. The researchers found four major themes regarding gender identity-related microaggressions received from mental health providers: 1) Lack of respect for client identity, 2) Lack of Competency, 3) Saliency of Identity, and 4) Gatekeeping (Morris et al., 2020). Participates in the study also regarded microaggressions, such as misgendering, non-affirming language, and denial of identity, as influencing their sense of safety, trustworthiness with their counselor, comfortability, and validity regarding their sense of

self. When harm does occur such as misgendering, the way that a therapist respond is very important. Maeder et al. (2019) urge clinicians that they be reflexive about the experience, while also holding space to correct the mistake and avoid drawing too much attention to the client, especially in a group space. Context plays a role in this decision, but the therapist should be mindful of not letting their feelings of discomfort or their embarrassment about making the mistake the focus on the harm (Maeder et al., 2019).

Microaffirmations can be utilized by therapists to validate gender experiences with clients and to offer affirming therapeutic practices (Anzani, Morris, & Paz Galupo, 2019). These can range from gestures, simple acts, responses, and affirmed practices. Acknowledging and affirming a client's gender as authentic can serve to communicate empowerment and validation (Anzani, Morris, & Paz Galupo, 2019). Anzani, Morris, & Paz Galupo's study (2019) also confirms how utilizing correct pronouns is seen as a microaffirmation for clients. Out of a pool of 64 participants, 44% of people identified correct pronoun usage as an experience of seeing their authentic gender and as an affirming practice. Incorporating actions such as this can work towards destabilizing cisnormative language and practice within therapeutic spaces.

Gender Identity and Group Settings

Creating an inclusive group space may require the therapist to raise consciousness towards social justice issues, especially those affecting marginalized clients within the group. While some therapists do aspire to engage in practice with an anti-oppressive and social justice lens, attention towards social justice matters can be regarded as "irrelevant" to treatment and goal alignment by many clinicians (Singh & Salazar, 2010). Chen, Kakkad, and Balzano (2008) argue that a person's culture cannot be separated from how a person presents their self-conception, expectations, perceptions, interpretations, and functions. In other words, clinicians

understand clients in group settings as not being separate from their sociocultural identities. Frey (2000) argues that the study of cultural diversity in group settings is a neglected realm within group therapy scholarship, despite it being an important element of practice. This is quite alarming considering that group therapy is a common therapeutic modality. DeLucia-Waack (1996) urges us to consider how all group work is multicultural, and that embracing uniqueness is an essential part to the functionality of group work.

Silence and lack of action on the therapist's part can lead to microaggressions as well as missed opportunities to challenge oppressive notions (Hadley, 2013). Challenging harmful gender discourse in group therapy is an important element of anti-oppressive practice in therapy. Any clients coming into a group space come with their unique lived experiences and biases. Therapists might avoid political discussions to try and create a neutral space; however, failure to challenge harmful discourse creates a space that upholds hegemonic values. This can create feelings of isolation for members with marginalized identities rather than feelings of support and positive regard.

To challenge held beliefs, there must be action towards noticing and addressing oppressive practice(s) that have been demonstrated. Therapists must be critically attentive when facilitating the group therapy space if they wish to promote brave spaces for all clients by challenging dominant narratives of gender identity. Hadley (2013) calls attention to the therapist's need to analyze their complicity to dominant narratives, synthesizing critical theories into practice, and being vigilant towards hegemonic practices. In relation to gender identity, the therapist may bring attention to political intersection of gender identity and the therapeutic space. Clinicians need to be reflexive regarding gender erasure and discrimination tactics that historically and currently exists in therapeutic settings. They also need to be aware of the power

dynamics in the client-therapist relationship. These are just two curiosities that a clinician might utilize in deconstruction of dominant narratives. Additionally, clinicians need to explore how other realms of politics inform the ways we interact with gender concepts in therapeutic spaces.

Group therapy can be an opportunity for clients to explore the self and their identities. Clinicians may choose to incorporate affirmative practices, such as personal affirmation, to encourage self-esteem building, connection with other group members, and to demonstrate safety and security (Mitten, 1995). While research has demonstrated that group therapy can be effective with increasing social supports, it is important to recognize that these experiences have not been adequately voiced by people of all genders, particularly transgender and gender expansive communities (Solness and Kivlighan, 2022). Affirmative group therapy can be utilized when working with communities to deconstruct stigmas against marginalized groups (Chen et al., 2020). This is observable through Chen et al.'s (2020) study where affirmative group therapy was utilized working with a group specifically composed of transgender and gender expansive members. The researchers observed that an affirmative structure provided clients with opportunities to discuss gender oppression, have their gender identity validated, and as a way of practicing disclosure (Chen et al., 2020). Group therapy research has revolved around exploring gender specifically in affirmative or queer closed spaces (Briggs et al., 2018; Chen et al., 2020; Heck et al., 2015; Solness and Kivlighan, 2022). While this research is also important, there is a need to explore affirming gender practices within other group ecosystems. Clinicians who engage in more affirming practices can influence a client's level of comfortability when discussing gender (Puckett et al., 2022). However, there is a need to explore how gender affirming practices are considered in groups of multiple sociocultural contexts.

Self-Disclosure and Therapy

Self-disclosure in therapy is a way of communicating personal information of the therapist to the client (Chorney, 2023). According to Bitar et al. (2014), self-disclosure can be understood as a clinical intervention skill of promoting authenticity. Additionally, Bitar et al.'s (2014) research found that self-disclosure strengthened therapeutic alliances, was a way of normalizing client problems, helped lessen the client-therapist power hierarchy, communicated therapists being more human, and modeled acceptability of self-disclosure to clients. Self-disclosure can be demonstrated through a multitude of ways such as body language, attire, appearance, and presentation (Hill & Knox, 2002; Lee, 2014). For this research, self-disclosure is situated strictly within verbal statements from the therapist.

Therapist self-disclosure of personal identities can be a powerful tool used by therapist in clinical spaces (Kelly, 2022). Disclosure of identities by the therapist has shown to provide opportunities for empowerment for clients and to increase the therapist's credibility (Borden et al., 2010; Jeffery & Tweed, 2015; Kronner & Northcut, 2015). The ability to self-disclose is dependent on contextual factors that intertwine with inherited privileges held by the individual. Additionally, self-disclosure should be critically analyzed regarding what is being communicated by the therapist in that moment. There is a lack of research that examines the role of gender identity and self-disclosure within the clinical setting, as most of literature is situated within self-disclosure of sexuality (Kelly, 2022; Jeffrey & Tweed, 2015; Borden et al., 2010).

Negative and positive feelings have been found surrounding the experience of gender identity disclosure for people holding gender expansive identities (Bethea & McCollum, 2013). Clients holding gender expansive identities may experience internal and external stressors when feeling obligated to disclose their gender identity (Bethea & McCollum, 2013). Some stress arises from the uncertainty of how they will be socially accepted upon disclosing gender identity

(Bethea & McCollum, 2013). However, a positive experience could be experiencing acceptance and freedom by expressing gender identity (Bethea & McCollum, 2013).

Kelly (2022) proposes ways in which the therapist self-disclosing identities could be harmful or helpful within a group therapy setting. Sharing identities may be done to establish commonality between client and therapist, to provide sociocultural positioning for the therapist, to decrease feelings of isolation, or to establish limitations of the therapist (Kelly, 2022). However, establishing commonality also risks further exploring the unique experiences of clients (Kelly, 2022). A final consideration Kelly (2022) urges clinicians to reflect on is to what degree of disclosing sociocultural identities is for our own personal development and healing, versus what is for the group. This is reminiscent of Zur's (2010) and Russell's (2006) scholarship that encourages therapists to consider intentionality of self-disclosing: is it for personal gain or in the best interest of the client?

Music and Gender

Music helps us gain a sense of ourselves, and our understanding of the world, and helps us form our social identity (Mercedes, 2003). From an early age, gender is experienced within music contexts, helps to instilling and communicating gender expectations and norms. This can be observed with musical instrument choices for players in environments such as school band programs. Instruments are often assigned as either masculine or feminine items, codifying who should play what according to gender identity (Abeles, 2009; Killian & Satrom, 2011; Rolvsjord & Halstead, 2017). Killian and Satrom (2011) found that participants from kindergarten, third grade, and fifth grade associated wind instruments such as the flute as a "feminine" instrument, whereas brass instruments such as the trumpet were observed as more "masculine." Additionally, the research supported that gender of the musicians demonstrating the instrument influenced

their perception of assigning gender to instruments. Similarly, Rolvsjord and Halstead (2017) state that instruments associated with popular music such as guitar, electric bass, and drums are often viewed as masculine, while violin, flute, and clarinet are viewed as more feminine. Instrument choice for a person then, can be seen as either gender disruption or gender affirmation.

Critical discourse within music has worked in tandem with several social justice movements. For example, in the 1970s the US witnessed songwriters using music to advocate for sociopolitical action and to create communities against violence (Scrine, 2016). Popular music became a way of challenging patriarchal norms, and bringing attention to oppression (Scrine, 2016). Music, therefore, can be understood as a discourse platform for people to advocate and promote various ideologies.

In understanding music as discourse we can understand music as a way of communicating gender concepts (Werner, 2019). This is inclusive of performance and music-making traits such as types of instruments used, genres, lyrical meanings, and performance presentation (Rolvsjord & Halstead, 2013; Werner, 2019). Messages within music either work to negate or promote gender disruptions. Historically, popular music has underrepresented non-normative bodies, sexualities, and gender identities (Scrine, 2016). James (2015) articulated that relevant pop music performance and lyrical content has shown an increase in supporting neofeminist agendas and political gender themes. Artist Olivia Rodriguez provided an example of this through music performance with her recent promotion of reproductive rights corresponding with her GUTS World Tour (Entertainment Industry Foundation, 2024). Additionally, music can be understood as either working towards the negation or promotion of the way gender is understood. Artists such as Antony & The Johnsons have produced songs such

as "Today I am a Boy," in which the lyrics tell the story of childhood struggles and inner turmoil experienced by a transgender female prior to transitioning. Songs contain narratives that reflective sociocultural identities such as gender, and they can be interpreted in different ways according to the songwriter's or listener's held identities. More attention needs to be drawn to the discourse used in songs and how lyrics either reinforce cissexist ideals or promote gender inclusion.

Mainstream music and lyrics have lacked representation of gender expansive experiences and narratives (Rolvsjord & Halstead, 2013; Scrine, 2016). Gender issues in music were first a major topic in the late 1980s, although the gender issues at that time focused on critique through a cisgender lens along the male/female gender binary, leaving a significant gap in the literature regarding music and gender (Maus, 2011). In more recent times, artists who identify as transgender, nonbinary, or gender expansive have provided representation and created space for gender diversity to be acknowledged in music. Artists such as Shea Diamond, Ethel Cain (Hayden Silas Anhedönia), and Skylar Kergil are all successful musicians within gender expansive communities who passionately advocate for equity. In 2019, Diamond collaborated with the Humans Rights Campaign for a promotional video for the Americans for the Equality Act (Human Rights Campaign, 2019). In this video, Diamond shared her experience as a queer person growing up in southern Alabama to critique the lack of supports that were in place to allow her to feel safe, accepted, and protected. She went on to say that as a singer, songwriter, and performer who travels across the United States, she has experienced various types of violence and bigotry in different parts of the country. She concluded with a call to action to pass the law so that members of the LGBTQIA2+ community are protected and affirmed uniformly across the country. Skylar Kergil has engaged in many advocacy projects through keynote

speaking, Youtube vlogging, publicized diaries, art, and music (Fragakis, 2019). Ethel Cain's latest album "Preacher's Daughter" is a concept album that is comprised of narrated metaphors tied to her memories living in the South, generational trauma, religious trauma, and her experience coming out as trans (Cain, 2022). Advocacy and storytelling by these musicians provide gender visibility and social support within the community.

Consideration of clinical music is an important part of a music therapist's practice. Music should not be understood as inherently good and safe (Scrine and Koike, 2022). Instead, it may be helpful to frame musical choices as a way of structuring safety (Richardson and Reynolds, 2014; Scrine and Koike, 2022). Scrine and Koike (2022) encourage therapists to recognize the music as being an opportunity for choices, expression, and share stories rather than a method of guaranteeing safety. In this same vein, utilizing music that works towards affirming gender identity could be an opportunity for the therapist to promote braver spaces and challenge gender norms. For example, Scrine (2019) utilized songwriting parodied and original songs as a vehicle to explore gender freedom, fluidity, and identity when working with groups of adolescents. Songwriting in this case was an opportunity for clients to process, share their gender experiences, and explore gender disruptions together as a group and through their music. This same consideration should be held towards music listening experiences, as there has been little investigation towards how client groups reify gender norms and codes demonstrated through gender discourse in music (Scrine, 2016).

Gender Identity and Music Therapy

Music therapy was established within a medical paradigm like the models that psychiatry and psychology are founded on. In response to oppressive systemic practices, some music therapists have implemented critical theories to mitigate harm. Some music therapy scholarship

has suggested anti-oppressive practices to address the role of sociopolitical contexts and cultures when working with clients, and to critically analyze power structures (Baines, 2013; Scrine & McFerran, 2018). Also we can consider a paradigm shift from a medical model to a biopsychosocial model (Anandarajah, 2008; Borrell-Carrio, Suchman, & Epstein, 2004), which encourages clinicians to recognize how health problems and difficulties are influenced "by multiple levels of organization, from the societal to the molecular" (Borrell-Carrio et al., 2004, p. 576). This becomes important when considering the sociopolitical role gender has in therapy. Music therapists who seek reformation of medical model and oppressive practices should recognize harm that occurs from the pathologizing of gender experiences. In addition to critiquing their own practice, music therapists navigate the challenge of working alongside other mental health professionals who might maintain unchecked oppressive biases and understanding regarding gender identity (Hardy & Monypenny, 2019). Gender inclusive practice may involve the integration of queer theory elements into clinical practice. Tenets of queer practice can be modeled through collaborating with clients, addressing questions regarding the intersectionality of both/and realities within gender identities, and considering how clients are impacted by rigid, normative binaries (Hardy & Monypenny, 2019).

In recent years, some music therapists have introduced the idea of "queering" their music therapy practice and adopting queer theory tenets to tackle the deconstruction of gender hegemony. Therapists that integrate queer theory into their approaches in therapy might examine gender and sexuality's relation to power dynamics, identity, and discourse (Boggan, Grzanka, & Bain, 2017; Goodrich, Luke, & Smith, 2016). The process of queering one's practice involves emphasizing the quality of therapeutic relationship between client(s) and therapist. Music therapists who strive to hold inclusive therapeutic spaces will both intentionally foster

relationships between marginalized and dominant groups as well as highlight their common cause for therapy (Boggan et al., 2017; Hadley & Thomas, 2018;). These music therapists encourage group members to move from rigid fixed categories of various identities (gender, sex, sexuality, race, disability and so on) to more fluid understandings.

Queering practice is a clinical approach to dismantling binaries, labels, and promoting fluidity in understanding gender and sexuality. In exploring music therapy pedagogy, Fansler, et al. (2019) encourage clinicians to understand queering as action toward destabilizing and deconstructing fixed categories of gender and sexuality. Queer pedagogy encourages disruptions of what is considered as socially "normal" categorizations to challenge ways that privilege intersects with presenting "problems" for a client. Music therapists who wish to queer their practice should strive to move away from fixed categories derived from normalcy in elements of therapy and music, particularly within the context of gender.

Queer practices cannot be separated from understanding and acknowledging power dynamics (Fent, 2019). Understanding power in the context of relationships is a part of how people make sense of and attribute meaning to their lived experiences. Members of marginalized communities face harm from members from dominant groups who utilize their privilege to uphold dominant normative ideologies. The influence of power exists in and outside the therapeutic space. Hardy and Monypenny (2019) stress that adopting queer practices helps marginalized communities across the board, and not just within queer spaces. Helping clients understand concepts in more fluid ways can offer more therapeutic opportunities for empowerment and validation of oppressed experiences. By queering practice, music therapists can work with clients to make meaning of how gender and power intersect to either oppress or empower clients. This is important when creating inclusive therapeutic spaces.

It is important that music therapists reflect on their biases regarding gender to form healthy therapeutic relationships, communicate effectively, and engage in allyship with clients with marginalized gender identities (Whitehead-Pleaux, 2020). Regardless of the setting, practitioners need to ask themselves how they construct therapeutic spaces that support gender diversity. Gender is a performative construct and unique to the individual, and clinicians must be cautious of how their stereotyped perceptions of gender impact practice (Hadley & Gumble, 2019). This requires challenging action against oppressive practices that present themselves in therapy so that clients can maximize their therapeutic potential (Baines, 2013). Bringing intentionality to our therapeutic discourse is necessary when establishing space that affirms identities so that each client's potential is maximized. The language music therapists utilize in sessions holds power in how clients are represented and acknowledged (Clements-Cortes & Jing Yee Yip, 2022). Clinical language that promotes gender diversity can be a way music therapists advocate for clients with marginalized gender identities and can provide opportunities to deconstruct fixed gender binaries.

Musical practices carried out by the music therapist can create spaces that either destabilize gender binary constructs or uphold them (Hadley & Gumble, 2019; Rolvsjord & Halstead, 2013). All therapeutic components, including musical, need to be critiqued according to how they affirm gender identities. What is communicated through music, actions, and words requires attention from the music therapist. Hadley and Gumble (2019) argued that in order to challenge cisgenderism (or again, now often named cissexism), we must queer our understandings of gender and sex, discourse, and listening and looking practices. This raises questions such as "how do we gender groups of people," "how do gender stereotypes impact our expectations of musical presentation," and "how do music therapy practices affirm or negate

gender?" Furthermore, in what ways do music therapists communicate messages that affirm identity, or devalue a client's identity? How do these messages strengthen or hinder the client-therapist relationship?

Biedka (2022) suggested that, when working with clients who belong to the LGBTQIA2 + community, one of the most important parts of the therapeutic relationship is the role of the implicit and explicit communication around gender and sexuality. In other words, in what ways do music therapists communicate validation of gender and sexual identities through non-verbal and verbal communication? Lack of regard of queer identities and the impact of cissexism in therapy spaces is harmful to clients who are not cisgender (McSorley, 2020; Neumann, 2023). Neumann (2023) exposed harm experienced by queer clients. More specifically, they highlighted therapist responses to queer clients, client responses to their therapist, qualities of the therapeutic relationship, client perceptions of their therapist, the impact of harmful experiences on the client and the therapeutic process, barriers to accessing therapy that is affirming to queer clients, and what builds safety and trust for queer clients. These themes prompt us to ask how might neglecting, or hyper fixating, on gender identity be harmful to the client and the therapeutic rapport?

I would argue that including opportunities to express gender identity in therapy (e.g., sharing pronouns) is a minimal step toward inclusive practice. However, providing these opportunities also requires cultural reflexivity for the therapist to minimize harm when working with queer clients. This further requires reflection on how music utilized within sessions might empower or disenfranchise a person's gender identity (McSorley, 2020).

An important concept for therapists to consider is "good intentions," which in my experience has been the root of many of my own missteps. The good intention of sharing

pronouns could potentially be harmful working with a group. We can relate this back to McKay and Watson (2020) describing negative experiences when clients felt forced to disclose gender identity. And, when we do misstep with good intentions, how we take ownership of harm done while navigating damaged rapport? A place for some clinicians to start would be questioning the ways they perceive cisnormativity. Inmon (2023) draws attention to how cisnormativity is typically understood as "a series of rigid lines of thought that create a specific shape every *human* 'should' *fit*-into" (p. 93). There are multiple ways regarding how a person experiences gender. Therapists therefore need to challenge the ways that they align gender to their perceptions to start breaking away from cisnormative assumptions and biases.

We need to understand that there is not one solution to solve the problem of cisnormativity. While we can take steps and actions, it requires a lifelong commitment to unlearning, learning, and challenging our hegemonic values, or what we've come to understand as "the way things are." Music therapists need to be mindful of how past healthcare experiences and interactions have impacted their clients. Healthcare systems continue to fail individuals of marginalized gender identities every day. Because of cost efficiency, group therapy remains as a popular medium for delivering treatment through healthcare organizations such as hospitals, care facilities, and recovery treatment centers. What is often overlooked, however, is how inclusive or not is the treatment provided towards people with marginalized gender identities. Music therapists find themselves in an important advocacy role when conducting group music therapy, and it becomes their responsibility to foster inclusive spaces for clients. For some, it might be the only gender-inclusive space they find themselves in when receiving treatment. Group therapy spaces need to be gender inclusive so that clients can feel safer, feel supported, and ultimately be able to work towards their healing goals.

Purpose Statement

The purpose of this study was to explore the ways in which music therapist conducting group music therapy come to the decision to share or not share their pronouns, and to explore their musical considerations towards pronouns in songs. Through this research, I sought to answer the following questions:

1. What conditions influence the clinician to engage in sharing or not sharing pronouns with a group?
2. How does communication of pronouns affect group rapport?
3. How are pronouns within songs considered by clinicians to use for groups?

Method

Research Design

Ontology and Epistemology. Traditionally, music therapy and medical-based research studies have prioritized using objectivist and post-positivist methodologies (Hiller, 2016). However, focusing on objective data alone might compromise the depth of understanding that can be gathered from research. For comprehensive findings, an array of research methods are needed to answer different kinds of research questions (Bruscia, 2005). Use of subjectivist methods bring the focus towards identities and attributes that shape the participant's experience. Additionally, subjective methods can work towards understanding topics in a more holistic way.

Social construction is understood to be how people form ideas and opinions through the way they experience the world (Matney, 2019). An individual's experiences lead them to act upon what they formulate their reality to be. The constructivist paradigm operates on the assumption that "meaning is created through interactions between object and subject" (Matney,

2019, p. 17). Constructivism negates the idea that there is one singular reality. Instead, multiple realities have been constructed from the lived experiences of a person or groups of. Because realities are understood as constructions and are subject to influence from lived world experiences, researchers' values cannot be held independent of the research they conduct (Mertens, 2015). Constructivism provides a holistic scope of collected evidence and the sociocultural impact that it has upon a person's lived reality. This type of research cannot only validate experiences but can also raise consciousness towards the realities of oppressed persons (Henrickson et al., 2020). As music therapists, it prompts us to analyze the lived experiences of the phenomenon that is being researched. Thus, data collection and analysis can be done through thematic analysis of semi-structured interviews between researcher and participants.

Methodology Rationale: In thematic analysis, semi-structured interviews provide the researcher with the opportunity to identify and interpret themes or patterns that arise within the data (Naeem, Ozuem, Howell, & Ranfagni, 2023). This type of analysis can reveal additional curiosities that are influenced by the original research questions in respect to acknowledging the multiple realities experienced by participants. I utilized semi-structured interviewing instead of completely structured interviewing, as the latter would not allow for the improvisational nature of the conversation to flow in ways that deepen the responses of the participants. I was therefore able to ask for clarifications that illuminated new curiosities for future research and add context to answers provided. This was necessary for the purposes of this research given the fact that the experience of sharing pronouns varies depending on how a person performs their gender and various dynamics within the group clinical setting. Use of the same core questions for participants provided congruency in all the interviews. By allowing for deviations from the core

questions, a richer understanding of participants' experiences was able to be collected within the data.

Participant Recruitment Participants were gathered by posting on Facebook pages such as "Music Therapists for Social Justice" and "Music Therapist Unite." While snowball sampling was considered as a recruitment method to be used only if online interest was minimal, it was not necessary to utilize. Those who were interested filled out a Google interest form that was attached to each online post. Responses were collected and sorted by the researchers to ensure that those interested met the following criteria:

A. The participant is 18+ and is a board-certified music therapist
B. The participant currently practices music therapy in a group setting
C. The participant was comfortable remaining in contact with the researchers for the duration of study
D. Participants were demographically diverse according to race, ethnicity, age, neurodivergence, and gender identity

Participant Demographics. Selecting participants for this study was done with the intention to (1) represent a wide range of demographic diversity and (2) consider the intersectionality of participants to be included. This was done with the understanding that a person's held identities affect their experiences of sharing pronouns with clients. To attempt equitable and diverse representation, race/ethnicity, gender, sexuality, ability, and age were prominent considerations when selecting participants from the pool of those who showed interest in participating.

A total of nine responses were received through the interest in participation google form. Both researchers collaborated in choosing five participants for this study, and they were

contacted via email about their selection. Due to the small pool of interested participants, it is acknowledged that diversity amongst participants is somewhat limited.

Participants ranged in age from 24 to 46, with the median age of 40. Three of the participants identified as cis women, one identified as non-binary, and another as gender fluid. Three identified as white, one as biracial, and one as Latinx. Three of the participants identified as neurodivergent, one as Autistic, and one as neurotypical. Two of the participants identified as disabled.

Data Collection. Data was gathered through qualitative interviews of participants. Semi-structured interviews allowed the researcher to interact with participants and probe with additional questions to gain a holistic understanding of their experience (McIntosh & Morse, 2015; Mertens, 2015, p. 384). Open-ended questions granted participants the ability to disclose what they believe was necessary, while granting space to explore curiosities as they manifested during the interview session. To challenge the typical hierarchical relationship between research and participant, the research remained in contact with participants during the research process and provided opportunity for them to confirm accuracy of data collected. By having the participants involved throughout the process and using direct quotes from them, this increased the trustworthiness of the findings.

Pre-Interview Procedures. Prior to interviewing, participants were contacted via email to establish a time and date for their interviews via Zoom. The interviews ranged in lengths of time from 40 minutes to 75 minutes, with a mean of 55 minutes. Each participant was sent a consent form and a video audio release form in which they had to return signed before establishing a meeting time. None of the participants chosen requested accommodations in addition to materials sent to them.

Interview Procedures. Interviews were conducted and recorded over Zoom. To transcribe interviews, the Zoom transcription service was utilized first. After downloading the text file from Zoom, any necessary edits were made to the transcriptions by listening to the audio recording of each interview so that the interview material was verbatim. After each document was corrected, a copy of the transcript was sent to the respective participant to ensure accuracy. After each participant confirmed the information transcribed was correct, a thematic analysis was performed.

Ethical Considerations. As a cisgender researcher engaging in gender research it was imperative that I engaged in reflexivity of my own biases and inherit gender privilege. It was my job as the researcher to ensure that I approached this study in a way that honored the lived experiences of the participants. Receiving feedback from peers, peoples of gender expansive communities, and seeking out additional ethics principles were important steps in the analysis and interpretation of the data.

The field of music therapy is relatively small and, therefore, participants in this study were at a higher risk to be identified based off shared information. People holding gender expansive identities may experience various social, emotional, and political risks when sharing their experiences (Henrickson, Giwa, Hafford-Letchfield, Cocker, Mule, Schaub, & Baril, 2020). To ensure the confidentiality of participants, precautions were taken such as assigning pseudonyms, aggregating participant demographics, and password protecting files. Additionally, the participants finalized what parts of their demographic information would be shared in the study so that nothing would be too revealing of their identity. Once the project was completed, transcripts and recordings were deleted.

There were no anticipated emotional risks for this research; however, as the researcher I was prepared to provide resources for emotional supports if necessary. Before finalization, member checking through email correspondence was utilized to ensure accuracy of collected data and to possibly uncover additional subthemes.

Data Analysis and Interpretation Procedures After interviews were transcribed and finalized, each transcription was read and reread several times. After the initial read through, I sat down and coded the transcripts. Once codes were generated and consolidated, I reviewed the codes to discover what themes emerged in the data. I utilized the software program ATLAS.ti to organize the data. Throughout the process, I consulted with my research advisor.

Location of the Researcher Providing a statement of my held identities is important for the nature of constructivist research. By acknowledging my identities, I also acknowledge that, while I took effort to minimize my bias, my sociocultural location influences how I understand and interpret the responses of the participants and the questions being asked in a research process. By stating my identities, I want to honor the idea that these are not fixed and rigid, rather they are capable of changing over time. At the time of writing this thesis I am a white, lower middle class, cisgender female, bisexual, able-bodied, and mentally ill person. I have resided within Western Pennsylvania for my entire lifetime and am a native English speaker. While I acknowledge how my identities have shaped my lived experiences, I also aim to hold myself accountable for biases and privileges I enact upon other marginalized people and hope to further unlearn oppressive practices.

Findings

The purpose of this study was to explore the ways in which music therapist conducting group music therapy come to the decision to share or not share their pronouns, and to explore

their musical considerations towards pronouns in songs. Four main themes emerged in the data: 1) Potential for harm (which had 5 subthemes); 2) Culturally affirming practices (which had 5 subthemes); 3) Context (which had 7 subthemes); and, 4) Musical considerations (which had 3 subthemes).

Table 1: Themes and Subthemes

Themes	# of Participants who endorsed the theme
Potential for Harm	
Assessed harm to therapist	4/5
Potential harm towards the client(s)	4/5
Establish Rapport [Trust and Comfort]	3/5
Client Advocacy	2/5
Therapist Assumptions	3/5
Culturally Affirming Practices	
Therapist's Values	3/5
Affirming Client Identity	3/5
Therapist Sociocultural Awareness	5/5
Therapist's Philosophical Framework	3/5
Therapist Self-Disclosure	4/5
Context	
Group Makeup	5/5
Clinical Setting	5/5
Geographic Location	3/5
Facility Policy and Attitudes	4/5
Clinical Goals	5/5
Client Cognitive Status	2/5
Group Expectations and Norms	3/5
Musical Considerations	
Artist Identity	1/5
Who Makes Music Choices	5/5
Intention for Musical Experience	4/5

Theme 1: Potential for Harm

This theme captured the harm that could be experienced by the participants, client, and precautionary elements to mitigate the potential for harm. The subthemes include: 1) assessed harm to therapist, 2) potential harm towards the client/clients, 3) established rapport measured by trust and safety, 4) client advocacy, and 5) therapeutic assumptions.

Table 2: Theme 1 with Subthemes

Subthemes	**# of Participants who endorsed the theme**
Assessed harm to therapist	4/5
Potential harm towards the client(s)	4/5
Establish Rapport [Trust and Comfort]	3/5
Client Advocacy	2/5
Therapist Assumptions	3/5

Assessed harm to therapist

Most of the participants recognized that an assessment of what potential harm could be inflicted upon them was a consideration to their experience. Participant 1 noted that a layer of their assessment was dependent upon not having a "neutral practice location." They stated, "I think it can be hard to decide if you want to disclose your own [pronouns] when you don't have your own neutral practice location, because then you are at their [the clients'] mercy. You are in their building, their literal house. And so, there's like a level of like being like, 'okay is this safe, can I do this?' Like, so if I do, what happens? And if I don't, what happens? And deciding [to

share] that way." Participant 2 noted that her sense of safety as well as the client's safety was of concern to her, stating: "…do I want to compromise my safety, but also the safety of potential group members as well within the space?" There was also reference to safety regarding how the therapist presented themselves to the clients with LGBTQIA2+ clothing and stickers.

Potential harm towards the client/clients

Most of the participants related their decision making to evaluating the potential of harm being done to the client(s) in their group. Participant 2 stated that part of her concern was singling out a group member who identified as gender non-conforming or transgender if they were to begin sharing their pronouns with a group where historically that did not happen. She stated, "there's been times when I didn't, because I wasn't doing it regularly and I was worried that I was only doing it because there was a trans or non-binary person in the group." She also reflected on her worry of singling out the group individual. "If I do say something, is it like putting like a bullseye on somebody who say is nonbinary or trans?" Other participants noted that sharing could alleviate harm experienced by their clients. Participant 1 reflected that sharing their pronouns to the group "takes the risk off the client." They went on to say: "It [sharing pronouns] takes risks off the kids. Or at least a level of it. You know they can then decide 'okay, this person is..[safe]'." For participants who identify as queer, transgender, and gender fluid, they viewed sharing pronouns as a way of taking the risk of ambiguity off the clients by communicating a sense of safety to them, and alleviating anxieties of not knowing if they could share their pronouns. These participants drew influence from their own negative experiences within healthcare settings, which provided additional insight for their considerations of pronoun sharing.

Established rapport

For the purpose of coding the data, rapport was encapsulated by responses related to trust and comfort. Participant 1 stated that sharing their pronouns helped to encourage the comfort their clients would feel when interacting with them. They described this as communicating to the clients the message of "oh, you get this." They went on to state that sharing pronouns was a way of building rapport with clients. "It also is a pretty quick rapport builder. Especially [because] so many queer kids, especially in their inpatient psych, are so vulnerable, and a lot of them don't have a ton of queer adults in their lives." They also noted that it "opens up a space for kids to feel safe to do it [share pronouns]." Participant 5 noted that sharing pronouns within group can offer a way to connect with the clients as well. They stated, "I look at the thing [group census], and I see everybody in here is using 'they' pronouns. Then that might be something where I'm gonna be like, 'hey me too, we all use they pronouns, this is really cool, isn't that fun thing that we have in common'." Participant 3 acknowledged that sharing her pronouns builds the foundations for rapport within her groups. "I feel like the impact that it has, and also through that appropriate self-disclosure as well that happens, and the rapport building that we build, it starts off the foundation for them to feel comfortable." Some participants noted that pronoun sharing was a way of demonstrating transparency and awareness of privileges, which was helpful when establishing rapport with clients in groups. Participant 5 noted that transparency was helpful towards removing hierarchical barriers between client(s) and therapist "so that you can connect."

Client Advocacy

A couple participants described the act of sharing pronouns as a form of client advocacy. Participant 5 noted that sharing pronouns is a way of "helping to create that environment and normalize it." In regards to sharing, Participant 1 also shared that their role of advocacy can look like uniting with the client to assert their gender identity in the midst of misgendering: "…when

harmful stuff is being done, like using our dead names or using the wrong pronouns, then, if they don't feel comfortable correcting somebody, I'm like, 'okay, well if you're okay with me correcting them I'm gonna correct them for you because I don't want you to feel re-traumatized by that.'" Participant 1 also noted importance to getting consent from the client to speak out against misgendering.

Therapeutic Assumptions

Three of the five participants noted that their therapeutic assumptions were an element of their decision-making process. Notably, some of the assumptions that were made in relation to how clients' visually presented in the group context. Assumptions were also made in relation to what the clients' viewpoints on gender might be. Participant 5 noted that decisions regarding safety were related to therapeutic assumptions made as a result of a group's presenting features within a "macho" group environment. They stated, "Am I negatively judging these people by assuming that they will be a little bit more conservative when it comes to gender? Yeah, I'm making that assumption." Interestingly, some of the assumptions mentioned by the participants were based on their expectations for specific identity presentations held by clients. Participant 2 noted a situation where she became aware of her not sharing her pronouns in the moment only after she saw "someone who I think was trans or maybe non-binary." Of course, this assumption suggests that there were certain identifiers that fit into her schemas of gender presentation.

Theme 2: Culturally Affirming Practices

This theme refers to ways in which culturally affirming practices were referenced or reflected by the participants. It is broken into the following subthemes: 1) therapist values, 2) affirming client identity, 3) therapist's sociocultural awareness, 4) therapist's framework, and 5) therapist's self-disclosure.

Table 3: Theme 2 with Subthemes

Subthemes	**# of Participants who endorsed the theme**
Therapist's Values	3/5
Affirming Client Identity	3/5
Therapist Sociocultural Awareness	5/5
Therapist's Philosophical Framework	3/5
Therapist Self-Disclosure	4/5

Therapist values

The theme of therapist values relates to how the participants understood their beliefs of authenticity, importance, and sense of responsibility. Regarding authenticity, Participant 3 noted "sharing my pronouns and things like that align with my belief of like authenticity within therapy." She also stated: "I don't want to discourage someone to feel like they can't share their identities." Participant 5 stated: "I think [it's] important for some of my patients to know that they have therapists who are not [cisgender]." When describing values, descriptors such as "responsibility," "I value," "it's our job to," and "align with my beliefs" were used. Empathy, humility, autonomy, and authenticity were also seen as important values to the participants.

Affirming client identity

A few participants noted how therapeutic decisions to affirm a client's identity implemented culturally affirming practices and visibility. Describing the work with their groups, Participant 1 highlighted the importance of modeling survival to transgender clients. "They've [the clients] never met a trans adult or an adult that they know is trans, let alone someone that

they see like in a situation that they can look up to as a functional role model versus people in the media." Participant 5 noted that sharing gender identity with adolescent clients can model "that people can survive and become adults." For non-cisgender participants who were working with adolescents, providing positive narratives about transgender and gender-nonconforming adults was an important part of their advocacy. Some participants also mentioned that supporting gender exploration within their groups was a way of demonstrating advocacy for clients. One participant mentioned providing gender affirming gifts to clients and coworkers such as pride postcards and art.

Therapist's sociocultural awareness

All the participants related their processes to their sense of self and their awareness of the impact of their sociocultural identities within the therapy space. Participant 4 stated: "… a big part of that is being able to just be comfortable enough in my own identities that it doesn't matter if people don't recognize them, you know?" She also noted that identifying as cisgender influenced her perception of sharing her pronouns with clients. "It doesn't bother me, so it feels not very important, and that's less to. . . And I guess well, I guess that is … that is related to me. If it bothered me to be misgendered, I would probably make sure that it was clear what gender identity I have, what pronouns I want to use." Participant 2 also acknowledged that her cisgender identity had an impact on the risks associated with sharing her gender identity. "I think the fact for me that I am cis that it's not a risk to me." Participant 5 noted that their autistic identity was influential to their relationship with their gender, and influential to their comfortability with sharing. "…being autistic is like a big factor that influences how I think about it and just like my comfort. I'm sure that it influences how I want to talk about myself or how I feel." Some

participants noted that their comfort within their sociocultural identities was impactful to how they understood sharing pronouns with groups.

Therapist's philosophical framework

This subtheme consisted of ways that participants understood their philosophical frameworks of practice and the influence of their framework on implementation of pronoun sharing. Influences of frameworks that were identified by the participants included social justice-oriented ideals as well as queer theory, systems theory, and resource-oriented ideals. Participant 1 described their philosophy of therapy to be "radically affirming, radically honest," "social justice oriented," and described it as a "queer version of resource-oriented music therapy." Participate 3 stated, "I believe that therapy is political." She also stated "…sociocultural identities are important to talk about in therapy. Because so often they're the source of so much of our like struggle which then impacts our mental health." The tenets that are important to practice as described by the participants suggest that they draw from social justice frameworks.

Therapist's self-disclosure

Four of the five participants stated that self-disclosing identities such as gender was an important element in their approach to therapy. Participant 3 stated that self-disclosure fit into her emphasis on authenticity when working with clients. "I just I really think it is beneficial to a lot of our clients if we are our authentic self and if we're transparent." Participant 1 noted how disclosure of identities serves to encourage future-oriented thinking with clients. "As someone who holds all these identities is really powerful for them. I think especially in situations where there's so little future-oriented thinking and insight and hope, it can provide a sense of like, 'oh, I've never thought about like I might be an adult one day, and there are other adults who use they/them pronouns it's not just me'." Most of the participants also noted that they had some sort

of verbal introduction about themselves that they routinely began groups with to present certain identifiers and information about the group.

Theme 3: Context

This theme included contextual factors that participants identified as important in their therapeutic decision around pronoun sharing. This theme had the largest number of subthemes. The subthemes are: 1) group makeup, 2) clinical setting, 3) geographical location, 4) facility policy and attitudes, 5) clinical goals, 6) client cognitive status, and 7) group expectations and norms.

Table 4: Theme 3 with Subthemes

Subthemes	**# of Participants who endorsed the theme**
Group Makeup	5/5
Clinical Setting	5/5
Geographic Location	3/5
Facility Policy and Attitudes	4/5
Clinical Goals	5/5
Client Cognitive Status	4/5

Group makeup

All participants noted that considerations for their group's makeup was of importance when considering whether or not to share pronouns. In the context of this research, group makeup encompasses ages of participants, size of group, frequency of meeting, and purpose of group meeting. Participant 1 said that a "high percentage of the kids we see are queer." They also explained that, with older adults, pronoun sharing was not typically done. "I did not usually do it [sharing pronouns] when I worked in older adult care." Participant 4 said that with her older adult groups pronoun sharing was not something she did, stating "they're older adults and so that feels weird in that context." The group size was not seen as a factor towards sharing, however the turnover rate for clients was. Participant 5 said that, for their inpatient group, the timeframe of treatment was influential for clinical decisions. "I don't do that [sharing pronouns] in my inpatient groups as much just because it's such a short period of time, and I don't ask for a ton of insight-oriented content in inpatient psych." There was consideration shown to the group's purpose of meeting, which related to different identities held by the clients. Participant 5 reflected that, for veterans or first responders groups, sharing pronouns was something that "I just never brought that up" and "I would actually like try not to wear any of my rainbow shirts or my pride shirts." Considering all the participants drew awareness to their group context, it suggests this is an important consideration.

Clinical setting

Considerations regarding clinical setting relates to the communities and establishments the participants conducted their groups in. Participant 4 noted that for her group at long-term aged-care facilities that pronoun sharing is not within the clients' context. She shared her assumption that, "It's really a modern phenomenon and so it's not part of their context." She also shared, "I don't think there are people that would not be meaningful to them, but just that the

majority of folks grew up in a context where I've lived in a context for most of their life, where people didn't do that." She also noted that she believed that her gender identity was not related to the therapeutic process with her clients. She stated, "…in the context of my group work in the long-term care facilities where I have contracts, my identities are not central to the process." Participants 1, 2, and 3 all provided group therapy services within psychiatric hospitals. Participant 5 provided group therapy to a community mental health clinic. Participant 2 also referenced several contexts including outpatient SUD, group homes, and outpatient groups.

Geographical location

Three out of the five participants referred to their geographical location as being influential to their decision around sharing of pronouns. Participant 2 noted that, in her large city, pronoun sharing isn't a radical idea for most. She stated, "….it's not like a radical thing here to share my pronouns. People expect it." Similarly, Participant 1 noted that "where I live is very queer friendly." And regarding pronoun sharing, they said, "I'm also seeing this all like in my social community spaces. Like it's not just happening at work." Participant 5 noted the risks that are associated with living in Texas and sharing gender identity. "I'm in Texas. So, it's like and maybe 5 years ago that's when I could kind of experiment more and talk about it more openly. But the transphobia, the homophobia, like all of those things, is just getting really a lot worse. And so it's like, I kind of try to just hide, to survive." Participants were from various regions across the country: Texas, Illinois, Michigan, Pennsylvania, and Wisconsin. All the participants provided group therapy in suburbs and/or cities.

Facility policy and attitudes

Four out of five participants mentioned the facilities they work with being influential to their clinical decisions. Facility policies and attitudes include paperwork, intake procedures,

affirming practices, workplace culture, and held beliefs of the institution(s). Participant 3 stated: "the hospital regulations are very conservative." Participant 1 and 5 both believed their facilities to be very affirming to transgender and gender non-conforming people. Participant 1 mentioned a virtual practice where respecting gender identity was ingrained into the workplace culture: "…that was also standard practice. You did names and pronouns every time, they were in your Zoom bio, every therapist had LGBTQ competence training, and most employees were queer." They also disclosed that the hospital they facilitate groups at has "no gender segregation" and a "gender forming clothing closet." Participant 5 noted that at the community center, "it's really part of the culture to like respect people's gender and their pronouns," and "they really try to make it an inclusive environment, even when it comes to selecting the patients." For most participants, it seemed that their facilities were gender affirming, and aligned with their held therapeutic beliefs and practices.

Clinical goals

All participants referred to the clinical goals of the group being a factor when considering the sharing of pronouns. There were frequent remarks made about meeting the clients where they need to be met, such as Participant 5 who questioned "what do these specific individuals who are in the room right now, what do they need today?" Participant 2 shared that she determines goals "in the moment with the group every time we meet." Participant 5 also stated:

> "the reality is like these are people that are dealing with suicidality and just getting their basic needs that get, like 'how do I get out of bed?' Just this for a lot of these folks if they were able to get out of bed and brush their teeth and put on clean clothing and like wash their face and physically transport their bodies to

> group. That is like an enormous success. So, I don't need to, on top of that, be trying to change their views about gender."

Participant 4 stated that: "As long as you're engaged in what we're doing, it doesn't matter if you recognize me for who I am at all." Her goals focused on memory, communication, and socialization. Coping skills and emotional regulation were common goals focused on by the other participants.

Client cognitive status

Level of cognitive functioning of the clients was mentioned by a few of participants. Participant 1, 3, and 4 all mentioned dementia in relation to their older adult groups. Participant 4 stated: "I don't think that it [sharing pronouns] makes any difference. Like I said, I feel like it's kind of background noise, the same as telling everybody what day it is. You know, 'today's Wednesday, January seventeenth.' By the time I'm done saying it out loud, nobody remembers that it's occurred." She added, "Sharing my pronouns, I think, would be the same sort of background noise as sharing the date." Regarding older adults, Participant 1 also remarked that "just like knowing that it was a locked unit, knowing the cognitive abilities and status of like people I worked with, they were barely gonna remember my name. I did not feel like that was, if I'd said it, it would have either cause confusion and irritation, or it would not have been remembered." Participant 2 identified severe psychotic illnesses and episodes as a consideration, that is, the client's presenting cognitive status, such as a client in psychosis, when deciding whether or not to share pronouns. Cognitive status was reflected in different communities and ages of clients by the participants. The participants seemed to correlate best practice reflection when considering sharing in regard to cognition status of their client(s).

Group expectations and norms

This subtheme depicted how each group's established expectations of behavior, etiquette, and ways of interacting with each other were influential to participant's decisions regarding pronoun sharing. Participant 1 noted that sharing their pronouns was a way of establishing a norm to share with the group members: "Usually when I did it, parents would do it." Participant 5 observed how the group members would set the norm of pronoun sharing: "most groups when they're introducing themselves, they're saying their pronouns and I'll like, let the patients kind of start." Participant 2 noted that for her adolescent group "they just know it's not the place to be bigoted outwardly." There were also ways in which the participants set specific guidelines in place for clients in their group. Participant 5 stated their expectation as being "you're gonna have to respect other people. And if you can't, this isn't the right group for you." Participant 3 was specific about the expectations she implements with her groups:

> "I am very quick to be like, 'alright, these are our boundaries.' And like even like before that, you know, like I do have like group guidelines that we read every group. And you know so many of the guidelines are like 'be supportive of each other, be respective or respectful to each other,' like no negative or derogatory language. Like, if you talk negatively about any like cultural or ethnic or racial group like, you know I will call you on that. Like if you continue to have like negative, hateful behavior, I will ask you to leave group."

Participant 2 noted that having groups where norms have already been established for a long period of time would be a barrier for her transitioning to sharing pronouns. "I guess I'm honest, like, if I wasn't doing it, and I've been working at a place for a very long time, it's harder to make that change." In some cases participants noted that establishing boundaries and expectations was

helpful in forming the group's overall expectations, whether directly stated or implied by the participant's therapeutic framework.

Theme 4: Musical Considerations

The last theme, musical considerations, relates to how the participants described their musical decisions such as their choice of songs to bring into the therapy space. This theme contained the smallest number of subthemes: 1) artist identity, 2) who makes music choices, and 3) intention for musical experience.

Table 5: Theme 4 with Subthemes

Subthemes	**# of Participants who endorsed the theme**
Artist Identity	1/5
Who Makes Music Choices	5/5
Intention for Musical Experience	4/5

Artist Identity

One participant noted the importance of thinking "who is the music coming from," and "I want queer people to feel represented." Despite only one participant speaking to this, it was decided to be included with the findings because it speaks to critical reflection of music utilized in the therapy space. Additionally, reflecting on who the music came from was in tangent with reflecting on the purpose of providing that music to clients.

Who makes music choices

All the participants incorporated ideas of who decides on music to utilize for groups. The data showed a range of perspectives regarding this, including the participant choosing, the group members choosing, or a collaborative approach to choosing music. Participant 4 stated that she chooses the music for her groups: "I usually try and use songs that are sort of generally what people are familiar with generally what people like." Participate 2 related that she asks the question "What do you all want to do with it?" as a way of approaching collaborative music choices with her groups. Participant 1 mentioned that having a collaborative approach to song choices was a way of practicing "good" and "bad" decisions and discernment. "…you should know how to discern music you like...Also, you are here. Like we are in inpatient psych, I think at this point you've realized, if these are good or bad decisions because you are here, you have seen the impact of set decisions in some way or another." Participant 5 described bringing in a list of songs for group members to choose songs from instead of picking the music for them, adding "it is really rare for me to select the music that we listen to." All the participants were aware of power differentials that could be communicated by who chooses the music, and this seemed to be a way of them addressing client/therapist hierarchy as well.

Intention for musical experience

Four of the five participants considered their intention for the music and musical experience being conducted with their group. Regarding pronouns, Participant 4 mentioned: "if the lyrics of the song make more sense as the gender that it was written as I want to stay authentic to that" and "if it's meaningful that it's a man who's singing it, or a woman who's singing it, I'll keep it with the original lyrics, the original pronouns, the original everything." Participant 2 said, "I purposely shared music that has either they/them pronouns" and "changed pronouns around it like as a support thing for people who are non-binary." Participant 3 reflected

that "it's so important that you know my clients see themselves represented in the music that we choose to bring into their group" and when bringing in songs for a group "I'll do them [songs] in a way that's more aligned" with the gender expression of the client(s). Most of the participants related their decision to the meaningfulness for the client experiencing the music. Participant 4 mentioned that if a song was personal to them, then the pronouns would be changed to match what the client wanted. While most of the participants reflected on how music would be meaningful for the clients, it is interesting that Participant 4 also notions towards meaningfulness for the songwriter's intention with the song.

Discussion

This research explored: 1) What conditions influence the clinician to engage in sharing or not sharing pronouns with a group? 2) How does communication of pronouns affect group rapport? And, 3) How are pronouns within songs considered by clinicians to use for groups?

Conditions influencing to share or not share

The findings show that there are many contextual elements that went into participants' decision of choosing to share or not share their pronouns with their music therapy groups. The data also suggest that there were interpersonal elements that influenced this decision. A common reason for not sharing pronouns was due to time constraints of therapy, sociocultural factors of the group members, and clinical goal priorities recognized by the participants. Participants were also conscious toward how sharing pronouns could get the group 'off track' from the group's goals. This is reminiscent of points shared by Singh and Salazar (2010) who noted that social justice aligned practices are often overlooked due to clinical priorities of the clinician. Biedka (2022) also found that prioritized clinical focus was a contender for how affirmation of gender and sexual identity could be communicate with clients.

Safety for the client was an important consideration for participants. To avoid drawing attention to a client, at times sharing pronouns was not initiated by some of the participants, even when pronouns were shared routinely. Interestingly, this consideration was only raised by cisgender participants. Even with good intentions, harm reduction efforts can result in greater harm for the client and towards the therapeutic relationship. I think this can also be expanded to how the therapist responds to situations where sharing pronouns opens potentially harmful comments. As Neumann (2023) suggests, responses from the therapist can either help or fail to communicate trust and safety. This makes me reflect on how our ways of responding to gender microaggressions are as equally important as creating space for sharing pronouns. This is in line with McSorley's (2020) identified need for dialogue and support when processing gender microaggressions. As a cisgender therapist who faces less risk with sharing pronouns, I must reflect on how I need to hold myself accountable to navigate situations where I need to show advocacy for clients with marginalized and minoritized gender identities. This finding also prompted me to ask: How can we ensure accountability for cisgender therapists when implementing inclusive practices? How can we best prepare for navigating conversations of gender with clients, and utilize our privilege in a way that also avoids saviorism and reduces the propensity for harmful avoidance of pronoun sharing?

The facility's policies and attitudes were also an element of consideration by the participants. There were some facilities mentioned that did not involve any inclusive practices according to gender identity, particularly within psychiatric and older adult communities. However, there were also facilities that were described as very gender affirming for patients. These facilities also were described as having a higher number of gender expansive clients or being sought out after within the transgender community, particularly by young people. These

facilities recognized the need for inclusive efforts for gender non-conforming clients, and by creating gender inclusive policies these facilities attracted transgender and non-binary clients to receive care there. Furthermore, facilities with gender-affirming practices were viewed as an important resource for transgender and gender non-conforming communities, particularly regarding accessing safe, quality healthcare in areas that were outside cities and seen as homophobic and transphobic. The findings reiterate the importance of research that demonstrate the lack of inclusive practices for gender expansive communities, as a barrier for people accessing healthcare (Costa, 2023; Hostetter et al., 2022; Nic Giolla Easpaig, et al, 2022). Participants in this research mentioned that staff at their facilities were influential in the overall attitudes towards gender inclusion. There were mixed responses as to how staff were or were not gender inclusive. Participants acknowledged that navigating a systems-based approach in therapy while facing staff pushing back on inclusive practice was a challenge in the clinical space, drawing parallels to Hardy & Monypenny's (2019) research. This research also supports findings that healthcare clinicians continue to fail to provide inclusive care and hold misunderstandings about gender (Ghorbanian et al., 2022; Hostetter et al., 2022; Smith et al., 2021).

Something that I found to be interesting as I was examining the data is how most of the information gathered on clients by the participants was based upon how they presented themselves, their age and generation, or if they belonged to a social group that was seen as hypermasculine. The decision to share or not to share was based on assumptions related to how the participants perceived client(s). As the researcher, this encouraged me to reflect on how I "expect" gender identities to present to me, and where these assumptions come from. Also, when working with certain communities how do I create negative stereotypes of intolerance and does that impact the way I bond with clients?

How does communication of pronouns affect group rapport

Participants frequently mentioned rapport and the impact of how pronouns sharing would positively or negatively affect the therapeutic relationship. Authenticity, trust, validity, and comfort were key words used by participants when describing the relationship with their clients. Power dynamics between client(s) and therapist were reflected by almost all participants. In some situations, the decision by participants about whether to share their sociocultural identities, such as gender, was purposely done in effort to minimize the hierarchal distance between therapist and clients. This included the language used to reflect their positioning to foster the relationship, which supports the findings by Smith et al. (2021) that reflexivity towards language was a way to strengthen authenticity in the therapeutic relationship. Additionally, use of correct pronouns and names by the participants was seen as fostering empathy, empowerment, and respect with clients. This draws parallels to Hostetter et al. (2022) study that demonstrates how correct names and pronouns communicated by clinicians communicated respect to gender identity, and overall was influential to having a positive healthcare experience. Although nonverbal language was not included as a consideration in this study, von der Warth et al. (2023) suggest that body language and tone of voice are also elements of positive atmosphere that could influence rapport quality between practitioner and client. The inclusion of nonverbal communication factors within this current study would have potentially expanded the research findings.

Clients were described as having negative visceral reactions to deadnaming and incorrect pronoun usage. While Nadal et al.'s (2010) study focused on sexual identity, similar negative interactions were described by the participants when their clients experienced harmful interactions. Interestingly, participants did not recognize instances when sharing pronouns

inhibited the relationship. But for the groups that they did share about, the participants described examples of clients confiding in them about personal, gender experiences. This makes sense as correct pronoun and name usage can communicate trust and respect in healthcare settings (Sevelius et al., 2020).

Therapeutic relationships either stabilize or destabilize systems of power (Biedka, 2022; Hadley, 2017). Self-disclosing gender identities to clients was viewed as having a positive impact on rapport. This is consistent with findings from Biedka (2022) and Hardy and Monypenny (2019) where self-disclosure was found to be valued by clients with marginalized identities. Gender identity was sometimes avoided by the participants while leading groups in order not to create friction between clients/therapist. These instances were mostly described by the participants who were cisgender and heterosexual. In attempts to remain neutral on the subject, this would fall into one of the seven discriminatory practices identified by Shelton and Delgado-Romero (2011) of avoiding or minimizing identity, and as a microaggression as described by Hadley (2017).

How pronouns are considered for songs used by clinicians

The findings show that there was consideration as to how gender was communicated through the songs used in clinical settings and that consideration expanded beyond pronoun usage. Acknowledgement towards the overall messages and themes communicated by the song used for session was of greater concern. Musical choices were made regarding how a song could be meaningful to the client. The participants were aware of ways that cisgender narratives were typically used in songs as noted in previous music therapy literature by Rolvsjord and Halstead (2013) and Scrine (2016). I found it interesting that meaningfulness to the client remained one of the biggest considerations for selecting music, and, in most cases, the clients chose the music to

be used during sessions. Clients choosing the music was also seen as a way of empowering the client to make decisions and take ownership of material in the session. McSorley (2020) also draws attention to the importance of questioning music's role in empowering or disenfranchising the client. In some situations, the participants would offer to change the pronouns, but would ultimately have the clients choose how they wanted the music to represent themselves. Collaborative song choosing between client and therapist could also be viewed as "shared-decision making," an element of health communication that transgender clients view as important when interacting with practitioners, along with empathy and compassion (von der Warth et al., 2023, p. 3).

Implications for Clinical Practice

This study focused on the considerations of sharing pronouns within the context of group music therapy. The findings, in addition to existing literature, demonstrates how disclosing gender identity could be impactful for clients. Depending on the sociocultural identities of the group members, there are different realms of safety for the clinician when considering sharing pronouns. Music therapists who hold dominant identities and are at less risk, such as cisgender clinicians, need to consider what the impact of sharing pronouns can have for a group. The 2019 AMTA member survey and workforce analysis reported 87% of clinicians being "female" (presumably cisgender), 12% being "male" (presumably cisgender), and 85% being "white" (American Music Therapy Association, 2019). No data is reported regarding transgender, nonbinary, and gender expansive individuals. While the survey isn't conclusive of all practicing music therapists, the data demonstrates how the field is made up predominantly by people who are white and presumably cisgender. It is important to highlight that sharing pronouns is only a part of what gender inclusive practice could look like. Clinicians should also engage in critical

reflexivity towards their biases, practices, and therapeutic discourse. Hadley and Norris (2015) suggest strategies to aide with increasing cultural awareness and sensitivity: 1) examine the societal systems that perpetuate inequality and inequity, 2) explore your cultural identity, 3) explore your own intrapersonal communication, and 4) stay engaged. These strategies are important for all to use, but especially for those who are members of groups that hold power, and who may be perceived as threatening for people with marginalized and minoritized sociocultural identities.

For some clients, the sharing of pronouns might offer a sense of being seen and communicate a message of respect and empathy (Smith et al., 2021). However, in other contexts it potentially would be harmful for the client to feel compelled to share in group. In this situation, the clinician could interpret a practice to be affirming, when instead it could be enacting harm.

McSorley's (2020) study on gender microaggressions in music therapy acknowledged a need for continuing conversation and exploration around gender microaggressions in therapy, starting with the clinician examining their cultural biases, values, and beliefs. Neumann (2023) encourages music therapists working with queer clients to seek out supervision from a supervisee of similar identity, or who is "advanced in their sexual and gender identity development" (pp.31). In an effort to reduce harm to clients, this is an important step for cisgender music therapists to engage in, especially when working with people who align themselves with gender expansive communities. Additionally, Neumann provided a series of reflexive questions to aide music therapists in their sociocultural self-reflexivity regarding one's gender and sexuality.

The facilities in which the participants work played a major role into their pronoun sharing considerations. Some facilities were seen as being very innovative in terms of inclusivity to sexual and gender identities. However, there were others that had neutral or no considerations

to inclusive practice. There are many facilities within the United States that continue to fail to acknowledge and consider the harm of systemic oppressive practices and policies (Costa, 2023; Williams & Rucker, 2000; Yearby, 2020). When working in clinical spaces that are non-affirming for clients, music therapists may find themselves advocating for change in their workplace or navigating relationships with colleagues who do not value inclusion. I think it is important to consider how we are training music therapists to be advocates for their clients. This could look like incorporating Hadley and Norris's (2015) strategies in student supervision; however, I also believe that students need to practice how to have conversations with clients and staff. Owen et al. (2014) found that within their participant pool of clients receiving therapy, 76% of them reported that the microaggression experienced was not addressed by the therapist, negatively impacting their overall rapport in comparison to those therapists who did discuss the microaggression with their client. Hadley (2017) emphasizes that music therapy education needs to work towards disrupting oppressive practices. Music therapists need to be able to address and navigate discussions around microaggressions, especially since implementing inclusive practices to a group such as pronoun sharing could trigger a harmful response from a group member. Incorporating practice of addressing microaggressions in addition to multicultural reflexivity and learning would be an important element for training music therapists in attempts to reduce harm.

Limitations

There were several limitations associated with this study. The first limitation I want to acknowledge is the impact of my biases. I understand that me being cisgender influenced what emerged for me in the data. I also understand that the data analysis was done so with the lens of a cisgender researcher, and that itself is a big limitation to this topic. In context of the research's design, recruiting participants through means Facebook groups limited the possibility of other

eligible and/or interested participants. The pool of participants was limited in terms of a range of sociocultural identities represented, as three of the five participants identified as cisgender. Having a more diverse participant pool, especially regarding gender, would have likely produced different data. Participants were required to speak fluent English for the interview, which excluded music therapists who speak other languages. Additionally, all the participants were from the continental United States only.

Being cisgender also influenced how I chose to explore certain answers provided by the participants or when not to explore something stated. Being a novice researcher and having never conducted qualitative research before, my experience may have hindered the quality of the data collection and analysis process. The questions could have been formulated in a way that encouraged participants to explore their privilege and implicit biases in greater depth. Additionally, I could have utilized more exploratory questions to gather more information within the interviews. I recognize that there are elements of myself, such as my internalized people-pleasing habits, that influenced the way I interacted with the participants during interviews. Additionally, my knowledge of gender and queer theory literature was novice at the time of my designing this study. Someone with stronger existing knowledge about gender, queer theory, and therapy may have chosen different questions to use to explore my topic.

Finally, I view my lack of experience as working as a music therapist as a limitation. At the time of formulating this project, I have been practicing for less than five years. My limited experience in the field influenced the way I created my questions and analyzed my data.

Throughout the extent of my research, I failed to journal routinely. I believe this impacted the ways I processed and reflected while conducting interviews and data analysis. Personally, I feel that my dedication to this research had an ebb and flow to it over the course of its

completion. There were many times throughout my master's degree where I was not giving my all; finding myself easily distracted with maladaptive coping routines in response to major life events I was facing at the time. And at the same time, I recognize that this was an abuse of my held privilege in being able to further my education and having the opportunity unlearn oppressive practices I have learned from within my membership in dominant sociocultural groups. These factors ultimately impacted the ways I approached this thesis.

Recommendations for future research

I believe that there are many directions this topic could branch into with future research. Such a topic could be exploring how harm is carried out through music therapist's assumptions of gender, and how the harm is processed afterwards by the therapists. It would be equally important to include participants of group music therapy to explore ways that harm was enacted, as it could illuminate assumptions that clinicians have about gender affirming practices that they themselves are not recognizing. It would also be important to investigate specific ways music therapists engage in reflexivity about gender identity and explore their assumptions and biases.

The participants in this study expressed curiosities that could expand this type of research. Participant 5 suggested that it would be good to have research that explores how music therapists can best support a client who is exploring their gender, and research focused on ways that harm could arise from what is viewed as gender inclusive practices. Participant 3 mentioned that exploring music therapists' educational experience regarding gender identity and expression during training would be an area of research she would be interested in. Participant 2 shared that she would be curious to explore appropriate timing of sharing with clients, and how contextual factors such as geographical location influence their perception of when clinicians should share. Participant 1 thought it could be interesting to explore how knowing demographics prior to

leading a group could influence self-disclosure, and exploring the music therapist's role of advocacy while working in environments that are not affirming.

Conclusions

All clinicians should be proactive in assuring correct pronoun use when interacting with clients in their care. Music therapists can demonstrate an aspect of gender inclusive practice by recognizing the importance of sharing pronouns. The decision to share or not to share is based on contextual and sociocultural elements including what identities are held by the therapist. Sharing pronouns was also associated with rapport building, particularly transgender and gender non-conforming clients. Finally, the data suggests that gender should be considered when selecting songs for use in therapy, focusing on qualities of meaningfulness and affirmation of gender identities that go beyond the binary. Inclusive and affirming practices are more than sharing pronouns. But, by providing the opportunity to share pronouns, therapists can communicate positive messages to clients who might be apprehensive towards healthcare systems due to disempowering, harmful interactions.

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