Exploring music therapists' attitudes towards disability and sexuality

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Abstract

Music therapy has historically not addressed sex as a topic within clinical practice despite its clinical relevance to the human experience. As a field that works with an abundance of disabled clients who are often harmed by social and systemic infantilization which prevents them from access to sexual knowledge, it could be argued that music therapists should be trained to provide basic levels of support to this community in particular given the high level of need. Nevertheless, there are many questions and conflicting ideas around music therapy scope of practice as it pertains to these topics, barriers to education and clinical implementation and viable solutions to this gap in knowledge as a profession. While the music therapy literature has seen an increase in disability justice research in recent years, it offers little to nothing on the topic of engaging in clinically relevant discussion of sex, and most certainly not within the context of disability. This study aimed to examine music therapists’ educational and clinical experiences on engaging in sexual topics with disabled clients, as well as measuring personal feelings of comfort in engaging in these conversations. It was conducted via an anonymous survey intended to collect quantitative and qualitative data from a wide array of music therapists. Data was collected and analyzed according to an objectivist framework and qualitative data in particular was analyzed for common themes. Results indicate a lack of training and education in the facilitation of such topics, and the majority of participants reported complex feelings on the various intersecting layers of these conversations. While many reported feeling discomfort in relation to this topic, so too did many indicate a desire to reflect more critically and intentionally on the subject. It is hoped that this study’s data will serve as an impetus for our field to shift cultural and education practices to better prepare therapists for these conversations on these topics.

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Thank you to my professor Susan Hadley for changing my life. It's hard to list all the lessons I've learned from you, but one of the most important is the ability to see myself in the larger context of the world. You've taught me that I can be compassionate with myself and still hold myself accountable for my own baggage and its impact. You taught me the importance of community and how to be responsible within them. You modeled for me how to fight for justice in professional settings, which is something I aspire to do every day. I hope to show my appreciation to you by helping pass along these lessons to as many people as I can. Thank you for your patience, grace, and accountability.

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Motivation for Research

In my earlier years as a music therapist, I began learning from Black, queer and disabled advocates on social media which changed my perception of the world in many ways. Some of these realizations were validating for me while others illuminated aspects of my own privilege I had never before considered. This led me to join the Slippery Rock University Master of Music Therapy program, a program which focuses on social justice, critical thinking about systems, and the importance of community building. This, in tandem with my work with disabled adults in particular, encouraged me to start reflecting on the deep-rootedness of ableism and the concept of disability as a cultural taboo. It also encouraged me to reflect on where it was coming up in the places I worked, as well as in my own views and biases.

This opening of my worldview allowed me to further reflect on my perception of sex as a taboo subject in my experience as both a therapist and a patient in therapy. This is particularly so with relationships which are queer in some way. In defining queer not solely as a sexual orientation but as a way of being in the world that exists outside cultural definitions of acceptability, one could argue that disabled sexuality is inherently queer. As a queer and disabled woman experiencing her own journey toward sexual liberation, seeing my adult-aged, disabled clients act out in "sexually inappropriate" ways made me reflect on the incredibly limited access disabled adults have to sexual knowledge, particularly those who are institutionalized and/or under guardianship. I noticed that this lack of appropriate sociosexual education geared toward disabled people often leads to disabled adults not understanding sociosexual boundaries or practices, which usually leads to them being referred to as "creepy" or "weird." While people are entitled to express their authentic response to being interacted with in a way which makes them sexually uncomfortable, it seems misguided to blame people who are not given access to sociosexual education for not understanding sociosexual conventions.

Toward the end of my time in the MMT program, we were shown a documentary film called "Crip Camp: A Disability Revolution" which I found to be life changing. This film documented a group of campers at Camp Jened, a sleepaway camp for disabled teens in the early 1970s. Many of these campers ended up becoming historic figures in the Disability Civil Rights Movement. This documentary not only showed me the power of advocacy and organized movements, but also the power of growing roots in communities which fight to support each other in a world that seeks to disable them. It made me reflect on the ridiculousness of seeing disabled people openly and freely discussing their sexuality as groundbreaking, the same way any friends at summer camp would. And yet it was, because that's how little I'd ever heard it discussed clinically, socially, in pretty much any context. It made me reflect on the dehumanization disabled people experience in terms of sex but also in so many other aspects of our lives. It made me want to work to help change that.

Operational Definitions.

For the purpose of this study, I will provide several operational definitions to help the reader better understand my intentions for this research. Though disability is an expansive and widely encompassing term which applies to many different communities, I will use the term disability here to describe those specifically with intellectual, developmental and/or neurological disorders. For this research, my operational definition of sexual topics—which can include a wide variety of topics—includes discussion of sexual health, logistical and sociosexual education, sexual or romantic attraction, sexual or romantic experience, masturbation, sexual safety and consent.

To operationally define ableism, I draw on the work of Rauscher and McClintock (1997), who describe ableism as "a pervasive system of discrimination and exclusion that oppresses people who have mental, emotional, and physical disabilities…Deeply rooted beliefs about health, productivity, beauty and the value of human life, perpetuated by the public and private media, combine to create an environment that that is often hostile" (p. 198).

Literature Review

Impact of Capitalism on disability

Though ableism has existed in many forms throughout human history, disability was not defined as a social category in the U.S. until the late 19th century. This is likely due to the timing of the Industrial Revolution and the subsequent push towards a more modern capitalist social framework, one which we still live under today. The impact of capitalism on ableism and the ways in which the medical model of disability reinforces capitalist values continue to harm disabled people to this day (Jenkins, 2021). In the U.S., Jenkins argues that the dominance of white, colonial values play a considerable role in the dehumanizing aspects of capitalism on disabled people.

Capitalist ideals which value members of society based on their ability to work and contribute to the workforce breed hierarchical systems of thinking to those existing within them. Turner and Blackie (2018) posit that the emergence of capitalism in18th and 19th century England led to the systematic marginalization of disabled people in the region. As a result, disabled people were viewed as "economically unproductive 'burdens', whose inability to conform to more stringent productivity demands, work or time discipline meant that they could no longer compete in the workplace" (p. 200). This system, in conjunction with other systems that further promote these ways of thinking, led to the creation of cultural hegemonies that work to harm different groups of people, particularly those who have multiple marginalized identities. To this point, Pimentel and Monteleone (2018) emphasize the importance of considering intersectional theory, which examines the ways these hegemonies operate and impact people who have intersecting identity marginalizations such as race, disability, gender, etc.

Changulani (2023) speaks of the influence of hyper-individualism, a guiding principle of capitalism. Hyper-individualism, structurally, emphasizes maximizing profit and gain as a means to attain value and contentedness. As Finlay (2000) noted about those who work with disabled people, "professionals are seen to act on behalf of the capitalist state by individualising social problems, and suggesting that individuals are essentially responsible for the plight in which they find themselves (which) shifts attention away from the structural inequalities" (p.83, as cited in Baines et al., 2019).

Within this hyper-individualistic culture, independence and self-preservation are often viewed as the only acceptable goals. In refusing to change the cultural script on living in ways that promote healthy interdependence, community support, and networks of care, we perpetuate the juggernaut of ableism in ways that will ultimately both impact disabled and nondisabled people alike (Changulani, 2023).

Impact of the medical model on disability

While capitalism may be one of the systems that contributed to widespread ableism as a cultural concept, the model under which healthcare professionals and the institutions that commonly train them function to reinforce these harmful concepts (Lundberg & Chen, 2024; Zaks, 2023). The U.S. healthcare system, though it has made strides over the years, still operates largely under the medical model, particularly as it pertains to disability. According to the Office of Developmental Primary Care at University of California San Francisco, "the Medical Model views disability as a defect within the individual. Disability is an aberration compared to normal traits and characteristics. In order to have a high quality of life, these defects must be cured, fixed, or completely eliminated. Health care and social service professionals have the sole power to correct or modify these conditions" ("Medical and Social Models of Disability", n.d., para. 2).

Disability is still widely seen by those working in healthcare as a personal problem to be fixed rather than the result of a society which *disables* people who have impairments. Placing sole responsibility on the impairment itself allows the systems doing the impairing to keep functioning without accountability. While impairments of any kind certainly add to the experience of disability, it is unproductive to look solely at this dimension of the disabled experience. Eisenberg et al. (2015) suggested that instead of viewing impairment as a sole cause, it should be examined for the ways it interacts with the limitations of social and physical environments.

Music therapists: Us and them

The impact that these systemic influences have on the praxis of music therapy clinicians working with disabled people is vast. As suggested by Fansler et al. (2019), the perpetuation of certain hegemonic ideals reinforce the concept of borders between ourselves as practitioners and our clients. In the case of disability, ableism and infantilization, assuming incompetence and social emphasis on individualism and ability to contribute to the workforce could all be considered such ideals (Campbell, 2014; Turner & Blackie, 2018). The American Music Therapy Association Workforce Analysis data (2021) indicates a significant overrepresentation of music therapists with dominant identities (88.3% white) and gender (96.6% cisgender, 86.4% women). The lack of data cited in the study regarding disability among other salient identity markers of clinicians such as sexuality and class indicate that disability is an identity associated with only the client and not with the clinician, reinforcing an "us" vs. "them" mentality. Furthermore, identity markers such as class and sexuality not being included in the data for clients nor clinicians suggests an assumption that these identity markers are not relevant in therapy and do not impact the therapeutic process.

Therapist bias

Fansler et al. (2019) also reflected on the impact that the perpetuation of binary thinking has on our perception of what is considered "normal" and "acceptable," and how that ultimately impacts marginalized communities. They referenced Britzman (1995) in their description of this dichotomized way of understanding the world: "Britzman (1995) noted that the production of binaries and our orientation to normalcy establishes the limits of what we can bear to know, without which our certainty is uprooted." In applying this thinking to music therapists' bias toward disabled people, even the best-intentioned therapists can and often do perpetuate harmful practices towards disabled people, sometimes due to bias and sometimes as a function of their job. Considering the influence of societal ableism in combination with the prevalence of the deficit-based medical model, therapists are likely to perpetuate these ideals without actively deconstructing such views (Eisenberg et al., 2019).

When considering therapist bias, it is also important to consider practitioner's own sociocultural relationship to disability (Hadley, 2013). Though the U.S. certainly perpetuates its own set of cultural values, the vast array of cultural diversity that exists in this country also contributes significantly to different people's perceptions of these topics. Much like sex as a topic, disability is often considered its own kind of taboo across many cultures (Cousins, 2009). In considering these sociocultural factors in tandem with systemic attitudes and barriers between disabled and nondisabled people, the potential for harm to disabled clients is self-evident.

Sexual topics and music therapy

Within the music therapy literature, the practice of working with sexual topics comes up in several contexts. The most commonly studied area seems to be utilizing music therapy in working with sexual abuse survivors. Several studies have been conducted highlighting the benefits of music therapy in working with this community, ranging from the power of improvisation through processes such as Analytic Music Therapy (Strehlow, 2009) to supporting clients in finding their voice again (Amir, 2004).

Furthermore, there has been recent work implementing Crip and Queer theories together in the music therapy literature. Crip theory is an academic field named after the reclamation by disabled people of the word “cripple” (McCruer, 2006). Kalenderidis' (2020) discussion of Crip theory was the one of the only sources found in the literature that spoke about disabled people and sexual desirability:

> Crip theory represents all disabled people, eliminating disability hierarchies…To identify as “Crip” is to celebrate disability pride, which disrupts internalised ableism and societal narratives that our lives are unlivable, and our bodies/minds are undesirable. It celebrates difference and positions disability as part of the human condition (Clare, 2017). (Kalenderidis, 2020)

Gaps in music therapy education and literature

While there has been an increased push for expansive, non-hierarchical ways of thinking in music therapy (Bain et al., 2016; Baines, 2013; Baines et al., 2019; Boggan et al., 2017; Fansler et al., 2019; Hadley, 2013), there is currently nothing within the music therapy literature that specifically examines music therapists' role in supporting disabled sexuality. One can only hope that our role in supporting disabled sexual experiences is an area that will be examined more often in the future. Similarly, my search of the literature found nothing in regard to education and training for music therapists' around exploring sexual topics with their clients. Though some research indicates an extremely limited number of academic music therapy programs or trainings which cover the topic of sexuality, there is currently no professional standard or competency for this to be included in the music therapy curriculum. Fansler et al. (2019) note the role that curriculum has on a clinician's knowledge-base and thus the clients they work with. They stated, "Curriculum takes on a function of gatekeeping when we allow for only one way of thinking to be acceptable and recognized. It is the soil into which we place our roots. If our ways of researching, educating, and interacting are rooted in dominant and oppressive ways of being, our profession limits itself in its ways of engaging with other 'worlds'" (Fansler et al., 2019).

How related fields address sexual topics with disabled people

In reviewing the literature of other related fields of professionals who work with disabled people, studies from family therapy, counseling, education and hospital-based healthcare providers show that there is more research that has been conducted in these fields than in music therapy.

From my evaluation of the literature, I would argue that most healthcare fields under-address the clinical discussion of sexual topics with disabled people. In the healthcare field in general, Eisenberg et al. (2015) noted that personal discomfort around discussing sexual topics often dooms budding professionals to a lack of competence in clinically addressing these topics. In contextualizing this alongside the tendency of most healthcare professionals to work under the medical model which encourages a deficit-based approach to disability, it is no wonder that professionals in healthcare are struggling to address sexual topics with disabled clients.

Even within the field of education, it has been noted that professionals experience difficulties in delivering contextually-appropriate sex education to disabled individuals. Hall et al. (2016) noted that the U.S. has a "highly diverse patchwork of sex education laws and practices" (p. 29, as cited in McDaniels & Fleming, 2018) which often results in school districts and educators creating sex education curricula based on personal worldviews and beliefs regarding things like the morality of sex, beliefs on gender, orientation and disability. McDaniels and Fleming (2018) noted that a consequence of this is that access to appropriate sex education for disabled people (in the case of the study: intellectually disabled people) is consistently lacking.

Solutions-based thinking

Despite the challenges faced by related healthcare fields, researchers in these fields are innovatively brainstorming ways to combat these challenges. Harris and Hays (2008) conducted a study measuring family therapist's comfort and willingness to discuss sexual topics with clients. Results indicated that most therapists' will only engage in these discussions if their comfort level in doing so is high and therefore must be given ample supervision and education-based opportunities to increase knowledge and comfort in this area (Harris & Hays, 2008). Studies such as these indicate a desire within the field to examine discrepancies in care and find effective solutions to combat them. Similarly, Burnes et al. (2017) noted the importance for counseling psychologists to consider the intersection of disability and sexuality in their clinical work. They stated, "addressing clients' diverse desires and expressions is of paramount importance when clients identify as having a disability, and psychologists should understand the various ways that these identities should be brought into a sex-positive conceptualization of the client" (p. 480). Likewise, Eisenberg et al. (2015) emphasized the need for all professionals working with disabled people to be educated on a) the social model of disability and b) the biopsychosocial factors affecting sexual health both in general and in the context of disability.

Scope of practice

While addressing sexual topics may be within the scope of practice of other healthcare professionals, music therapy is not a field that specializes in addressing sexual topics. However, it is my assertion that given that sexuality is a major part of the human experience, music therapists should at the very least be knowledgeable about how to support this aspect of our clients' humanity at a fundamental level. The Certification Board for Music Therapists (CBMT) defines music therapy's seven domains of practice as a) cognitive b) communicative c) emotional d) musical e) physiological f) psychosocial g) sensorimotor h) spiritual ("Board Certification Domains", 2014). In examining these domains, it could be argued that outside of the musical domain, no area mentioned is one that music therapists could consider themselves expert in without additional training from a source outside the field. And yet, we educate music therapists to have a baseline understanding of addressing needs in each of these areas, knowing that these are needs that will likely emerge in therapy. It begs the question: why, then, are sexual topics largely ignored in music therapy?

Impact on disabled people

A lacking sexual education

Sexuality is often conceptualized by people in isolated segments rather than a multitude of aspects of the self, woven together into a rich, complex tapestry of being. While sexuality may encompass things such as sexual knowledge, attitudes, and behaviors, its definition spans far beyond these aspects alone. McDaniels and Fleming (2019) expand on the need for a more holistic view of sexuality as a whole:

> Sexuality is greater than just participation in sexual relationships; it encompasses sexual knowledge, beliefs, attitudes, and behaviors (Murphy & Young, 2005). It also includes gender expression, how we feel about our bodies, how we feel about our relationships with others, our physical and emotional growth, and how we reproduce (Alberta Health Services, 2009). Sexual development is intertwined with fulfilling basic social needs such as being liked and accepted, giving and receiving affection, maintaining privacy and control over our own bodies, and feeling attractive (Murphy & Young). (McDaniels & Fleming, 2018)

In view of this expansive definition, the need for contextually appropriate sexual education is crucial for disabled and nondisabled people alike. For years in the U.S., sexual education has been predominantly based on promoting abstinence and reduction of pregnancy and STDs amongst primarily young, unmarried heterosexual couples. Though times have changed the practices of many educators, the lack of federal standards in regards to sexual education allows for an exorbitant amount of freedom for educators to mold the curriculum around their personal views and beliefs (McDaniels & Fleming, 2018). With popular social norms and federal policies still in place that echo eugenicist sentiments, the risk of exclusion for disabled people in this regard is high (Turner & Crane, 2016). Guttmacher Institute (2016) reported that:

> 24 states and the District of Columbia (DC) mandate sexual health education, and 27 require that when it is provided, it meet specific requirements: 13 require medical accuracy of information; 26 require that the information be age appropriate; 8 require that instruction be culturally appropriate and free of racial, ethnic, or sex bias; and two prohibit programs from. (Sex and HIV Education, 2023).

Turner and Crane posit that to restrict disabled people's access to their sexual identity is to impact their well-being as a whole:

> The erotic potential of a (disabled person) is often overlooked, but according to Moin, Duvdevany and Mazor, sexual identity is very important to the 'overall psychological well-being and life satisfaction of all human beings' (2009: 84). One should keep in mind that a person's sexuality does not develop in isolation from other aspects of identity (Edwards and Elkins, 1988), (Turner & Crane, 2016).

Quality of life: Sociosexual skills and knowledge

Quality of life encompasses a wide variety of areas. Access to sexual knowledge is a significant area of quality of life in that it allows for both a more intimate understanding of self and potentially richer socialization experiences. If this knowledge is not contextually appropriate in relation to disability, disabled people are at a major disadvantage in terms of developing relevant sociosexual skills (Murray & Minnes, 1994). Halpern (1994) argued that the development of sexual knowledge and sociosexual skills is crucial to one's ability to experience intimate relationships and make a healthy transition into the adult world (as cited in McDaniels & Fleming, 2018). Accordingly, Betz, Hunsberger & Wright (1994) contend that learning responsible adult sexual behaviors is a vital part of the developmental transition between adolescence and adulthood. This ultimately frames the apparent lack of appropriate sociosexual education for disabled people as a factor that is additionally disabling.

Similarly, Harader, Fullwood, and Hawthorne (2009) spoke about how educator's disability-negative assumptions and biases encroached upon disabled people's access to equal opportunities for appropriate sexual education. Studies have shown that intellectually disabled adolescents consistently have reduced sexual knowledge and reduced sexual education opportunities as compared to their nondisabled counterparts (Cheng & Udry, 2002; Dukes & McGuire, 2009; Konstantareas & Lunsky, 1997; McCabe, 1999; Murphy & O'Callaghan, 2004). The result of this reduced access to knowledge and education often results in disabled people experiencing little awareness of social taboos, misinterpretation of boundaries, or behaving in ways that make people sociosexually uncomfortable in bids for connection (Timms & Goreczny, 2002; McDaniels & Fleming, 2018). This often leads to less success at connecting socially on an intimate level, which further isolates disabled people who are already navigating systemic and social ableism. In their comprehensive review of the literature, Turner and Crane (2016) cite various studies which reference a theme of deep loneliness felt by disabled people in terms of intimate and sensual relationships.

Increased risk for sexual exploitation and violence

According to the Disabilityjustice.org, disabled people are sexually assaulted at nearly three times the rate of nondisabled people. In a 2005 study of disabled people, nearly 60% of participants indicated they had experienced non-consensual sexual experiences. It is predicted that 83% of women and 30% of men with developmental disabilities in particular will experience sexual assault at some point in their lives (DisabilityJustice, 2023). Notably, of those who have reported sexual assault, half of these women have reported being assaulted more than 10 times (Disabled World News, 2012). These alarming statistics can be attributed to a variety of systemic and interpersonal factors highlighted by Curtiss and Kammes' (2020) examination of the risk of sexual abuse of disabled adults via an ecological framework. Ecological Systems Theory seeks to understand the individual within the context of the various systems that make up their environment (Bronfenbrenner, 1979, 2005). The ways in which the exosystem, or the social structure within which the individual lives, impacts disabled people can be seen in examples such as their lack of access to appropriate legal statutes regarding sexual assault which serve to disenfranchise them, etc. The microsystem refers to the individual's immediate settings such as home, school and work, while the mesosystem refers to ways in which these systems interact. Disabled people can be impacted at these levels by experiencing sexual violence from someone within these immediate settings, and the risk for this is great considering that disabled people are more likely to be sexually abused by those people within their microsystems (Curtiss & Kammes, 2020). Curtiss and Kammes (2020) refer to the literature in determining a variety of risk factors for sexual assault at the individual level, such as: "childhood victimization, drug and alcohol use, parent's marital abuse, depression, young age at first sexual experience, and being a person of color (Brooks-Russell, Foshee, & Ennett, 2013; Cloutier, Martin, & Poole, 2002; East & Hokoda, 2015; Makin-Byrd et al., 2013; Ullman & Vasquez, 2015)." As research shows, disabled people experience risk of sexual violence at each level within this framework. This illustrates a clear need for changing the ways we increase safety for disabled people in this context in ways which favor education and empowerment over paternalism.

Infantilization as a barrier

A major factor that impedes disabled people's access to sexual knowledge and education is infantilization of disabled bodies and minds. Disabled people are often viewed socially as inherently child-like and innocent or are, conversely, demonized. While infantilization harms disabled people in a multitude of ways including assumptions around competence which lead to social and vocational isolation, its impact is particularly evident in regards to their ability to access sexual knowledge and education.

> People with intellectual disabilities are commonly targeted by desexualizing and infantilizing stereotypes. They face what Collins (1990) calls *controlling images*—social constructions aimed at normalizing and justifying forms of inequality—that, in this case, desexualize and construct disabled people as "eternal children" and, on the other hand, portray especially men with intellectual disabilities as potentially "dangerous." (Santinele Martino, 2020)

When disabled sexuality is not being discussed and disseminated through a paternalistic lens, it often is not being discussed at all—least of all as a goal area or inherent human right. As inferred by Turner and Crane (2016), "perhaps this is because adults with intellectual disabilities seem to be sexual outsiders living on the fringe of normative sexual experiences" (p. 678). They also noted the potential sabotage these infantilizing stereotypes have on access to realistic representation of sexuality for disabled adults. Covarrubius and Fryberg (2015) expand upon the concept of positive and realistic representation through the concept of "self-relevant role models," which is defined as people who share marginalized identities with the people they clinically or professionally serve. In their work with Native American teachers working with Native American middle school students, self-relevant role models proved to have a notable effect on students' positive feelings of belonging as well as their academic performance. This supports claims in the literature that people belonging to marginalized communities benefit considerably from positive and accurate representation in terms of both their confidence and understanding of complex topics.

Purpose Statement

Given the gap in the music therapy literature and my assertion that sexuality is a major part of the human experience and therefore must be a topic that we can address in music therapy, the purpose of this research was to explore the attitudes of music therapists as they pertain to the domain of sexuality, and how these attitudes translate into their work with disabled adult clients. This study aimed to examine the impact that cultural beliefs, personal feelings, education level, and systemic ableism has on music therapy clinicians' inclination to addressing sexual topics in therapy with disabled clients.

Methods

Research Design

This research was an anonymous survey which intended to collect data from a diversity of music therapists. Both quantitative and qualitative data were collected and analyzed according to an objectivist framework. Quantitative data was collected through multiple choice and Likert scale questions, while qualitative data was collected through short written responses. All questions (Appendix B & C) were developed under the supervision of my thesis advisor.

The survey contained a total of 25 questions, beginning with two pre-survey questions to ensure those interested met the necessary criteria. The next five questions were multiple choice questions and asked participants for demographic information in terms of race, age, disability, gender and sexuality for the purpose of studying possible relationships or patterns amongst these groups. Of the remaining questions, 20 were Likert-scale-style, ranging from "strongly disagree" to "strongly agree" and another three were short answer. Questions 6 through 23 were written based on six subcategories: 1) background attitudes and training 2) personal comfort level and view of appropriateness discussing sex in general, in clinical scenarios, and specifically with disabled clients 3) the tendency to wait or initiate these topics 4) approach in these discussions with disabled vs. nondisabled clients 5) views on advocacy and 6) personal reflection. The purpose of these questions was to get an overarching view of participants' attitudes, feelings, experiences and training in the context of discussing elements of culturally taboo aspects of human experience such as sex and disability. Moreover, questions were designed to examine participants' views on the intersection of both these topics. The content of the written responses was analyzed in terms of frequency of response rather than an interpretation of underlying themes.

Recruitment

To recruit participants, I acquired access to the Certification Board for Music Therapists (CBMT)'s official email list. The list contained the email addresses of 9,975 certified, US-based music therapists. A recruitment email was sent out upon the opening of the survey, and two follow-up emails were sent out on the seventh and fourteenth day respectively.

To qualify to participate in the study, respondents had to:

1. *Be a US-based, board-certified music therapist*
2. *Have worked with disabled clients ages 18 and up*

All participants had to consent to take part in the survey after reading the informational letter, and were made aware that they could withdraw participation at any time.

Data Collection Instrument and Procedures

Data was collected through an online survey platform, Qualtrics XM, which I was provided access to via Slippery Rock University. All data was stored securely within this platform. The survey was made to be anonymous in that it did not require any identifying information from participants and was open to anyone with access to the link who fit the study criteria.

Data Analysis Procedures

Quantitative data was analyzed via the descriptive statistics feature of Qualtrics XM. Qualitative data was analyzed for common themes within participants' responses.

Results

Participants were asked to fill out a 23-question anonymous online survey that was designed to examine music therapists' personal beliefs and biases around addressing sexual topics in music therapy with disabled clients. This included investigating participants' educational experiences on the topics of sexuality and ableism, both concurrently and independently of one another, examining their contextual and/or personal feelings about elements of sexuality and their ability to address these within therapy, and studying their general responses to the ways these themes emerge in the context of working with disabled clients in music therapy. A total of 526 people consented to participate, though most questions received an average response rate of 307 after the survey weeded out those who do not work with disabled adults.

Participant Demographics

Participants were additionally asked to complete two pre-survey questions, which included 1) whether they worked with disabled clients and 2) whether they worked with disabled clients over the age of 18. While 91%, or 451 of the 497 respondents indicated that they do work with disabled clients, only 82% or 410 indicated they work with disabled clients over the age of 18.

Participants were instructed to respond to a series of demographic-based questions, including racial identity, age range, sexual orientation, gender expression and disability status. When asked about their racial identity, 286 out of 307 respondents (93%) indicated that they identify as white or Caucasian. Further, 21 respondents (7%) identified as Hispanic or Latino, 14 respondents (5%) identified as Asian, and 10 respondents (3%) identified as Black. Additionally, 1 respondent identified as American Indian or Native Alaskan and another as Native Hawaiian or Other Pacific Island, with both together ultimately equating to less than 1%. This aligned with the racial demographics of AMTA, which are as follows: 88.3% white or Caucasian, 3.6% Hispanic or Latino, 2.5% Asian, 2% as Black, 1.4% Native Hawaiian or Other Pacific Islander and .29% American Indian or Native Alaskan (AMTA Workforce Analysis, 2021).

In reference to their age range, 182 out of 308 respondents (59%), indicated that they are between the ages of 20-35. Of those 308 respondents, 63 (20%) indicated being between the ages of 36-45, 47 (15%) indicated being between the ages of 46-59 and 29 (9%) indicated being age 60 or above. This somewhat aligned with the age demographics of AMTA, which are as follows: 22.8% are between 20-29, 29.1% are between 30-39, 18.5% are between 40-49, 14.2% are between 50-59, 11.6% are between 60-69 and 3.9% are 70 and over (AMTA Workforce Analysis, 2021).

When asked about their disability, only 21% of 307 respondents, or 64, identified as disabled. When asked about their sexual orientation, 55% of 308 respondents, or 180, identified as heterosexual. AMTA does not gather information about disability or sexuality so we cannot compare these demographics. When asked about their gender identity, 78% of 306 respondents, or 239, identified as cisgender women, 12% or 36 identified as non-binary or third gender, 8% or 24 identified as cisgender men and 2% or 7 indicated that they preferred not to say. This was somewhat aligned with the gender demographics of AMTA's gender statistics with a slightly higher average of non-binary therapists: 88.4 identify as female/woman, 10.2% identify as male/man, 1.4 % identify as gender queer/non-conforming, .2% identify as nonbinary, .2% identify as trans male/man, 0.0% identify as trans female/woman, .7% indicated they go by a different identifier and .9% indicated they preferred not to say (AMTA Workforce Analysis, 2021).

Quantitative results

The survey was designed to start by examining participants' attitudes towards topics such as sexuality being a human right and their sense of responsibility as it pertains to initiating topics such as sexuality and/or other elements of sociocultural identity with their clients. The majority of participants (71%) strongly agreed with the statement that sexuality is a human right for all people regardless of disability status. Interestingly, strongly disagree is the second highest-rated response (12%) to this statement (see Figure 1). When asked about whether or not it is the responsibility of the therapist to initiate sociocultural conversations, including those around sex and sexuality, 30% indicated that they neither agree nor disagree, with those who somewhat agree not far behind at 28% (see Figure 2).

Figure 1

Attitudes on Sexual Rights For Disabled People

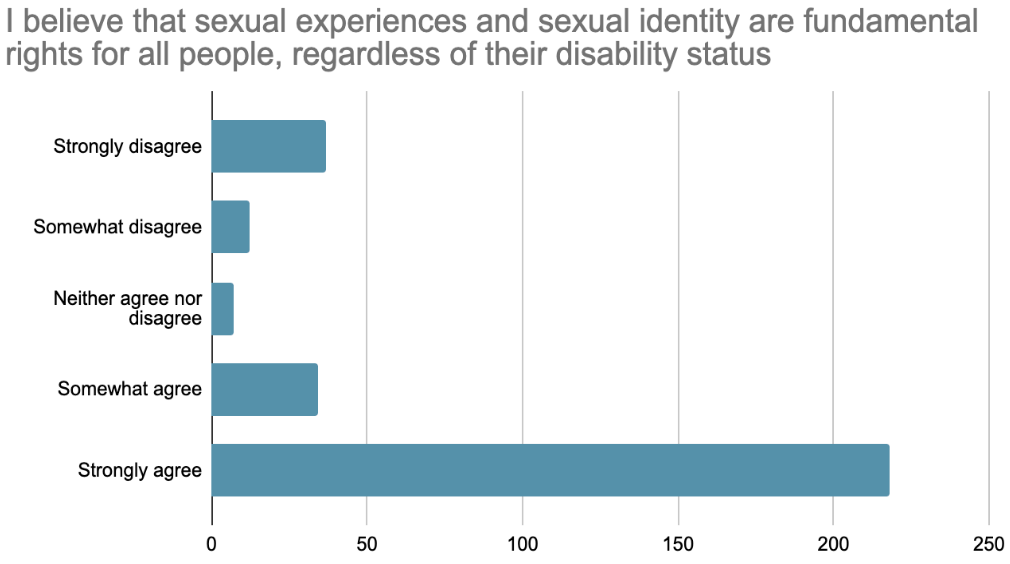
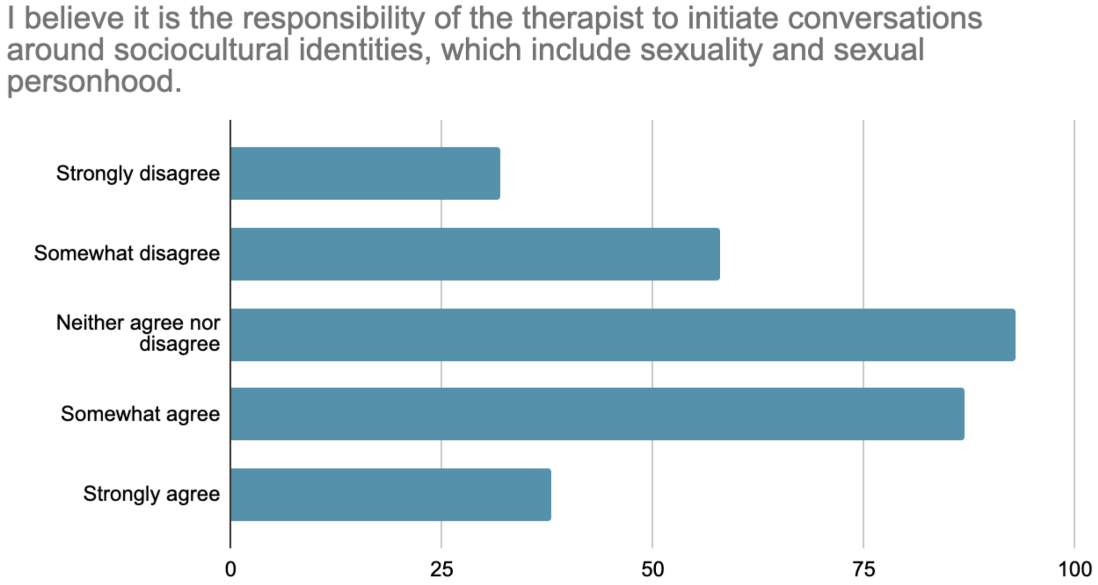


Figure 2

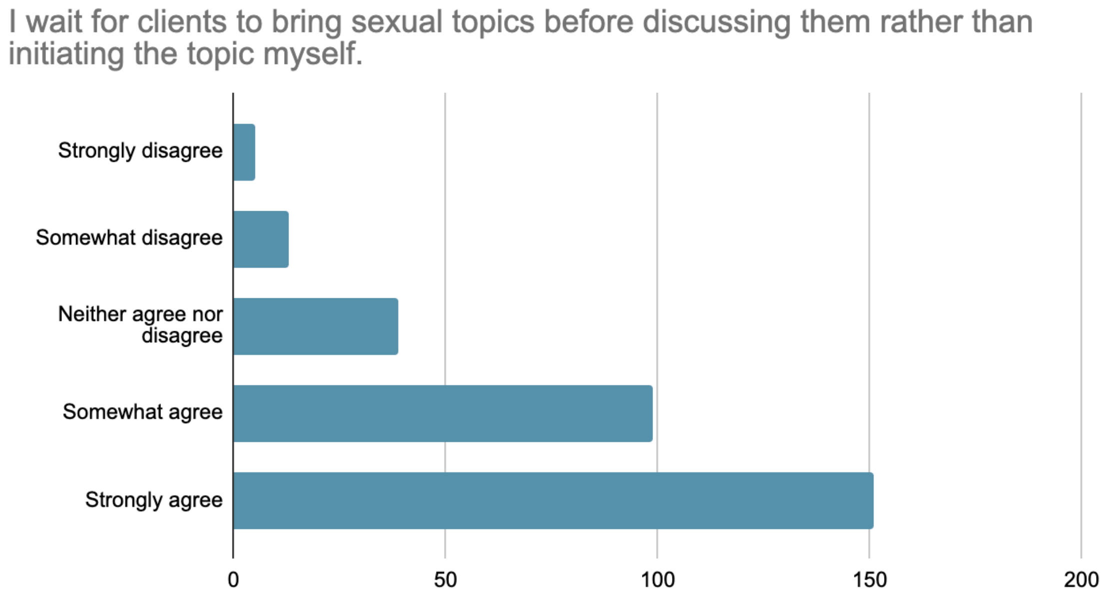
Attitudes on The Therapist' Responsibility To Initiate Sociocultural Conversations



The next set of questions aimed to examine participants' opinions about who should initiate sexual topics, as well as their comfort level in addressing sex as a topic both personally and clinically. The overwhelming majority of participants (49%) indicated that they strongly agree with the statement that they wait for clients to bring up sexual topics before initiating them themselves (See Figure 3). A large number of participants (41%) indicated that they somewhat agree with the concept of being comfortable discussing sex in social, non-clinical situations, and a further 39% indicated they are somewhat comfortable engaging with music that contains sexual themes in clinical contexts with clients (See Figure 4). When asked if they feel comfortable addressing romantic themes within music but not explicitly sexual themes, most participants indicated that they either somewhat agree (35%) or strongly agree (30%). Similarly, the majority of participants indicated they either strongly disagree (35%) or somewhat disagree (32%) with the idea of being more comfortable addressing sexually explicit themes in music versus romantic themes (See Figure 5).

Figure 3

Attitudes On Waiting For Clients To Initiate Sexual Topics



The next section of questions focused on participants’ attitudes specifically as they pertained to the role or appropriateness of sex as a topic in the clinical space. Most participants (43%) strongly disagreed with the idea that sexual themes within music are generally inappropriate and seldom clinically useful, with more than half (58%) indicating agreement with the sentiment that examining these themes in sessions can be both clinically relevant and therapeutically valuable (See Figure 6).

Figure 4

Attitudes On Discussing Sexual Topics In Non-Clinician Scenarios

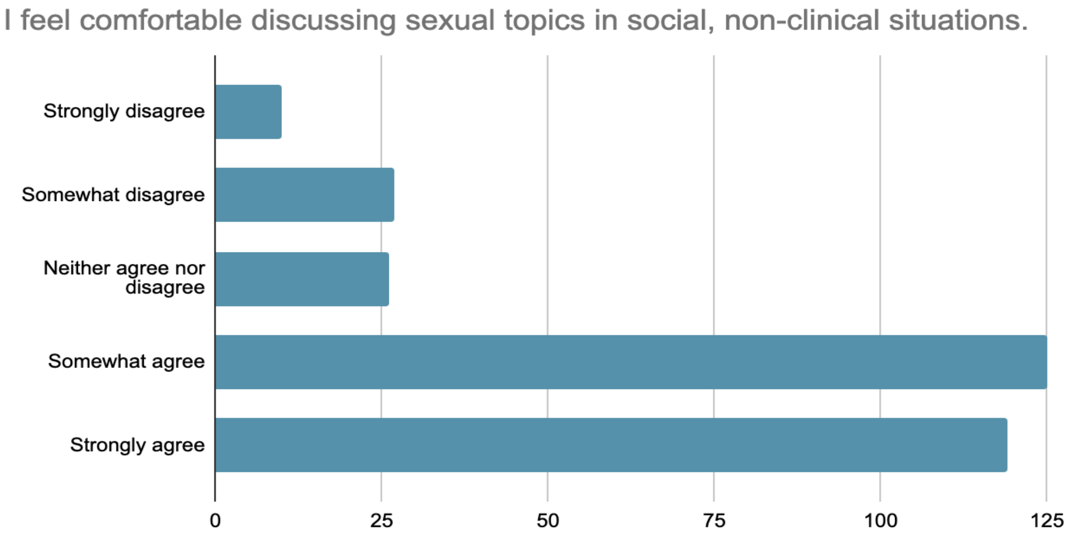
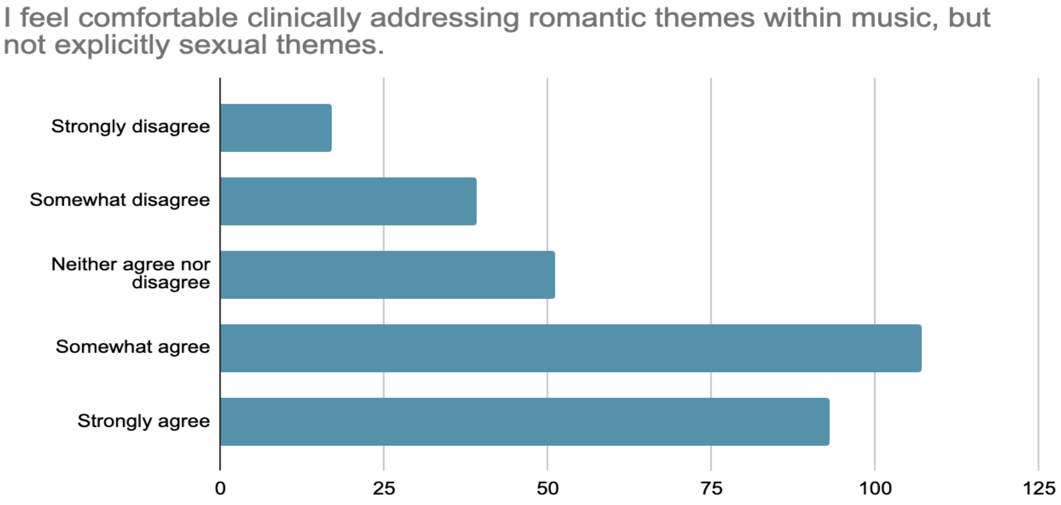


Figure 5

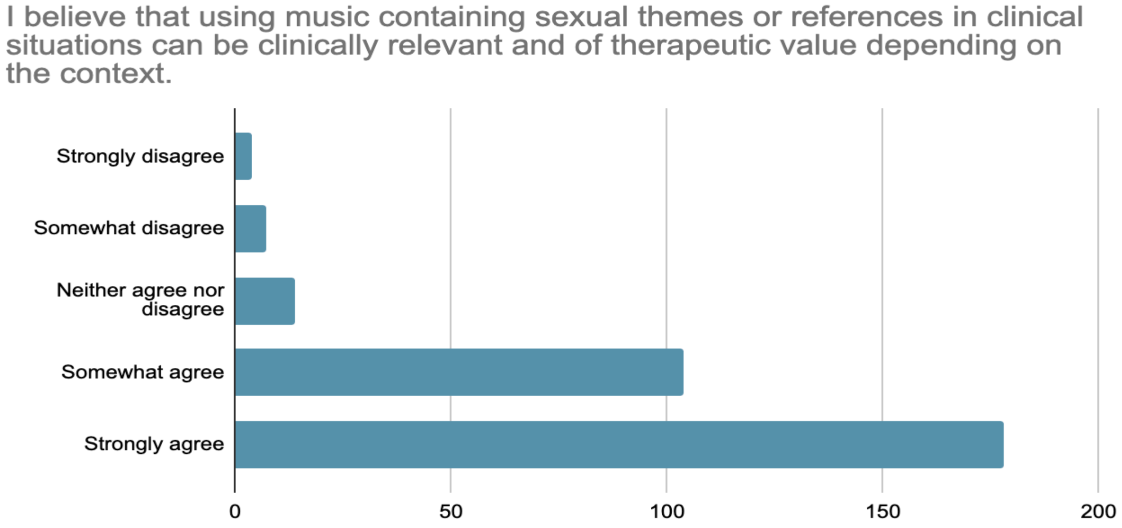
Attitudes On Discussing Romantic Vs. Sexual Themes



The next question aimed to assess whether or not the attitudes and comfort level of participants change when discussing or initiating these topics specifically with disabled clients. "Neither agree nor disagree" was the most commonly indicated response at 32% followed by "strongly disagree" at 24% (See Figure 7).

Figure 6

Attitudes On The Therapeutic Value Of Using Music With Sexual Themes



The final few questions sought participants' feelings on the responsibility of the clinician in the realm of advocating for the disabled clients' right to openly discuss sexual topics in therapy, particularly when this was at odds with the opinions or requests of caregivers and/or legal guardians. When asked whether they would stop engaging in clinically relevant sexual topics in therapy if a caregiver or guardian found this inappropriate, 58% of participants stated that they would not. The majority of participants suggested that they would advocate for their client in this scenario, with 52% indicating they strongly agree with this statement followed by 34% indicating that they somewhat agree (See Figure 8).

Figure 7

Attitudes On The Therapeutic Value Of Using Music With Sexual Themes

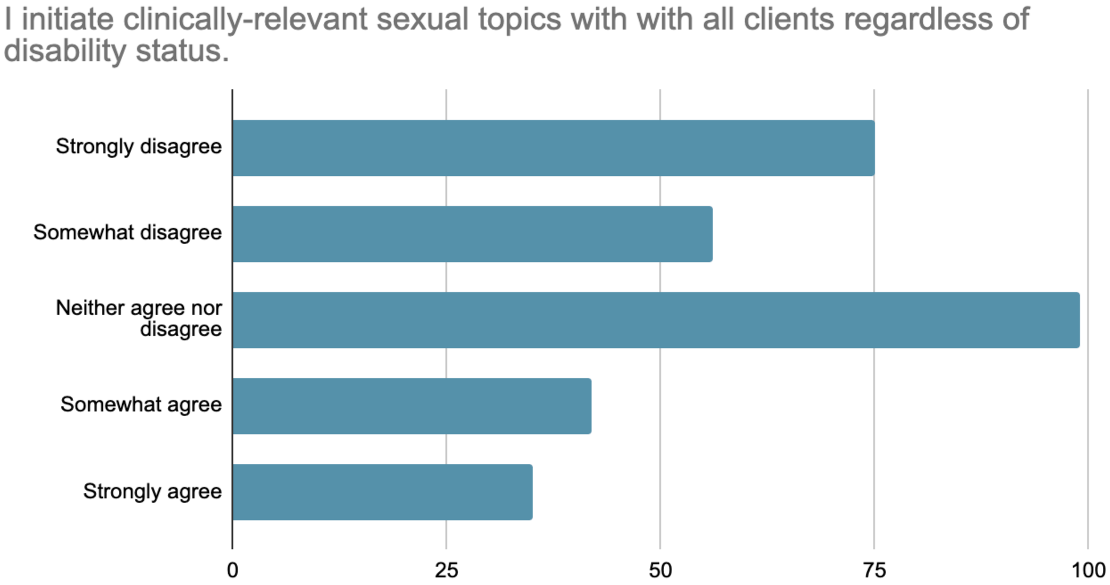
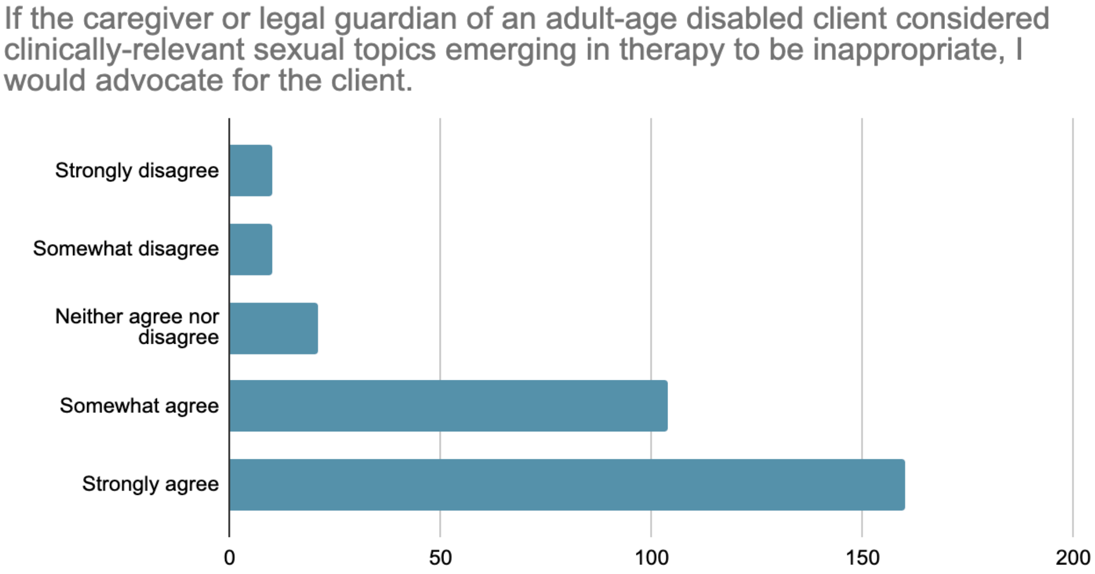


Figure 8

Attitudes On Advocating For Clients Whose Caregivers Find Sexual Topics Inappropriate



Qualitative results

In order to analyze the written responses, the researcher coded responses according to frequency and forcefulness of response. These codes were then categorized into themes and subthemes (see Table 1). Six main themes emerged: 1) Training, 2) Clinical praxis regarding discussion of sexual topics, 3) Scope of practice, 4) Impact on disabled people, 5) Desire for further reflection, and 6) Need for more concise definitions.

Table 1

Themes and Subthemes

Themes	Subthemes
Training	1. No formal training 2. In counseling classes 3. Additional training in and outside of the field 4. Self-taught
Clinical praxis regarding discussion of sexual topics	1. Lack of experience engaging in these topics 2. Ableism's impact on addressing the topic 3. Expanding beyond disability alone
Scope of practice	1. Appropriateness of initiating topics 2. Ethical considerations for client safety 3. Risk of retraumatization
Impact on disabled people	1. Lack of access to sociosexual education 2. Decreased access to healthy sexual scenarios 3. Increased risk for sexual abuse
Desire for further reflection	1. The intersection of disability and sex 2. The impact of taboo topics and ableism on clinical practice 3. Respect for the client's sociocultural background

Need for more concise definitions	1. Definition differences of caregivers and legal guardians 2. Legal and ethical implications of disobeying a legal guardian 3. Participant desire for increased written reflection space

Theme I: Training

Within the theme of training there were four subthemes: 1) No formal training, 2) In counseling classes, 3) Additional training in and outside of the field, and 4) Self-taught. Over half of participants indicated that they did not receive training or education in or outside the field on addressing sexual identity and other sexual topics with disabled clients. At least 11 participants indicated being “somewhat” educated on these topics, though many stated it was not in-depth. Participants who affirmed being educated to address sexual topics in therapy often referenced individual professors, supervisors, or facilities who felt it was important to integrate these topics into their education. Another common theme amongst those who indicated being educated on these topics was access to counseling classes. 10 participants who were not formally educated on these topics in the field became more educated through direct work experience, gaining the knowledge and understanding on this subject which came from that experience. 9 participants indicated that they sought training both in and outside of the field, such as Continuing Music Therapy Education workshops and seminars to other kinds of workshops, courses and conferences. 5 participants named self-study as their main source of knowledge on this topic.

Theme II: Clinical praxis regarding discussion of sexual topics

Within the theme of clinical praxis regarding discussion of sexual topics there were three subthemes: 1) Lack of experience engaging in these topics and 2) Ableism’s impact on addressing the topic. When asked about their level of experience addressing sexual topics with disabled clients, over 50 participants indicated that they generally do not, and in some cases have never approached this topic with clients regardless of disability status. The most common reasons cited for this were fear of being misconstrued and that these topics have not come up in sessions. Still, around 40 participants indicated an understanding of the importance of making space for these topics in therapy and voiced a willingness to do so in clinically relevant scenarios. According to one participant:

> "I have never had the opportunity to study this topic officially outside of my own personal investigations and attempts to listen to disabled voices at large on the topic. This leaves me feeling under qualified to engage in sexual topics with any client at all, knowing 'good intentions' aren't enough to avoid possible harm. If presented the topic or a situation related, I think I would seek supervision or getting the client in touch with a more qualified professional (which at that point could I guess lead to the topic being addressed in MT with enough coordination!)"

Roughly 45 participants also indicated feeling more comfortable discussing these topics when clients initiate them first, while others stated that sexual topics should only be client-initiated regardless of disability status. Some spoke to feeling comfortable specifically discussing consent education and processing negative sexual experiences with disabled clients given their increased risk to sexual abuse and violence. When asked whether ableism impacts their approach to addressing sexual topics with disabled vs. nondisabled clients, just under 100 indicated that they would address sexual topics as a whole differently with disabled and non-disabled clients due to the impact ableism and infantilization have on these conversations for disabled people. One participant wrote:

> "In theory I agree, but I don't work directly with disabled clients on a frequent-enough basis to address sexuality related issues. If I (worked with disabled clients frequently), I believe that (they) would require different kinds of support than non-disabled clients primarily due to the stigma of infantilization/being viewed as non sexual that disabled people have to deal with. Then there are the additional physical, emotional, medical and/or cognitive barriers that may be involved."

Others stated that they would address these topics the same way regardless of the client's disability status. Some cited sexuality being a human right as to their reason for this, while others felt conversations on sexual topics need to be highly individualized and based on a broader sociocultural than disability alone. As one participant put it, "Cultural attitudes and availability of knowledge on disabled sexuality is so taboo in our society, unfortunately, and it does not serve a client to pretend like that doesn't exist".

Theme III: Scope of practice

Within the theme of scope of practice, three subthemes emerged: 1) Appropriateness of initiating topics, 2) Risk of retraumatization and 3) Ethical considerations for client safety. A few participants stated believing that these topics are outside the scope of practice of music therapists. Some felt these topics were not necessarily appropriate in music therapist settings while others reported being actively discouraged from engaging in this topic in certain settings, particularly mental health programs. Risk of retraumatization of and increased harm to disabled clients by well-intentioned professionals who are untrained in facilitating these discussions was also referenced almost 30 times. This coincides with another widely-reported view on the consequences of academic and clinical lack of training in these areas and the need for trauma-informed education. As stated by one participant,

> "If a therapist were to initiate the conversation, the therapist would need to be trauma informed, and have a strong rapport with the person. Initiating the conversation in the wrong way could be exploitive in its own right, and would trigger traumatic symptoms in the wrong way. Specific and detailed training and protocols would be needed."

According to participants, ethical considerations must be made in terms of one's clinical ability to safely facilitate sexual discussions. As another participant stated, "Ethics also needs to be considered in terms of training of the music therapist and what is within scope of practice when determining facilitation of discussions surrounding these issues as not to cause potential harm to the client due to a well-meaning yet unprepared clinician."

Theme IV: Impact on disabled people

The subthemes found in the theme of impact on disabled people were: 1) Lack of access to sociosexual education, 2) Increased risk for sexual abuse, 3) Decreased access to healthy sexual scenarios. Commonly referenced amongst participants was the impact that lack of access to relevant sexual education has on disabled people. As one participated noted,

> "Sex and sexuality is as important in the lives of adults with disabilities as it is for neurotypical people has been my experience. However, since many assume adults with disabilities don't have sexual desires or shouldn't, access to sex Ed is even more limited than the neurotypical population. This creates many issues for folks trying to navigate romantic and sexual relationships in a healthy way."

Some consequences mentioned by participants include a higher risk of sexual violence or coercion and increased likelihood of engaging in unsafe or unfulfilling sex practices. Further, lack of access to developmentally appropriate sociosexual education often leads to a lack of social skills to be able to engage in this aspect of life which can result in lower happiness overall.

Theme V: Desire for further reflection

The subthemes contained in the theme of desire for further reflection were: 1) The intersection of disability and sex, 2) The impact of taboo topics and ableism on clinical practice, 3) Respect for the client's sociocultural background. Participants gave wide-ranging commentary when asked to consider the thoughts and reflections that emerged for them while taking the survey. Widely commented-upon was a noted desire to reflect further on the intersection of sex and disability, as well as appreciation that these topics are being examined. Noted by one participant:

> "Disability is such a wide term, and sexuality in and of itself is such a varied experience that it's going to be different for each individual. I also recognize that disability is an intersection that has to be approached in an informed manner and you must actively listen to the client to understand what they need and the difficulty posed by ableism in having the conversation in the first place."

Similarly, close to 75 participants noted the impact that both systemic ableism and sex as an often-taboo and deeply culturally-specific subject have on their own views and clinical practices. At least 15 participants also referenced the idea that discussions around these topics must work within the framework of the client's sociocultural values and belief systems, ranging from wider, culturally-specific beliefs to access needs such as communication methods for non-speaking clients. One participant made a poignant point regarding the reality of these different factors intersecting:

> "Initiating conversations with clients about sexuality in a clinical setting - especially with clients who do not communicate verbally - is tricky because those sessions are seldom private (in home setting or group settings) and navigating other caregiver biases and perceptions is very challenging. That deeply impacts my ability to support clients in

> processing topics related to their sexuality. Many folks desexualize disabled people and, as a result, seem to think that any discussion around sexuality must be exploitative or abusive by nature."

Theme VI: Need for more concise definitions

The final theme, which focuses on the need for more concise definitions within the study, contains three subthemes: 1) Definition differences of caregivers and legal guardians, 2) Legal and ethical implications of disobeying a legal guardian and 3) Participant desire for increased written reflection space. Close to 25 participants indicated that they would advocate for disabled clients whose caregivers or legal guardians did not feel sexual topics were appropriate in a clinical setting. Around 40 participants spoke to the importance of differentiating between a caregiver and legal guardian, as well as the legal implications of disobeying a legal guardian's wishes. The potential consequences of this could include discontinuing therapy, which could ultimately cause more harm than good. According to one participant, "I think it's complicated, because the client has the right to ask questions, learn about and explore their sexual identity, and be interested in sexual topics. But addressing those when the legal guardian has said not to I think runs the risk of them discontinuing therapy, which could be more harmful." The general sentiment of participants (just under half) who discussed this question expressed a desire and willingness to advocate in this scenario, while acknowledging the multilayered complexity involved in doing so. One participant surmised:

> "I have found that I have to remind those around my clients that they are adults with healthy and normal feelings. Many caregivers of clients with development disabilities believe that because they enjoy children's toys and TV shows that sexual topics of exploration are unnecessary and inappropriate. It takes a lot of advocacy. I have also

> found that many of my clients with disabilities develop romantic or sexual feelings towards me, their therapist. This can be a great opportunity to model healthy boundaries and to discuss these topics further, if appropriate."

Several participants also spoke to the limitations of having most of the questions in Likert-scale style given the nuance and complexity of the discussion. More than 10 participants referenced a desire to have more space within the survey to speak more in-depth about these complexities. A participant who summarized this notion, wrote:

> "This is an immensely complex issue concerning intersectionality that cannot be answered in a Likert fashion. The lived experience of every individual is unique within the context of their community and as they interact within and across other systems throughout their lifetime. Then to consider one's sexuality as an additional variable—which may include different aspects of trauma and multiple layers that impact mental health."

Discussion

Due to the extremely limited data on this topic in the music therapy literature, I will discuss the results of this study in relationship to the few music therapy studies I found, as well as in relationship to the literature from related fields.

The first major point of comparison can be seen in the context of barriers to conversations on sexual topics with disabled clients. More than half of participants cited lack of training in these areas, which leads to feelings of inadequacy and under-qualification in terms of knowing how to address them. This referenced lack of training is supported by the absence of nearly any music therapy-specific literature on this topic. One participant stated:

> "I am now working more with school aged individuals and I really wish there was more sexual education for students who are in special day classes. They do not receive the same quality of education in this area as their general education peers and I believe it sets them up for greater challenges as they transition into adulthood. Parents of teenagers in my experience are very uncomfortable with this topic."

In addition, literature in related fields also speaks to lack of uniform training opportunities and noted high levels of discomfort noted in fields such as counseling and psychology (Burnes et al., 2017; Hanzlik & Gaubatz, 2012). This literature indicates that the personal and professional discomfort clinicians state experiencing in addressing sexual topics with disabled people are due in large part to the uniform under-addressing of such topics with disabled people specifically. This is significant despite the literature also consistently suggesting that they are interested in engaging in these conversations (Eisenberg et al., 2015).

Several participants also referenced lack of appropriate sexual education (or in some cases *any* sex education) available to disabled people as an injustice which also impacts their feelings of comfort and confidence in their ability to address sexual topics in this context. This is supported throughout the literature of related fields (Burnes et al., 2017; Eisenberg et al., 2015; Gill & Hough, 2007; Hall et al., 2016; Hanzlik & Gaubatz, 2012; McDaniels & Fleming, 2018).

In addition to traditional means of sexual education, McDaniels and Fleming (2018) noted the importance of providing opportunities for sociosexual skill development in areas of emotional intimacy ranging from platonic friendship to romantic love. They emphasized the need for clinicians to assume competence and see disabled people as both capable and worthy of experiencing platonic and intimate forms of love. This sentiment is expressed by the following participant:

> "It is, in my opinion, an enforcement of a dehumanizing dominant narrative about disabled people that they are not qualified, mature, intelligent, or independent enough to love, feel arousal and/or attraction, or have meaningful sexual or romantic partnerships to avoid conversations about disability and sexuality in any therapeutic encounter. Presenting an openness and willingness to hold space in therapy for clients' experiences of sexuality and disability, in their own sociocultural context, is a meaningful act towards deconstructing the narratives around sexuality and disability."

Harris and Hays (2008) spoke about the role of the clinician in initiating conversations on sexual topics with families that tend to avoid discussing them. By modeling an ability to move past personal feelings of anxiety around discussing a subject, clinicians assist both clients and their families in having these conversations despite feelings of vulnerability or discomfort. The same can be said of the benefit of modeling healthy boundary setting with clients when sexual topics or feelings arise. One participant spoke to the importance of modeling this when clients develop romantic or sexual feelings towards them: "I have also found that many of my clients with disabilities develop romantic or sexual feelings towards me, their therapist. This can be a great opportunity to model healthy boundaries and to discuss these topics further, if appropriate."

A commonly agreed upon stance amongst participants was the importance of and desire to advocate for clients' ability to access and discuss sexual topics. The literature in related fields overwhelmingly supported the view that advocacy is sorely needed in a variety of areas (Burnes et al., 2017; Eisenberg et al., 2015; Harris & Hays, 2008; Hanzlik & Gaubatz, 2012; McDaniels & Fleming; Turner & Crane, 2016). Turner and Crane (2016) spoke to the importance of directly assisting in as well as advocating for disabled people's physical and emotional access to pleasure in terms of sexuality and intimacy:

> "Adults with ID rely on others for advocacy in many areas of community integration…Including sex and relationships as rights would challenge advocates for those with disabilities to step into the role of sexuality advocate, viewing access to pleasure as a social justice issue. Access to dating partners depends on one's support system, thus transportation and freedom of movement without supervision must also be provided."

While this sentiment was widely shared among participants, many also spoke to the possibility of caregivers pulling clients out of therapeutic services as a result of clinically engaging in topics they did not want discussed in therapy. To that end, many echoed the need to measure risk versus reward to the client. As one participant stated:

> "I think the question about caregivers deeming sexual topics inappropriate is difficult. In a previous work setting, part of our funding came from these caregivers. While therapeutic work shouldn't be about money, employee livelihood unfortunately is. Such a discussion could result in the client being pulled out of therapy and a potentially more affirming space. So, whether or not to discuss sexuality is intermingled with client advocacy and employee salaries, the decision becomes a little more complex."

In reflecting on these possibilities, it is important to consider what is ultimately best for the client in the big picture rather than imposing ideas which could lead to clients having decreased access to valuable areas of support and care.

Limitations, design reflections and future considerations

There were multiple limitations noted in this research, the first being the expansive nature of "disability" and "sexual topics" in terms of definition. Because both of these terms cover so much complex ground, it may have been confusing for participants to fully consider the breadth of their intersection, particularly in a survey predominantly composed of Likert scale-style questions. One participant pointed out:

> "How someone experiences and processes their sexuality, sexual urges/impulses or sexual desires is inherently going to vary based on their disability status. Is it a physical disability? Is it a new disability that has changed their perception of their body/self-image? Is it a cognitive disability that potentially impacts their ability to consent? Do they have a history of being victimized by perpetrators who took advantage of them because of their disability? All of this plays into how/if I would bring sexuality into the session…"

This issue is further complicated by the clear indication that sexual topics in general are not uniformly taught to music therapists. To expect clinicians who have not been trained in a complex area of experience to apply that experience to as complex a subject as disability is not a reasonable task.

To that point, several participants indicated frustration regarding this style of question in reference to such extensive topics and cited a desire for additional short answer space to verbally reflect. As one participant stated:

> "This is an immensely complex issue concerning intersectionality that cannot be answered in a Likert fashion. The lived experience of every individual is unique within the context of their community and as they interact within and across other systems throughout their lifetime. Then to consider one's sexuality as an additional variable—which may include different aspects of trauma and multiple layers that impact mental health."

Furthermore, I mistakenly neglected to include operational definitions for these terms in the survey cover letter as originally intended. This led to participants using their own discernment to define them, which adds an additional layer of variables and could potentially skew data in considering participants' responses. There were also several instances where the wording of the survey questions used the terms "sexuality" and "sexual topics" interchangeably, which could have further skewed data based on participants' perception of these terms.

Another aspect of the survey which was pointed out as a limitation by numerous participants was the wording of question nineteen. Participants were asked how they would respond if the caregiver or legal guardian of their client did not want them discussing sexual topics, which prompted many to reference the differences between these two terms. These participants pointed out that while a "caregiver" has certain levels of authority over those in their care, a "guardian" has the legal right to make decisions on behalf of the client. Not only can this lead to discontinuation of services with the client, but it could possibly open therapists up to litigation should they not comply with the guardian's requests. One participant noted the need for more concise definitions: "I think you should more clearly define terms. This is exceptionally subjective; caregiver and legal guardian aren't the same....difficult to answer the previous questions in that a legal guardian can make binding demands."

Future Research

Given that this is one of the first studies examining music therapists' attitudes on addressing sexual topics with disabled adults, it would be worthwhile for a more thorough examination of this subject with tighter, more concise terms and definitions. I strongly suggest that more studies take place on the subject of the ways in which music therapy can play a role in disability-affirmative sexual education, support and empowerment of clients as they navigate intimate areas of their lives. The role of supervision in these conversations could also be a valuable study. Additionally, the perspectives of disabled people should be studied in continuing to study this subject and gain firsthand knowledge from those directly impacted by the issues highlighted in this paper.

Conclusion

Disability and sexual topics have in common that they are both often viewed as taboo and/or sensitive subjects within a multitude of cultures. As a result, disabled people often have limited access to a) appropriate sexual education and sources of knowledge b) support systems in the context of their intimate lives and c) the quality of life associated with these aspects of experience. To quote Tepper (2000), "pleasure in an affirmation of life… (and sexual pleasure) is particularly powerful in making one feel alive" (p. 288). This is an area of life everyone should have access to regardless of disability status. As music therapists, the addressing of sexual topics may not be our niche or specialization. That said, it is an area of the human experience in which every person has a unique and distinct connection, and to deny our responsibility in addressing these areas as we would with any other area of humanity is misguided at best and dangerous at worst. In a profession where we are considered qualified to provide baseline levels of support in the realms of spiritual and psychosocial domains, we have a responsibility to learn the same skill sets as they pertain to sexual topics, despite cultural attitudes and norms. The field-wide hesitation to discuss sexual topics as a whole contributes to disabling limitations placed on disabled people's access to support in these areas, which is antithetical to our roles as therapists and advocates. It is on all of us as clinicians to continue moving toward liberatory practices that aid disabled people in living lives of their choosing.

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APPENDIX A:

Recruitment email:

Dear music therapist or music therapy intern,

My name is Francesca Miller (she/her) and I am an MMT student at Slippery Rock University. I am conducting my thesis, "Exploring music therapists' attitudes towards disability and sexuality," under the direction of Susan Hadley, Ph.D, MT-BC with the approval of SRU's IRB.

Participants are invited to take a 19 question survey, which will take about 15 minutes to complete, and can be filled out via computer or smartphone. In order to participate, you must be a US-based music therapist or music therapy intern who has had experience working with disabled clients ages 18 and older. Music therapists and music therapy interns of all ages above 21, backgrounds and levels of education are eligible.

If you are interested in participating, please click the link below to be directed to the survey. If you have any additional questions, please contact the researcher and co-researcher at susan.hadley@sru.edu or fjmiller92@gmail.com.

Sincerely,

Francesca Miller, MT-BC, Co-researher, MMT candidate Slippery Rock University

Follow this link to the survey:

Or paste this URL into your browser:

Recruitment facebook post:

Hi all,

My name is Francesca Miller (she/her) and I am an MMT student at Slippery Rock University. I am conducting my thesis, "Exploring music therapists' attitudes towards disability and sexuality," under the direction of Susan Hadley, Ph.D, MT-BC with the approval of SRU's IRB.

Participants are invited to take a 19 question survey, which will take about 15 minutes to complete, and can be filled out via computer or smartphone. In order to participate, you must be a US-based music therapist or music therapy intern who has had experience working with disabled clients ages 18 and older. Music therapists and music therapy interns of all ages above 21, backgrounds and levels of education are eligible.

If you are interested in participating, please click the link below to be directed to the survey. If you have any additional questions, please contact the researcher and co-researcher at susan.hadley@sru.edu or fjmiller92@gmail.com

Thank you!

APPENDIX B:

Informational Letter

Exploring music therapists' attitudes towards disability and sexuality

Start of Block: Informational letter

Informational letter
Susan Hadley, PhD, MT-BC
Professor, Director of Music Therapy
101 Central Loop, Suite 225
Slippery Rock, PA 16057-1326
724-738-2446 office
724-738-4469 fax
e-mail: susan.hadley@sru.edu
http://www.sru.edu/depts/artsci/music/index.htm

RESEARCH PARTICIPANT INFORMATIONAL LETTER

Exploring music therapists' attitudes towards disability and sexuality

Francesca Miller, fxm1007@sru.edu; Susan Hadley, susan.hadley@sru.edu

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a US-based music therapist or music therapy student (at internship level) who work or have worked with disabled clients ages 18 and up. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of this survey is to examine music therapists' personal beliefs and biases around addressing sexuality in music therapy with disabled clients. If you choose to participate, you will be asked to complete an anonymous online survey. This will take approximately 10-25 minutes.
- We do not anticipate any outside of potential personal discomfort from this research.
- The study may benefit you directly in shifting your perspective on addressing sex as a topic with disabled clients or disability in general. It may benefit disabled clients who have not

previously had the opportunity to explore this subject with clinicians increased access to such conversations.

- Taking part in this research project is voluntary. You do not have to participate and you can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the Study About and Why are We Doing it?

The purpose of this survey is to examine music therapists' personal beliefs and biases around addressing sexuality in music therapy with disabled clients.

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be asked to complete a 23 question anonymous online survey containing 20 multiple choice and 3 short answer questions. We expect this to take about 10-25 minutes.

How Could You Benefit From This Study?

The study may benefit you directly in shifting your perspective on addressing sex as a topic with disabled clients or disability in general. It may benefit disabled clients who have not previously had the opportunity to explore this subject with clinicians increased access to such conversations. It will ideally encourage clinicians to think more critically about this topic to the benefit of their disabled clients.

What Risks Might Result From Being in This Study?

While we do not anticipate risks or discomforts associated with this study, it is possible that you may experience some emotional discomfort when answering questions regarding your feelings around the topic of ableism and how it relates to a variety of subjects including individual perception, training, clinical experience. We have taken precautions to eliminate or reduce these risks by developing an anonymous survey. We also want to assure you that participation in the research is completely voluntary and that declining to participate will not negatively affect you in any way. You can withdraw from the study at any time if you feel discomfort.

How Will We Protect Your Information?

We plan to publish the results of this study. To protect your privacy, we will not include any information that could directly identify you. Your survey responses will not be connected with your email address.

What Other Choices do I Have if I Don't Take Part in this Study?

If you choose not to participate, there are no alternatives.

Your Participation in this Research is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you decide to withdraw before this study is completed, just exit the survey.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact Francesca Miller, fxm1007@sru.edu.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 302
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. You indicate your voluntary agreement to participate by clicking BEGIN SURVEY.

End of Block: Informational letter

APPENDIX C:

Survey Questions

Start of Block: Pre-survey question block

Pre-survey 1 Do you work with disabled clients?

○ Yes (1)

○ No (2)

Pre-survey 2 Do you work with disabled clients over the age of 18?

○ Yes (1)

○ No (2)

End of Block: Pre-survey question block

Start of Block: Default question block

1 Check all the apply in regards to your racial identity:

☐ American Indian or Alaska Native (1)

☐ Asian (2)

☐ Black or African American (3)

☐ Hispanic or Latino (4)

☐ Native Hawaiian or Other Pacific Islander (5)

☐ White or Caucasian (6)

2 Check the age group of which you are a part:

☐ 20-35 (1)

☐ 36-45 (2)

☐ 46-59 (3)

☐ 60 and above (4)

3 Do you identify as disabled?

○ Yes (1)

○ No (2)

4 Do you identify as cisgender?

○ Male (1)

○ Female (2)

○ Non-binary / third gender (3)

○ Prefer not to say (4)

5 Do you identify as heterosexual?

○ Yes (1)

○ No (2)

6 I believe that sexual experiences and sexual identity are fundamental rights for all people, regardless of their disability status.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

7 I believe it is the responsibility of the therapist to initiate conversations around sociocultural identities, which include sexuality and sexual personhood.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

8 Has any part of your training, either inside or outside of the field, included education around addressing sexual identity and topics with disabled clients?

____

____

____

____

____

9 I wait for clients to bring sexual topics before discussing them rather than initiating the topic myself.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

10 I feel comfortable discussing sexual topics in social, non-clinical situations.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

11 I feel comfortable engaging with music with sexual themes in clinical situations with clients.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

12 I feel comfortable clinically addressing romantic themes within music, but not explicitly sexual themes.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

13 I feel comfortable clinically addressing sexually explicit themes, but not romantic themes.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

14 I believe that using music containing sexual themes or references in clinical situations is generally inappropriate and seldom has any therapeutic value.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

15 I believe that using music containing sexual themes or references in clinical situations can be clinically relevant and of therapeutic value depending on the context.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

16 My comfort level in clinically addressing sex as a topic in therapy remains the same regardless of a client's disability status.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

17 I initiate clinically-relevant sexual topics with with all clients regardless of disability status.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

18 I initiate clinically-relevant sexual topics with speaking disabled clients, but not with non-speaking disabled clients.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

19 While there are similarities, the ways in which I support disabled and non-disabled clients in processing their sexuality are ultimately different given the lived experience of disability and the impact of ableism on community members.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

20 Please elaborate your thoughts on question 19.

____

____

____

____

____

21 If the caregiver or legal guardian of an adult-age disabled client considered clinically-relevant sexual topics emerging in therapy to be inappropriate, I would no longer engage in discussing that topic with the client.

○ Yes (1)

○ No (2)

22 If the caregiver or legal guardian of an adult-age disabled client considered clinically-relevant sexual topics emerging in therapy to be inappropriate, I would advocate for the client.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

23 What are some thoughts and reflections that came up for you while answering these survey questions?

____

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____

End of Block: Default question block