# Group Music Therapy for LGBTQIA+ Parents Experiencing Postpartum Depression and Anxiety: A Mixed Methods Study

Maryrose Nieman Nelson, MT-BC, CD(DONA)

Advisor: Dr. Susan Hadley, PhD, MT-BC
Reader: Dr. Melody Schwantes, PhD, MT-BC
Reader: Heidi Lengel, MMT, MT-BC

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Maryrose Nieman Nelson, MT-BC, CD(DONA)

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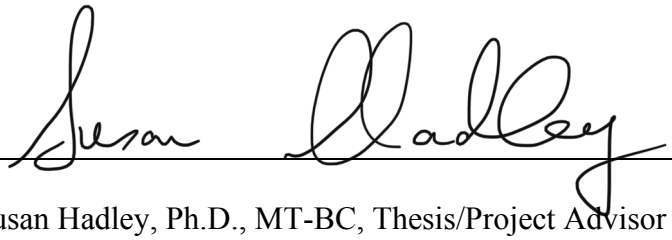
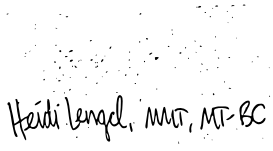


Susan Hadley, Ph.D., MT-BC, Thesis/Project Advisor

Melody Schwantes, PhD, MT-BC, Reader



Heidi Lengel, MMT, MT-BC, Reader

**Abstract**

A mixed methods research study involving an eight-week music therapy group was facilitated virtually for LGBTQIA+ parents experiencing postpartum mood and anxiety disorders. The Edinburgh Postnatal Depression Scale was administered upon first session and last session to capture potential impact of music therapy group on mental health over time. The Brief Mood Introspection Scale was administered at the beginning and end of each session to capture short term impact of group music therapy. A semi-structured focus group was facilitated to capture experiences of and feedback from participants, and interviews were scheduled with participants who did not attend the focus group. Interviews and the focus group were transcribed and analyzed and six themes were identified: community and solidarity built around shared experiences, music within and beyond the group, expansiveness and generativity in parenthood, response to experience, attendance and timing challenges, and accessibility. The Edinburgh Postnatal Depression Scale did not show statistically significant changes in mood over the course of the eight-week group but was limited by sample size and an outlier score. The Brief Mood Introspection Scale showed more significant trends in increased pleasant mood, decreased stress, and increased positivity after the session. When LGBTQIA+ parents were able to attend the session, they reported meaningful impacts despite attendance challenges. Findings may be useful in developing music therapy practice and research.

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loving you, and I love that we continue to grow together. I promise I won't go to school again for at least five years (I think…).

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# Introduction

## Motivation for the Research

Growing up fourth in a family of eleven children, I spent my childhood surrounded by pregnancy, birth, and babies. I knew my family was unique for having that many kids, but I did not realize how the normalization of all things pregnancy, birth, and babies set me apart from my peers until well into my undergraduate work. As I learned about various contexts music therapists work in during my introduction coursework, I remember my curiosity growing the younger the clientele age got, from young children, to babies, and to neonates.

It was later that I stumbled into the work of Dr. Dianne Allison and Dr. Mary DiCamillo, and discovered that music therapy can benefit people before or as they are being born. I completed Dr. DiCamillo's Sound Birthing, LLC training, and completed birth and postpartum doula trainings between undergraduate coursework and music therapy internship. I attended births throughout my internship and teamed up with a birth center in the early stages of the COVID-19 pandemic when music therapy jobs were largely on pause. I've attended around 35 births to date and supported a variety of postpartum families as a doula and beyond.

As I engaged in coursework in Slippery Rock University's master's in music therapy program with a mental health counseling endorsement and working in various music therapy contexts, I found myself becoming interested in utilizing my deepening counseling skills in perinatal mental health contexts. Recently, I became more interested in perinatal mental health. Witnessing my closest sister become a new parent in the height of a pre-vaccine COVID-19 pandemic left me thinking that for all my emphasis on pregnancy and childbirth, I have noticed much less support, conversation, normalization for parents following the birth. I found myself

wondering reading about postpartum mental health and wondering how music therapists might step into support.

It doesn't have to be this way. I believe that humans are not meant to live in isolation and shouldn't have to raise a family in isolation. The "nuclear family" is not capable of handling all the things that parenting and working in a country that provides critically little paid-parental leave or other supports (Li, et al., 2022) and leaves new parents saddled with a hefty hospital bill (Chua et al., 2021) and potential fertility-related costs (American Society for Reproductive Medicine, 2021). Growing families need community care now more than ever. We need to shift from thinking about families as "units" and more about families as interconnected branches of a network of trees. It's no wonder that perinatal mental health concerns in the United States are so devastatingly common (McNab et al., 2022).

As I worked as a birth doula, and even now as I work as a music therapist in postpartum mental health spaces, I was inundated with reminders of how cis-hetero-normative conception, prenatal, birth, and postpartum community spaces are. These spaces are exhausting for the queer, trans, and gender-expansive folks I work with and for me as a queer person with a trans partner. Queer and trans parents are more at risk for isolation and lack of resources due to potential disconnections from family of origin and navigating legal, financial, and reproductive challenges associated with queer and trans conception (Greenfield & Darwin, 2021; Marsland et al., 2021; Ross et al., 2012). Adding racial (Doherty et al., 2023), class (Dagher et al., 2021), body-size (Vats, et al., 2021), disability (Tarasoff, 2017), immigrant (Fellmeth, et al., 2016), and language disparities (Willey et al., 2019) to queer and trans families add event more harmful experiences.

My hope is for music therapists to get curious and comfortable in journeying with queer, trans, and gender-expansive clients in all contexts, and more specifically in perinatal mental health. My hope is to provide to my fellow queer kin as they endeavor to do what I personally believe to be one of the most beautiful and hopeful tasks anyone can do: grow a family. I recognize that many may not feel the journey to family building is beautiful or hopeful, especially those who may be going through fertility challenges, adoption processes, or reproductive loss.My hope is to challenge music therapists to consider robust perinatal mental health care for parents, and to immerse themselves in relevant literature, training, and communities doing helpful work like Postpartum Support International. Generally, I hope to both see and contribute to a growing body of robust research that contextualizes perinatal mental health, queer perinatal mental health in a way for mental health practitioners, physicians, and queer families to learn about the benefit of music therapy in this context.

**Positioning Maryrose: a white neurodivergent queer sister, auntie, doula, music therapist**

I am a white-settler colonizer: on one side a fourth-generation immigrant to the United States from Malta and Poland, and on the other the descendent of German immigrants from the early 1800s. I am the product of ancestors who shed much of their heritage to assimilate to whiteness. I hold much privilege in the way I exist in a white-supremacist reality, and yet I also carry the grief of what meaning, joy, and connection was lost in the assimilation and immigration process.

I am autistic, have ADHD, and am a survivor of complex trauma. I benefit from the advantage of speaking being my primary mode of communication, but I also love writing, poetry, and music as modes of communication. My journey as a late-diagnosed autistic adult is to unlearn 29 years of hiding who I really am and how I experience a sensory and social world.

I am what I lovingly call a demi-fem, in that I consider my gender to be expansive beyond the expectations expected of cis-women in United States in Christian-dominant spaces. I do resonate with aspects of my fem identity, and yet I sometimes feel confined by it. I am so much more. However, I benefit from the advantage of passing as a ciswoman. I am queer, in that I am drawn to people of all genders, and in that I am married to a trans-woman. Until recently, I moved through the world in a hetero-passing relationship and was able to selectively disclose my queer identity. As my dear wife transitions and comes home to herself in breathtakingly beautiful ways, I feel deeply dedicated to advocating for trans-rights and to speak out against the anti-trans rhetoric spreading around in particularly evangelical Christian spaces.

I am the fourth of eleven children, all born genetically to my mother and father, who were college campus evangelical missionaries for most of my childhood and adolescence. I remember being taught early on about hell , a place of torture and absolute isolation you could be sent to if you weren't right with God. As I grew up, all the moments my queerness could have or did become noticeable to me were shoved deeply into the depths of my subconsciousness and I didn't realize I didn't fully realize it until I was 25 and married due to fear of how that might impact my "rightness" with God. It would be later when my wife would realize she was trans. My spiritual journey has been one of healing, confronting, and expanding beyond everything I was told was definitively true.

Having grown up surrounded by pregnancy, birth, and young children, it makes sense that I ended up going into birth and postpartum doula work, and that I would be interested in how music therapy might support people across the perinatal experience.. What's more, my favorite thing about myself is that I am an auntie, or Tia, as my niece calls me. I often get the question about when, or whether or I'll have kids myself. Even now that my family knows that I

most likely will not, they struggle to grasp how I can find my role as an auntie just as compelling and meaningful as some people find their roles as parent. But raising a family can be hard work, and extended family can play a significant role in the wellbeing of families. I believe my life's calling is to "sister auntie doula" my way through life, supporting my community through kinship.

**A Note on Gendered Language and a Definition of Terms**

It is unfortunately common to see exclusively feminine-gendered parental identities in literature surrounding reproduction. However, not every person with the genetic material to bear a child identifies as a mother, mum, or mama. Some identify as fathers, daddies, papas, and some are madas, maddies, and other creative, expansive names. For clarity and consistency, I will use terms original to the research I reference. In all other contexts of this paper, I will use non-gendered language in describing parents, unless I am referring to people who use certain terms and pronouns. I am aware of the weight that comes with not changing gendered language that exists in existing literature. It is imperative to critique the use of generalized gendered language, and I intend to do so in this work and beyond.

Beyond gendered language, there are many evolving terms used within reproduction and the perinatal experience that warrant definition and distinction. Similarly, the language used to describe sexuality and gender, particularly in LGBTQIA+ contexts, is constantly evolving. Many of these terms may be used interchangeably or may have regionally specific or individualized meaning; the purpose of the list of terms is to provide the reader with context, largely based on my limited position to provide clarity to the reader.

This list of terms and definitions is by no means universally agreed upon and may not feel most accurate as time passes and language evolves. I embrace the ever-expanding journey of gender identity and expression, and intend to embrace curiosity, gentleness, and playfulness along the way.

*Ace (asexual) spectrum:* The colorful umbrella of sexuality experiences relating to varying levels of sexual connection including asexual (ace), grey-ace, demisexual, and queer-platonic. See also: Asexual (Trevor Project, 2021).

*Asexual (Ace):* Experiencing little or no sexual attraction but experiencing emotional and/or romantic connection. Asexuality is also a spectrum of identities with varying shades of experiences (Trevor Project, 2021). See also: *Ace spectrum*

*Assisted Reproductive Technology (ART):* The Center for Disease Control and Prevention (n.d.) defines ART as any means of reproduction that involves working with eggs, including egg retrieval and in vitro fertilization and implantation.

*Birth person or birthing person:* Refers to a person who will, is presently, or who previously carried and birthed a child. See also: gestational parent.

*Chestfeeding or bodyfeeding*: Refers to the process of feeding a child through lactation, or mimicking lactation through feeding tube or spoon-dripping.

*Chosen family*: “Nonbiological kinship bonds, whether legally recognized or not, deliberately chosen for the purpose of mutual support and love” (Gates, 2017). Sometimes a mix of biological and nonbiological kinship.

*Cisgender (Cis):* Refers to identifying with the gender assigned at birth.

*Donor:* Any genetic material needed for reproduction (eggs, sperm, embryo) provided by an outside source.

*Doula*: A term typically understood to be translated from Greek as "a woman who serves", historically denoting someone who assists with pregnancy, birth, and postpartum care (Birth Arts International, 2023). Understood in a present-day Western context as a term to describe someone who provides emotional, educational, and physical nonclinical care to people. Birth doulas provide support in a birthing context, postpartum doulas provide care to the family after a baby is born, and death doulas provide care to a person and their families/loved ones leading up to and during the dying process. There are also antepartum doulas, who specialize in working with medically complex pregnancies and full-spectrum doulas, who work across contexts: in pre-conception, pregnancy, postpartum, adoption, and abortion (Cleveland Clinic, 2022).

*Gametes:* Refers to genetic material needed for reproduction (e.g., egg, sperm, embryo) in a nongendered way (Kali, 2022, p. 77).

*Gender-expansive:* An "umbrella term" for anyone that falls outside of typical gender norms (Resnick, 2022).

*Gestational parent:* Refers to a person who will, is presently, or who previously carried and birthed a child. See also: birth person or birthing person (Darwin & Greenfield, 2022)

*Induced Lactation:* The process of promoting lactation in non-gestational parents or in gestational parents who have had top surgery.

*Intersex:* Term for a variety of conditions where a person is born with reproductive, genetic, or sexual anatomy that "doesn't seem to fit the typical definitions of female or male" (Intersex Society of North America, n.d.).

*IUI (intra-uterine insemination)*: A procedure in which sperm is placed directly into the uterus using a catheter, sometimes in time with ovulation (Mayo Clinic, 2023, September 13).

*IVF (in vitro fertilization):* A series of procedures which help with fertility and prevent genetic problems in the conception of a child. Mature eggs are retrieved from ovaries and fertilized in the lab before transferring an embryo to the uterus (Mayo Clinic, 2023).

*LGBTQIA+ or LGBTQIA2S+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two-Spirit, and More):* A set of initials for an umbrella term which is commonly used to refer to those who have divergent and/or expansive genders, sexualities, and/or romantic identities. This term is certainly not all-inclusive and does not capture the true diversity of the people it aims to describe (American Psychology Association, 2022).

*Nonbinary (enby):* A general term used to describe individuals who do not identify with the gender binary, and is considered to be within the transgender umbrella. The shortened version, enby, is written out because the initials "NB" are already used in Black communities to denote "non-Black" (Kapitan, 2018).

*Nongestational Parent:* A parent who did not carry their child in utero. This person may or may not have contributed genetic material toward reproduction (Darwin & Greenfield, 2022).

*Nongendered parenting terms*: Include Mada, Maddy, Maddie, Mader, Bubby, Bapi, Mapa, and many more (Minor, 2022).

*Perinatal:* The International Statistical Classification of Diseases and Health Related Problems or ICD-10CM (2019) classifies the perinatal period and the time before birth starting at 22 weeks gestation to 28 days postpartum. However, the term is also used to have various meanings across the world including all of pregnancy, birth, and postpartum period (Nguyen & Wilcox, 2005)

*Prenatal or Antenatal or Antepartum:* Terms that mean 'before birth' (National Health Services, n.d.)

*Perinatal (or Postpartum) Mood and Anxiety Disorders (PMADs)*: Refers to the range of mood and anxiety disorders that one may experience onset during pregnancy and/or up to one year postpartum, (O'Hara & Wisner, 2014). This may include depression, anxiety, OCD, and/or psychosis and would be classified in the American Psychiatric Association's (2022) *Diagnostic and Statistical Manual of Mental Disorders* as "with peripartum onset".

*Pronouns:* Any word that takes place of the noun. Personal pronouns include names for nouns, such as Maryrose or North Carolina. In the English language some pronouns are gendered, such has he/him/his and she/her/hers. Some pronouns are non-gendered , like they/them/their/theirs. Some people use other pronouns when referring to them, such as ze/zir and xe/xem; still others prefer you to use their name (e.g., "Maryrose would like us to use Maryrose's name instead of pronouns.").

*Transgender (Trans):* An umbrella term which refers to any person or persons whose identity is outside of what was assigned to them at birth. This includes binary trans folks, such as a trans-woman or trans-man, nonbinary folks, and anyone else who is genderqueer, genderfluid, gender-expansive, pangender, bigender, agender, and more (National Center for Transgender Equality, 2023).

*Queer:* A term reclaimed from its use as a derogatory slur against "homosexual" folks in the 20th and early 21st centuries (Perlman, 2019), which presently means many things to many people. It typically refers to those who are not heterosexual, cisgender, and/or heteroromantic.

# Literature Review

## Music Therapy Across the Perinatal Experience

### *Music Therapy in the Prenatal Stage*

While there is a growing emphasis on preparing for birth and even on postpartum mental health in research and practice, little emphasis is placed on the potential for prenatal mood and anxiety disorder onset (Biaggi et al., 2016). This gap is reflected in the lack of music therapy literature in prenatal contexts. Existing literature includes the Limerick Lullaby Project, which addresses singing lullabies throughout pregnancy in musician-led groups (Carolan et al., 2012), and a systematic review of music and psychological stress and anxiety in pregnancy (Corbijn Van Willenswaard et al., 2017). The prominent music therapy literature addressing music therapy during pregnancy is Chang, Chen, and Huang (2008)[1] who examined the effects of music therapy on stress, anxiety, and depression in pregnant people in Taiwan in a randomized controlled trial that demonstrated significant decrease in anxiety and depressive symptoms.

Further research is warranted to differentiate between music therapy and general music in prenatal contexts and to focus more on the effects of physiological factors (e.g., hyperemesis gravida, or excessive vomiting), racial disparities in perinatal care, disabled and body-sized disparities in perinatal care, lack of queer and transgender competence in perinatal care, and the Covid-19 pandemic creating further isolation and impacting mental health.

### *Music Therapy Assisted Childbirth*

As childbirth theory and practices moved towards approaches which leaned into support and stimulus for pleasure response, and as music therapy theory and practice moved towards music for relaxation techniques and for alternate states of consciousness, opportunities arose to

[1] It is not clear whether these authors utilized music therapy and credentialed music therapists.

examine music therapy as pain management in childbirth. Clark, McCorkle, and Williams (1981) presented the possibility of incorporated elements of Guided Imagery and Music (GIM) into childbirth, hoping that non-ordinary states may allow birth persons to reclaim the natural process of childbirth from the fear, pain, and tension that recent decades of obstetric medicine had instilled into the experience. The researchers acknowledged the limitations of this study and insisted on the potential for further research to reveal the benefits of the approach.

Hanser, Larson, and O'Connell (1983) examined the use of music to decrease responsiveness to pain in labor by using rhythmic cueing to increase the effectiveness of breathing techniques. Gonzalez (1989) evaluated the effect of music therapy-assisted childbirth on stress reduction for the mother during pregnancy, preparedness for childbirth, and on the experience between mother and childbirth postnatally. The study emphasizes the importance of emotional preparation, parent and infant relaxation through music prenatally, and breathing techniques in music. McKinney (1990) provided another early publication reviewing existing literature relating to pregnancy and childbirth. Shortly after, Allison (1991) published a case study on the experience of working with a first-time mother and her partner throughout pregnancy, childbirth, and into the postpartum stage using pre-programmed music. The music therapist created several cassette tapes of music for various stages in pregnancy and childbirth. It was concluded that the case study subjects found pre-programmed music facilitated by the presence of a music therapist to be an effective form of pain management during childbirth.

DiCamillo (1999, 2000) developed a method of music therapy that uses specially created playlists that include client-preferred music with differing tempos to be used for various stages of labor and birth. The program also includes "womb song", which is a special song created for the baby during the pregnancy. Parents actively engage in the process of writing the song and make

it specific to their forthcoming child. Following the birth, a music therapist will sing and play the song while the parent(s) bond with the baby, usually during skin-to-skin care. The research has demonstrated that the experience of co-creating the song, singing it to the baby in utero, and surrounding the momentous occasion of birth with that song has had impact on parents' lived experiences of their birthand there is much to learn from unexplored aspects of this experience.

There is a limited but growing body of research about music therapy in the childbirth setting. Existing literature focuses on the role of music therapy and pain management (Browning, 2001; Creighton et al., 2013; DiCamillo, 1999, 2000; Fulton, 2005; Liu et al., 2010), and stress reduction and relaxation (Gonzalez, 1989; Hanser et al., 1983; Lin et al., 2019) in childbirth. Fulton (2005) facilitated a pilot study comparing the experiences of full-term birth persons using music listening (N=20) and toning (N=20) through measured changes in physiological state including fetal heartrate and uterine contraction intensity from the medical charts, and perceptual change and fatigue reported in pre- and post-test pain perception through a Visual Analog Scale (Gift, 1998) and in post-discharge interviews. No significant changes were found, but further research is needed to gain a better understanding of the impact music therapy may have in this context. Chang and Chen (2005) focus on the effects of music therapy on physiological measures, anxiety, and birth satisfaction for parents undergoing cesarean section. Results of this randomized, controlled trial indicate that music had "an anxiety-relieving effect" (p. 458) and greater level of birth satisfaction. Liu, Chang, and Chen (2013) facilitated a randomized controlled trial and found that music therapy had a significant effect on reducing pain perception and anxiety during early labor for first-time Taiwanese mothers, but no significant effect during active labor.

While most of the literature that addresses music therapy and childbirth addresses pain and anxiety, studies by Gonzalez (1989) and DiCamillo (1999, 2000) touch on the importance of music therapy-assisted childbirth and parent-infant bonding.

### *Music Therapy in Antepartum/Postpartum Hospitalization*

A similar growing area of interest is music therapy in antepartum and early postpartum hospitalization. A birthing person may be hospitalized during pregnancy due to pre-existing conditions or factors such as parental age, pre-eclampsia, preterm labor, preterm pre-labor rupture of membranes, or vaginal bleeding during pregnancy (Beth Israel Deaconess Medical Center, n.d.). Antepartum hospitalization impacts mental health both due to isolation and to worrying about the pregnancy outcome. A meta-analysis by Toscano, et al. demonstrated that one in three people hospitalized during pregnancy for complications have depression and/or anxiety, which is twice the reported prevalence of the general perinatal population (2021).

In a randomized controlled trial involving 61 high-risk hospitalized antepartum patients, participants who had even one music therapy or recreation therapy session demonstrated a significant decrease in antepartum distress compared with control group participants (Bauer, et al., 2010). In fact, participants who had a recreation therapy session chose creative arts interventions such as listening to relaxing music over other interventions, demonstrating greater desire for music related therapies. Similarly, Horn et al. (2022) reported that antepartum patients who had between one and five music therapy sessions experienced a significant impact on emotional health.

Corey et al. (2019) verified the feasibility of a beside music intervention for birth person/infant bonding for hospitalized parents during antepartum and postpartum stages, reporting high satisfaction, positive effects on participants' relaxation and perception of bonding

with infant. Yang et al. (2009) reports the use of carefully chosen recorded music[2] for three days in an antepartum unit in a hospital in China and found decreased levels of anxiety. Researchers emphasized the importance of client music preferences in this context.

Music therapy has been found to increase heart-rate variability in patients experiencing antepartum hospitalization in Finland (Teckenberg-Jansson et al., 2019), using anthropological music therapy wherein an instrument is placed in physical contact with a person to feel the vibrations. Music therapy has been found to reduce adjustment-related stress in parents hospitalized in antepartum and for parents whose infant is in the neonatal intensive care unit (Bollard-Marcovitz et al., 2022).

### *Music Therapy in the Postpartum Space*

There is significant research focusing on parent-infant attachment and infant-directed singing which is admittedly interconnected with perinatal mental health; however, there is little if any adequate emphasis on the mental health of parents during the perinatal experience or beyond. Due to the nature of this research, this section will highlight literature which focuses on parental mental health rather than parent-infant attachment and infant-directed singing. There is more literature examining general music experiences for parental mental health than that specific to music therapy, so literature across music-adjacent disciplines will be highlighted.

**Music Therapy and Postpartum Mental Health.** First, literature within music therapy, or which explicitly indicates the work or research of credentialed music therapists, will be highlighted. Friedman et al. (2010) highlight the work of an integrated program combining the resources of a music therapy lullaby program and perinatal intensive outpatient groups for individuals ranging from prenatal to three years postpartum who are experiencing perinatal mood

[2] It is unclear whether music therapists were involved.

or anxiety disorders. Parents participated in the "lullaby 101 program." The program consisted of a variety of music therapy experiences including song discussion, music listening, music-assisted relaxation, various forms of songwriting, interactive music-making, and the creation of music projects. Changes in mood were indicated via the Rogers Faces Scale (Third World Congress on Pain for the International Association for the Study of Pain, 1981) and reported an average increase of +0.8 on a five-face scale.

The only other literature that directly addresses music therapy for postpartum mental health, Du (2016), explored music therapists' perspectives on preventing and treating postpartum depression. Four music therapists who have worked directly within perinatal mental health were interviewed to gain a sense of efficacy of music therapy in this context. Du found that so few music therapists worked in this context that she had to open her study to engage music therapists who work towards preventative mental health in these contexts. The analysis indicates that music therapy may be helpful in addressing perinatal mental health in tandem with counseling, but that music therapists should know when to refer out to medical and mental health resources.

**Music Interventions for Postpartum Mental Health.** Terry and Terry (2012) performed a literature review across disciplines covering the areas of postpartum depression and music. Forty-three articles met the inclusion criteria, but it was found that the existing literature highlights a significant lack of research in this area and an area of need. Sanfilippo et al. (2021) provides a broad, cross-disciplinary descriptive overview of how music-based interventions may help perinatal mental health.

**Singing Interventions for Postpartum Mental Health.** Fancourt and Perkins (2018) facilitated a randomized controlled trial examining the effect of singing interventions on postpartum depression symptoms. Women were randomized into ten-week group singing or

group play workshops compared with the control group of usual care. Isolating for parents with severe symptoms, the singing group demonstrated a significant decrease in symptoms, and that the singing interventions proved to impact the speed of recovery as compared to the play group and control group. Participants were interviewed in a follow-up comparative qualitative study by Perkins, Yorke, and Fancourt (2018). Parents who had completed the ten-week singing program reported the impact of authentic, social and multicultural creative experience; learning to calm babies; providing immersive 'me time' for mothers; facilitating a sense of achievement and identity; and enhancing mother-infant bond. The authors point out the significance of the group being catered to the parents and not exclusively for their benefit of their babies (p. 9).

Fancourt and Perkins (2019a) analyzed data from the original randomized-controlled trial (Fancourt & Perkins, 2018) to explore the implementation of group singing for parents experiencing postpartum depression, detailing specifics about the music group and the control play group. This process evaluation demonstrated a high fidelity for singing and play groups for parents experiencing postpartum depression, particularly the singing groups.

Reilly et al. (2019) explored and evaluated singing groups for parents admitted into a specialist mother-baby unit in Australia. In Australia and throughout the United Kingdom, mother-baby units provide inpatient psychiatric care to parents experiencing postpartum mood and anxiety disorders, which emphasize keeping mothers with their babies. 37 women attended at least one singing group session over the inpatient period of 12 weeks. Participants were assessed prior to and following each session and "reported feeling significantly more relaxed, more cheerful and more clear-headed than they did before the session began" (p. 125).

**Parent-Infant Bond and Postpartum Mental Health.** Some literature focuses on the relationship of singing, maternal-infant bond and perinatal mental health. Van Puyvelde et al.

(2014) examined the role music played in opening maternal-infant subjectivity, or the "dance" of shared involvement and responsiveness between a baby and their mother, in an inpatient mother-baby unit. Five mother-infant dyads participated in five weekly music groups led by musicians. Results demonstrated an increase in the amount of intersubjectivity moments and total time of intersubjectivity from session one to session five.

Still, other research connects the impacts of singing to babies on a parent's mental health in the postpartum context. Fancourt and Perkins (2017) examined associations between daily infant-directed singing and postpartum depression, parental mental wellbeing, and self-reported parent-infant bond. Results demonstrated that singing to infants was associated with fewer symptoms of postpartum depression and a greater sense of wellbeing and parent-infant bond. Research demonstrates that singing and making music during pregnancy can have a positive effect on postpartum mental health and parent-infant bond. A three-arm randomized controlled trial by Wulff et al. (2020) demonstrated that both music and singing groups during for parents during pregnancy had positive impact on postpartum mental health and parent-infant bond by measuring cortisol levels in parents; the singing group showing greatest changes in cortisol.

**Music Therapy with LGBTQIA+ Individuals and Communities**

As of this writing, the literature reflects three categories of music therapy theory, research, and/or practice relating to work with LGBTQIA+ folks: music therapy that involves working with individuals and groups within the LGBTQIA+ community, a queer music therapy theoretical framework which is grounded in queer theory, and gender-affirming voicework, a specific approach to music therapy with transgender, gender-nonconforming, or gender expansive individuals which draws from speech language pathology, vocal psychotherapy, and other practices within and adjacent to music therapy.

### *Music Therapy Competency and Work with LGBTQIA+ Individuals*

Perhaps the first publication offering the perspective of a music therapist working with a queer individual is in the original edition of Collin Lee's text, *Music at the Edge: The Music Therapy Experience of a Musician with AIDS* (1996). The book-long case study chronicles the experiences of a gay man and musician near the end of his life and experience with AIDS. In another early publication, Cordobes (1997) examines group songwriting as a means for group-cohesion in a group of individuals with HIV sero-positive status or AIDS. It is unfortunate that the first music therapy literature addressing the queer community was within the contexts of the AIDS epidemic, but it is worth noting that until the decade prior, "homosexuality" was considered a mental illness (APA, 1974; Drescher, 2015). Chase (2004) reviewed literature which addressed mental health practices with gay and lesbian clients to render implications for music therapy practice. Chase states that music therapists should be aware that if they don't encounter queer clients in clinical practice, then they may encounter queer family members or friends or loved ones. She concludes further that music therapists should refer clients out if they "feel uncomfortable and/or inexperienced" working with queer people (p. 36).

General awareness and competency surrounding work with queer, transgender, and gender-expansive individuals and communities seemed to gain attention of the broader collective in the early 2010s within music therapy education and practice (Ahessy, 2011; Aronoff & Gilboa, 2015, Aronoff, 2016; Bain et al., 2016; Baldwin et al., 2012; Baldwin et al., 2013 Berry, 2019; Boggan et al., 2017; Hardy & Baldwin, 2017; Hardy, 2018; Hardy & Montypenny, 2019; Leske, 2016;). A global survey demonstrated that "a large proportion" (Ahessy, 2011, p. 26) of music therapy training programs do not prioritize queer competency although it did not address transgender, intersex, and gender-expansive competency. Baldwin (previously Whitehead-

Pleaux) et al. (2012) felt that more competency and higher standards of inclusion of LGBTQ individuals was needed than the American Music Therapy Association Standards of Practice and Code of Ethics offered at the time, and offered implications for best practice across clinical, multi-disciplinary, and educational settings. Authors encouraged music therapists to commit to ongoing self-education and humility. A preliminary report of a US-based survey demonstrated that over half (57.9%) of respondents did not receive training on LGBTQ+ issues in their music therapy education, over half (59.2%) did not feel equipped to work with LGBTQ+ clients and, equally or perhaps more troublingly, that some (2.2%) had reported using reparative and/or conversion therapy (Baldwin et al., 2013).

The role of music in the coming out process has been examined (Aronoff & Gilboa, 2015) and the role of a music therapy group for gay men (Aronoff, 2016). Further, music therapy has been examined in community contexts for queer college students (Berry, 2019), in queer community choir (Leske, 2016), with transgender and gender-expansive youth (Hardy, 2018; Hardy & Montypenny, 2019), and in identity exploration for Black queer men (Perkins, 2021). It is hoped that the field of music therapy will continue to expand and make space for queerness and gender-expansiveness, and to be transformed by the beauty it brings.

### *Generating Theory for Queer Music Therapy*

While there have been significant gains in research surrounding competency surrounding and work with LGBTQIA+ individuals, there have only been a few who have sought to generate theory or draw from neighboring theories (Bain et al., 2016; Boggan et al., 2017). Hadley (2013) calls for the critique of dominant narratives within creative arts therapies and draws from queer theory among others such as critical race, disability studies, and feminist theory to build awareness of complicity. Bain et al. (2016) posit that creating competencies for working with

LGBTQIA+ individuals within music therapy is “more complex” than adding awareness within existing frameworks (p. 22). Bain et al. conceptualize a theoretical framework grounded in queer theoretical notions of empowerment rather than pathologizing, “fixing”, or upholding harmful structures by emphasizing individual survival rather than contesting hegemony within a community. Five aspects of a queer music therapy based on interdisciplinary research are as follows: 1) combat heteronormativity by emphasizing the complexity and fluidity of sexual orientation; 2) support expression of unique personal and social conflicts due to oppression; 3) empower queer individuals to find strength in differences by freely expressing and performing their gender and sexual identity; 4) positively impact interpersonal relationships to counteract negative social pressures; 5) emphasize common cause rather than commonality of identity. (p. 26).

Music therapy interventions for LGBTQIA+ adolescents are suggested based on the proposed theoretical orientation, including musical autobiography assessments, gender-bender song parodies, an intervention involving transitions from past, present, and future using creative arts, critical lyric analysis, and anthem songwriting. Building upon Bain et al.’s (2016) earlier foundational work examining queer theory in the context of music therapy, Boggan et al. 2017) conducted interviews with music therapists and students who either identified as LGBTQIA+ or worked with LGBTQIA+ clients. Interviews with twelve board-certified music therapists and one music therapy student were analyzed using critical discourse analysis. The major strengths Boggan et al. found in queer music therapy were its connection to queer theory, rejection of the patronization of LGBTQIA+ identities, use of group work, and emphasis on common cause rather than causality. Most significantly, results in Boggan et al. revealed the need for queer music therapy to address the intersectional identities of a person, particularly disabled and

elderly identities while in comparison, (Bain et al., 2016) focused primarily on nondisabled LGBTQIA+ adolescents. Specifically, participants worked primarily with disabled clients, and encouraged researchers to emphasize the importance of making interventions accessible, and to combat ableist narratives that would erase the sexuality of disabled people. Participants in Boggan et al., (2017) also spoke to issues within music therapy education – the lack of LGBTQIA+ related content within programs, and the inaccessible nature of a music therapy training within bachelor's degrees in music schools. There are some  within music therapy educational settings who have engaged in destabilizing power dynamics within (Fansler et al., 2019; Baines et al., 2019). Indeed, examining the lack of prioritization on minoritized experiences within music therapy programs has gained attention in recent years, largely owing to the work of minoritized voices (Gombert, 2017; Gombert, 2020; Gombert, 2022; Hadley & Norris, 2016; Kim, 2011; Leonard, 2020; Webb, 2019).

Finally, Scrine (2019) facilitated action, arts-based research with LGBTQ+ young people in schools. Scrine theorized that songwriting may be used as an "after queer" methodology for instilling in LGBTIA+ young people "agency and authority over their own narratives" (p. 13). Scrine (2019) describes "after queer" as going beyond the pursuit of working with queer people as subjects but as collaborators or co-conspirators and going beyond the binary of homosexual versus heterosexual as well as the "universalizing discourses of 'problems' and 'solutions'" (p. 2).

The development of queer (and after-queer) music therapy theoretical framework acknowledges that music therapists must reconceptualize a radically affirming and inclusive practice which celebrates identity and critiques systems which pathologize and disempower. In moving towards this aspiration music therapists must also consider intersectional identities and

how they shape the person and reject the superficial and largely symbolic inclusivity efforts that are popular. It must critique power and dominant narratives and resist the pathologizing paradigm.

### *Gender-Affirming Music Therapy*

Maevon Gumble (2019a; 2019b; 2020a; 2020b) developed gender-affirming voicework, a new method rooted in queer theory and embodiment practices, focusing on "accessing and embodying affirming and authentic expressions and healing from gender-based trauma" through focusing on the intersections of the body, the physical voice, and the psychological voice (2019b, p. 6). The foundational work was their master's thesis (2019a), a queer autoethnography in which they chronicle their personal experiences as a nonbinary person looking for ways to access an embodied voice. The practice involves singing, speaking, toning, chanting, moving, and vocal improvisation with a music therapist formally trained in the method.

## Perinatal mental health within the LGBTQIA+ community

### *Competence, Language, and Inclusion in Healthcare and Society*

The language used in conception, perinatal, and family contexts often exclude families that deviate from parentage between a heterosexual cisman and ciswoman. Renaud (2007) highlights just how much planning and hopefulness goes into reproductive care in lesbian families; four themes from the ethnography highlight the experiences of preparing the way, conception, pregnancy, and birthing. Brennan and Sell (2014) explore how language affects lesbian non birth mothers as they transition into parenthood. Results showed that language affects non birth mothers on the individual level, making them feel "less" of a mother than the birth mother. Mothers reported that they had to educate healthcare providers about family planning for lesbian couples. Ultimately, inclusive language in reproductive healthcare is helpful

for multiple types of people, including adoptive parents, trans men, women who are infertile or never wish to gestate, birthing people who act as surrogates, and parents who utilize surrogates (McKinnon et al. 2020). Gender-inclusive language in medical contexts heeds the imperative for harm-reduction (Samoud et al., 2022).

The need for competency in reproductive healthcare providers regarding LGBTQIA+ family-building is well documented (Klittmark et al., 2020; Rogers, 2020; Trettin, 2005). Indeed, transgender pregnant people may need to seek specialized care due to the inaccessibility of trans-inclusive reproductive and perinatal care, despite transgender and cisgender people experiencing desire for pregnancy and birth at similar rates (Gedzyk-Nieman & McMillian-Bohler, 2022). In fact, research continues to capture the range of experiences of pregnancy transgender and gender-expansive people regardless of hormone use (Moseson et al., 2021).

### *Trans Perinatal Experiences: Perinatal Mental Health and Wellbeing*

Transgender and gender-expansive parents may choose to add to their families in myriad ways, as with their cisgender counterparts. The lack of visibility and barriers to assisted reproduction, surrogacy, and adoption resources compound this in addition to discrimination and sometimes dysphoria. Isolation, loneliness, and the navigation of shifting identity in parenting are common themes, and for many, pre-conception can be the most isolating time (Ellis et al., 2015). Charter et al. (2022) found that transgender parents in Australia were predominantly concerned about mental health, particularly the role of gender dysphoria causing depression and anxiety, suicidality, disordered eating, and substance use. In an earlier study, Charter et al. (2018) found that while dysphoria increased with gestational time, trans-masculine parents constructed their own parenting identity.

One significant factor in isolating trans parents is the false notion that trans pregnancy is exceptional and abnormal in reproductive healthcare and society (Dietz, 2021). In fact, Dietz argues that trans pregnancy is not unusual, and that complications related to being a trans pregnant person are manufactured by institutions that lack imagination. Assisted reproductive technologies such as in vitro fertilization (IVF) and expansive ways of family building including surrogacy and gamete donation increase options for all parents, including cisgender women, and that by expanding their realm of care to include transgender parents they create more options for all people. Regardless, while many trans-masculine gestational parents experience increased gender dysphoria in gestation and in chestfeeding (Garcia et al., 2019; MacDonald et al., 2016), some found it empowering, and others experienced it as non-gendered, highlighting that transgender pregnancy experiences are not monolithic (Kirczenow, 2021; MacDonald et al., 2021).

A scoping review of birth trauma and perinatal mood and anxiety disorders in transgender and nonbinary people found twelve articles from which six themes emerged (Greenfield & Darwin, 2021). Dysphoria, visibility and recognition, isolation, and exclusion, anticipated and experienced poor care, choice and control, and increased vulnerability to perinatal mental health concerns and traumatic birth were all themes. Ultimately, while there has been an increase in transgender perinatal mental health research, more is needed to address this expansive, diverse group of parents.

### *Queer Perinatal Mental Health Outcomes*

Perinatal mental health outcomes vary across human experience. It has been indicated that sexual minority women score well-above the typical indicators for perinatal mood and anxiety disorders than their heterosexual counterparts (Marsland et al., 2021). Low social support

from friends and family is indicated as a risk factor for increased perinatal mood and anxiety disorders. The same study found that bisexual women in heterosexual-passing relationships were more likely to conceal their identity than lesbian women in homosexual relationships. It is indicated that bisexual erasure may factor into perinatal mental health outcomes. Male-partnered bisexuals who have had sex with women in the past five years reported higher levels of discrimination, poorer perinatal mental health outcomes, and the misconceptions of others surrounding bisexuality (Ross et al., 2012). A longitudinal study found that sexual minority women currently partnered with a man had worse experiences of postpartum depression than female-partnered sexual minority and heterosexual couples (Goldberg et al., 2020). Contrary to these experiences, Flanders et al. (2016) found no significant difference between postpartum depression in sexual minority women and heterosexual women, purporting that sexual minority women are "not homogenous enough to be considered as a single entity" within postpartum mental health research (p. 5). Alang & Fomotar, 2015, facilitated an internet-autoethnography of an online support group for lesbian moms with postpartum depression. Messages and comments were analyzed, and themes emerged demonstrating the importance of this group for disclosure and companionship, discussing ways of coping, reluctance to seek treatment, medication, perseverance, and comorbid conditions.

Gay fathers who became parents through surrogacy in Israel experienced both higher levels of life satisfaction and posttraumatic growth than heterosexual fathers *and* higher rates of postnatal depressive symptomology (Shenkman et al., 2022). Gay fathers in Israel who have had to seek surrogacy services outside of their home country have reported compounded challenges, and yet may have heightened sense of growth.

### *Navigating Relationships, Family-Identity, and Minority Stress*

LGBTQIA+ parents navigate family-building and parenting in a world that often depicts parentage as exclusive to cisgender heterosexual couples: that is one cis-man and one cis-woman who build their family through intercourse. Despite this, queer, trans, and gender-expansive people find ways to build families and surround themselves by community support and resources. Gay fathers were found to have "queered their family experiences" by challenging schools and other communities to include representation, school events, and families that go beyond the "standard North American family" model to include experiences of all kinds (McKee, 2022). Grigoropoulos (2022) examined the experiences of gay fathers through the lens of minority stress theory, finding that wellbeing is often influenced by social factors and internalized prejudice. Similarly, Horne et al. (2022) utilized minority stress theory to explore LGBTQIA+ parental satisfaction and unequal rights to parenthood . While the results did not indicate independent relation to parental stress, the combination with related stressors is certainly of concern.

An autoethnography (Rogers, 2020) highlighted queer women experiences of conception and pregnancy. Queer women often bypass the medical system in different stages of conception, pregnancy, birth, and postpartum due to mistrust in the level of LGBTQ competency despite increased mental health concerns. What's more, communicating family identity to non-family members presents a burden and anxiety to LGBTQIA+ parents. Gillig and colleagues (2022) highlight the results of a questionnaire which revealed that all participants felt their family was "different" some of the time even if some felt "the same" most of the time. LGBTQIA+ parents often were expected to answer how they "got" their children to people in a variety of contexts.

Ignoring and avoiding were the most used strategies when called into question regarding their family identity.

**Conclusion Based on Existing Literature**

Lesbian, gay bisexual, transgender/nonbinary, intersex, asexual-spectrum parents and families navigate access to surrogates, adoption, and assistive reproductive in a world which often fails to recognize or make space for them. Their postpartum experiences are often complicated with increased levels of postpartum mood and anxiety disorders. The literature highlights the importance of community, chosen-family, representation, and access to queer and trans-competent medical care, healthcare, reproductive care, and media.

Of particular concern is that no existing research for asexual and ace-spectrum postpartum and perinatal mental health could be found. Two articles with the word “asexual” in the title described the de-sexualization of mothers rather than asexual as a sexual identity. Similarly, no literature was found regarding perinatal mental health of intersex individuals.

In recent decades, music therapy research, theory, and practice has been addressing perinatal mental health and separately has addressed support for LGBTQIA+ individuals, however much more is needed to address the vast support needs of these groups. There is no literature within music therapy that addresses perinatal mental health in LGBTQIA+ individuals.

**Purpose Statement and Research Question**

The purpose of this research is to explore the impact of a music therapy group for LGBTQIA+ parents experiencing postpartum mood and anxiety disorders and to highlight perceptions of participants. The intent is to highlight shared experiences of LGBTQIA+ parenting within a music therapy group, and its impacts on individual and communal mental health.

How might a music therapy group for LGBTQIA+ parents experiencing postpartum mood and anxiety disorders impact their mental health?

a. What changes, if any, occur between week one to week 8?
b. What patterns, if any, occur from pre- to post-session?
c. What themes emerge from participant perspectives that may help music therapists in this context?
d. What considerations should music therapists make in working with perinatal mental health for LGBTQIA+ parents?

# Method

## Research Design

Mixed methods research is often poorly understood as incorporating two dichotomous "types" of data: quantitative and qualitative. Matney (2019) describes how these concepts fail to capture the complexity and richness of how data is interpreted. What is understood to be quantitative research may include elements of storytelling, assessing, comparing, and connecting. What is understood to be qualitative research may include counting and other mathematical elements (p. 8). The methodology used for this thesis is one example of many methodologies within mixed methods research and should not be held up as an example for all mixed methods methodologies.

Mixed methods research provides a strong framework for research, weaving multiple strands of research into a tapestry which makes up the whole. I am a storyteller and story enthusiast, and as I grow into the role of researcher, I am learning that numbers can play an important role in the storytelling process. Since there is so little research on music therapy with postpartum parents and no research on music therapy with LGBTQIA+ postpartum parents, I hope to provide foundational research in this area that may capture the interest of researchers and providers who would not be interested in research based purely on participant experiences, (Johnson & Onwuegbuzie, 2004).

In light of my background, I have chosen a partially mixed concurrent mixed methods design**,** in which data will be gathered, analyzed, and interpreted simultaneously and separately with an emphasis on the shared experiences of participants. Leech and Onwuegbuzie(2004)describe partially mixed concurrent dominant status design as one where the forms of data (considered quantitative and qualitative) are gathered concurrently and not mixed

until they are analyzed separately. The participant experiences and investigator journals are given more weight than quantitative scores (Mertens2007) . I will be favoring the experiences of participants over the pre-posttest scoring changes because I believe that numbers are only one component of stories.

**Theoretical Perspective and Epistemological Positioning**

The research design is informed by constructivism as a theoretical perspective, not to be confused with constructionism, which is, incidentally, the epistemological underpinning of this study. Matney describes constructivism as the "creation of meaning" outside the social constructs (2019, p. 11). I have used a mixed methods design to capture the meaning made in a music therapy group for LGBTQIA+ postpartum parents, highlighting the experiences and feedback of participants and integrating the strands of data results in rich storytelling which I hope adequately captures the experiences of those in the group.

As described above, constructivism as a theoretical perspective clarifies the connection to constructionism as an epistemological position. In constructionism, there is no objective truth waiting to be discovered (Crotty, 1998). Meaning, which is "truth," comes out of "our engagement with the realities in our world" (Crotty, 1998, p. 8); it is created, or "constructed," and unique to the individual or group experiencing it. Essentially, there is no "truth" to discover but rather meaning to create. In music therapy contexts, meaning can be created collaboratively in group music therapy..

**Method of Data Collection**

Throughout the eight-week group period, four strands of data were gathered and eventually analyzed, interpreted, and integrated. I kept a reflexive journal and captured my immediate reactions, thoughts, and feelings following each session. Jane Lovesick (1999, 2015,

2016) describes reflexive journalizing as a way for researchers to better understand the research process and their positionality throughout the research. The journal included process and product: a way for me to be grounded in my place as a researcher and group facilitator while sorting out my reactions and perspectives about sessions, and another source to sift for themes.

Participants completed the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) during their first and final group attendance. The EPDS consists of ten questions scored on a Likert scale capturing the measure of perinatal depressive, anxious and suicidal symptoms within the past week. Questions with a more positive indication are scored standard, while questions with a more negative indication are reverse scored. A score of ten or higher may indicate perinatal depression, with 30 being the maximum score. The change in score from the beginning of a participant's involvement in the group to the end of the eight weeks may contribute to capturing the impact over the group period on postpartum mental health.

At the beginning and end of each session, participants filled out the Brief Mood Introspection Scale (BMIS) (Mayer & Gaschke, 1988), a short assessment that captures more acute changes in mood. The BMIS presents the participant with sixteen mood descriptors such as "lively," "drowsy," and "calm" and to rate them on a four-point Likert scale from "definitely do not feel" to "slightly feel" and are scored into four scales (Mayer & Cavallaro, 2019). The pleasant-unpleasant score is based on reverse scoring unpleasant descriptors, with higher scores indicating a more pleasant overall mood and lower scores indicating a more unpleasant overall mood. The arousal-calm score is based on the level of arousal (stress or dysregulation) versus calm, with higher scores indicating greater arousal and lower scores indicating more calm overall mood with reverse scoring for descriptors that indicate low arousal. The positive-tired score is based on mood descriptors that indicate levels of positive mood versus tired mood, with higher

scores indicating a more positive, less tired mood and lower score indicating more tiredness and less positive mood, with tired indicators being reverse scored. The negative-relaxed score indicates relaxed moods (lower score) versus more negative moods (higher score), and more relaxed mood indicators are reverse-scored. The exploration of nuance in moods may be helpful in learning how the moods of participants shifted throughout the session. These strands were analyzed using descriptive statistics (Vetter, 2017), capturing changes over time in the mean, median, mode, and standard deviation. The sessions occurred weekly on Saturdays for 60 minutes at a time and day chosen to fit the availability of the participants. Of the eight weeks dedicated to the group, five weeks were attended by participants and one week was dedicated to the focus group, one week no one showed, and one week one person showed but did not want to participate in the music therapy session independently . Sessions that were attended opened and closed by singing "I Am Enough" by Beautiful Chorus (2021) as a group, a song which repeats the lyrics, "I see myself in joy and love, I know myself I am enough." Participants were encouraged to check in with their bodies, breath, minds, spirits, and environments and to join in singing if or when they felt comfortable, with their Zoom audio muted or unmuted. Participants were given the opportunity to introduce themselves and to check in verbally among the group. Participants would share how they were doing, share about their kids and families, challenges, and joys. Several sessions involved the discussion of infant-directed singing through lullabies and parent-preferred music and lyric content in lullabies. One week the session check-in led to a discussion which lasted the duration of the session about navigating gender identity, sexuality, and advocating for parenting decisions within extended families. This conversation led to the exchange of resources, educational, and advocacy materials such as children's books and parenting guides. One week included a song discussion and lyric analysis of the song You're

Enough by Sleeping At Last which led to the idea of creating a collaborative Spotify playlist to share songs among one another (See Appendix D). Another week the parents learned words and motions to the song Bikeride, by Vered, a movement song that can be used for connecting with babies and young children that involves wheeling the child's legs like bicycle pedals, which can also promote bowel movement. Parents also learned the song When You Smile by Vered and engaged in a discussion about seeking the small moments of joy among the difficult and often messy moments of parenting.

The last session of the eight doubled as a focus group, where participants were asked to share their experiences throughout the group – what was most meaningful to them, what they would have wanted differently, and any feedback they have for future practice. Those who could not attend the focus group met for individual interviews and asked the same questions. The focus group, subsequent interviews were recorded and transcribed, and the resultant transcriptions and the therapist's reflexive journal were coded using the qualitative analysis software Atlas.ti, and analyzed using thematic analysis, an iterative process of organizing codes, or topics that occurred multiple times throughout the transcripts, and organized into greater patterns of meaning through negotiated themes (Braun & Clarke, 2006). Six themes and their subsequent subthemes were identified throughout the qualitative analysis and were examined in context alongside the descriptive statistics from the pre- and post-testing, and analyzed as parts of a whole, with a weighted emphasis given to the themes.

## Recruitment and Demographics

### *Recruitment procedures*

This study was approved by the Slippery Rock University Institutional Review Board in October 2022 and revised in January 2023. This music therapy group was initially intended to

take place in person at a wellness practice in Durham, North Carolina. However due to low recruitment and the number of requests for a virtual group, I changed the format, increased the inclusion criteria to parents 36 months postpartum from 12 months, and made the days and times based on participant preference. Fliers were distributed locally in Raleigh/Durham, North Carolina in coffee shops, libraries, community centers, and grocery stores. Advertisements were posted on social media and in Facebook groups specific to postpartum, LGBTQIA+, and music therapy. Potential participants met with me via Zoom and were offered the chance to share what they most hoped to get out of the group.

***Participant Demographics***

Out of eleven who expressed interest, six participants signed on to participate in the research and five attended the minimum number of sessions required for inclusion (N=5). All participants lived on the East Coast of the United States, identified as LGBTQIA+, and had a child under the age of 36 months at the time of recruitment. The age of the participants' children ranged from six months to 35 months at the time of recruitment. Three of the five participants carried the child gestationally and gave birth, and two participants had a partner that gave birth. The participant group consisted of four people who are nonbinary, gender fluid, and/or gender expansive, and one person who is cisgender. Two participants listed their racial and/or ethnic identity as Asian American/Pacific Islander (Filipino American and Pacific Islander), one as Black and African American, and two as white or cultural white. All listed themselves as queer, with various additional sexual identifiers listed in Table 1.

**Table 1**

*Participant Demographics*

| Pseudonym/ Pronouns | Gender | Sexuality | Race/Ethnicity | Child Age | Birth Person |
|---|---|---|---|---|---|
| "Cat", They/Them | Fluid, Expansive, Nonconforming, | Queer, Grey-Ace | Filipino-American, Mixed-Race, Armenian, Sicilian | 6 months | Gave birth |
| "X", They/She | Fluid, Expansive, Creative, Nonbinary | Bi, Pan, Queer | African American, Black | 28 months | Gave birth |
| "M", They/Them | Nonbinary | Lesbian, Queer | Pacific Islander | 6 months | Partner gave birth |
| "DeShane", She/Her | Nonbinary | Gay, Demisexual, Homoromantic, Pansexual | Cultural white (English, Irish, French) | 35 months | Partner gave birth |
| "Michelle", She/Her | Cisgender | Queer | White | 11 months | Gave birth |

## Results

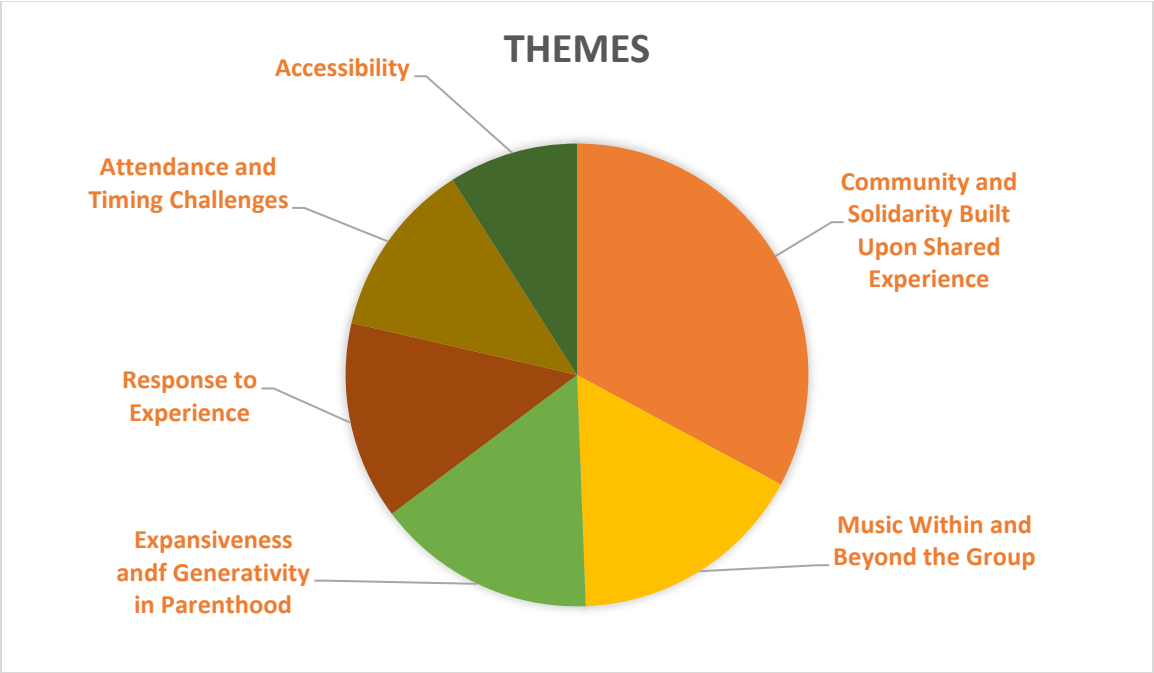
The purpose of this research was to explore the impact of a music therapy group for LGBTQIA+ parents experiencing postpartum mood and anxiety disorders and to highlight perceptions of participants. The intent was to highlight shared experiences of LGBTQIA+ parenting within a local community music therapy group, and its impacts on individual and communal mental health. Six people signed on to participate, and five participants across three Eastern United States attended the minimum of two of the eight weeks of virtual music therapy group in April and May 2023.

### Themes

Of the eight weeks dedicated to the group, five weeks were attended by participants and one week was dedicated to the focus group, one week no one showed, and one week one person showed but did not want to participate in the music therapy session independently. Three participants attended the focus group and the two participants who were unable to attend the focus group were interviewed separately. All participants were asked a series of questions in a semi-structured interview process (See Appendix A). The eight therapist reflexive journal entries, the focus group, and two interviews were transcribed and analyzed, and six themes and their subsequent sub-themes were identified. The themes identified are community and solidarity built upon shared experience, music within and beyond the group, expansiveness and generativity in parenthood, response to the experience, attendance and timing challenges, and accessibility (See Figure 1).

**Figure 1**

*Themes and Their Occurrence Within the Narratives*



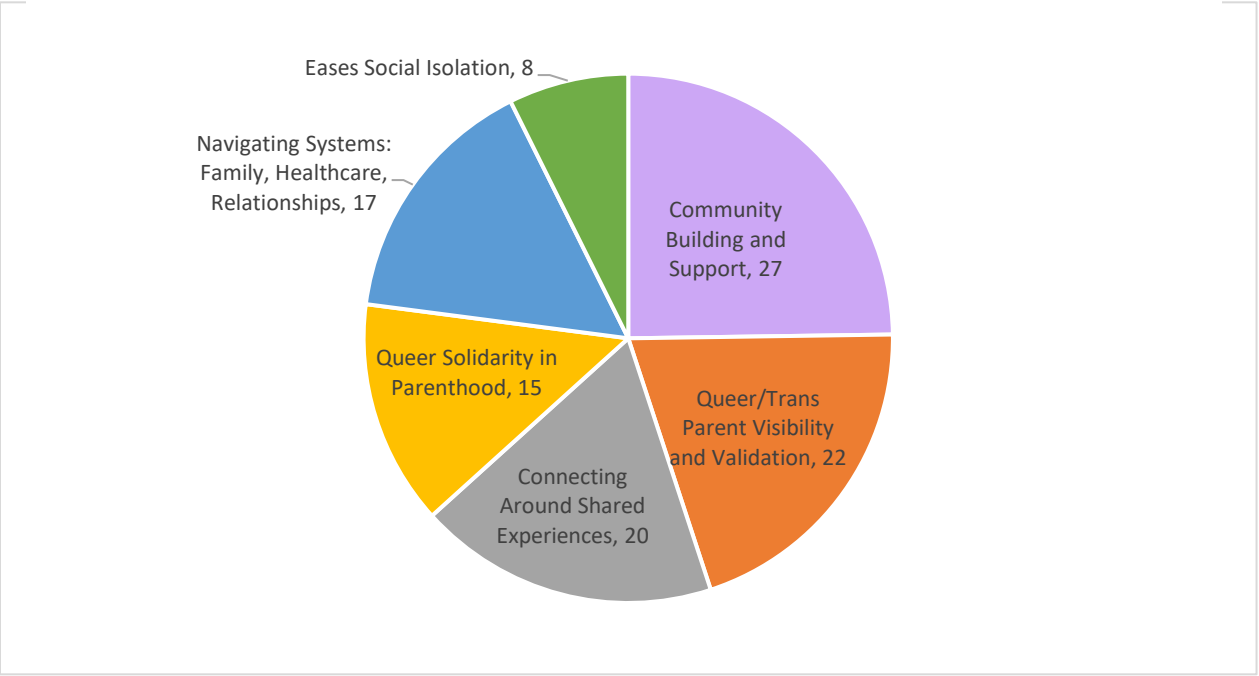

### *Community and Solidarity Built Upon Shared Experience*

This theme occurred 109 times throughout the focus group, interviews, and therapist journal entries, highlighting various areas within the theme which occur as subthemes: community building and support, queer/trans visibility and validation, connecting around shared experiences, navigating systems: family, queer solidarity in parenthood, healthcare, relationships, and eases social isolation. This theme, which showed up most frequently of the six, conveys the importance of finding community among other queer and trans parents, its role in easing

isolation and improving mental health, and the potential for that community to be built within the

**Figure 2**

*Subthemes for Community/Solidarity Built Around Shared Experiences*




music therapy context. Subthemes are organized according to distribution in Figure 2.

**Community Building and Support.** Participants consistently described the desire and need for building community around their lives and family and their motivation for building this in the music therapy group. As intentional as they were about surrounding themselves with community, it has been challenging finding community within the intersection of LGBTQIA+ and parenthood. Cat described a moment in a session where Michelle, who Cat had just met, validated their experience struggling with advocating for their parenting choices to their family: “that felt so like relieving and validating, and like, um just like cut through all the baloney that I deal with on a, on an everyday basis be being like specifically a queer parent”.

**Queer/Trans Parent Visibility and Validation.** Participants describe that witnessing the existence of other queer and trans parents was impactful and validating in and of itself. They also described how validating it was to learn about music and other resources that are intentionally inclusive of LGBTQIA+ families. X describes witnessing other queer and trans parents with their babies during groups:

> I mean, like even just the act of seeing other group parents is kind of like, because I mean, like on base level, where, like, "yeah, of course, we exist" but like seeing other [queer and trans] parents and the baby, and like being pulled everywhere and having a really normal experience felt really cool, really nice.

**Connecting around Shared Experiences.** Throughout the group, participants were able to identify experiences that they had in common, and this was highlighted in the focus group and interviews as being meaningful. Michelle shared that she "felt really touched to hear the challenges people were facing, and see pieces of it in my own life, too, that I hadn't fully pinpointed it like, 'Oh, yeah, like, I'm not alone.'"

**Navigating Systems: Family, Healthcare, Relationships.** Participants described the challenges of navigating healthcare systems, family systems, and relationships as LGBTQIA+ parents. The challenges of navigating lack of awareness of queer families, transgender health, and assisted reproductive technology in healthcare were highlighted. Family systems stretched around growing families and participants desired that their families understand and be willing to grow in areas of gender-expansiveness and "nontraditional" families. Relationships with partners and friends changed as families grew as well. DeShane describes the way that the VA fell short in helping them identify and understand their postpartum anxiety:

> I never really sat down and thought about it, and like with my own therapy through the VA, like, that sort of thing doesn't come up, because they, you know, have to check off, you know. “Do you have PTSD?” “Do you have this that the other?” But you know it, the VA, still has a long way coming for queer folk.

**Queer Solidarity in Parenthood.** Based on the narratives shared in the focus group, interviews, and throughout the music therapy group meetings, the concept of queer solidarity in parenthood came up frequently, both explicitly by name and implicitly in concept. Based on these narratives I understand queer solidarity in parenthood to be a sense of kinship and empowerment based on shared values, identities, and experiences that comes up out of the marginalization of LGBTQIA+ people and the lack of awareness, competency, and visibility within parenting spaces. Michelle highlighted this sense of queer solidarity in parenthood beautifully:

> There is a lot of beauty in the commonalities and connections and knowing that we were with people who like get it on a different level than random people in parent groups like there - there is a sense of a queer solidarity that I could feel in this space that I don't get in the general public. I have great friends that I'm building, but not all of them are queer parents.

Michelle also shared the importance of coming into intentional spaces designed for queer parents, highlighting that these spaces are not just meaningful, but vital:

> Coming to spaces with people who get it makes it so that I can rest, or I can like cry or complain, or be held in the complexity of it and get resources and support to help carry

> through. So that I can keep going and keep fighting and keep loving in powerful ways. This is lifesaving work: showing up in solidarity for and with each other.

**Eases Social Isolation**. Participants described the role of community and shared experiences in easing social isolation, especially for those who became parents during the COVID-19 pandemic. DeShane describes this:

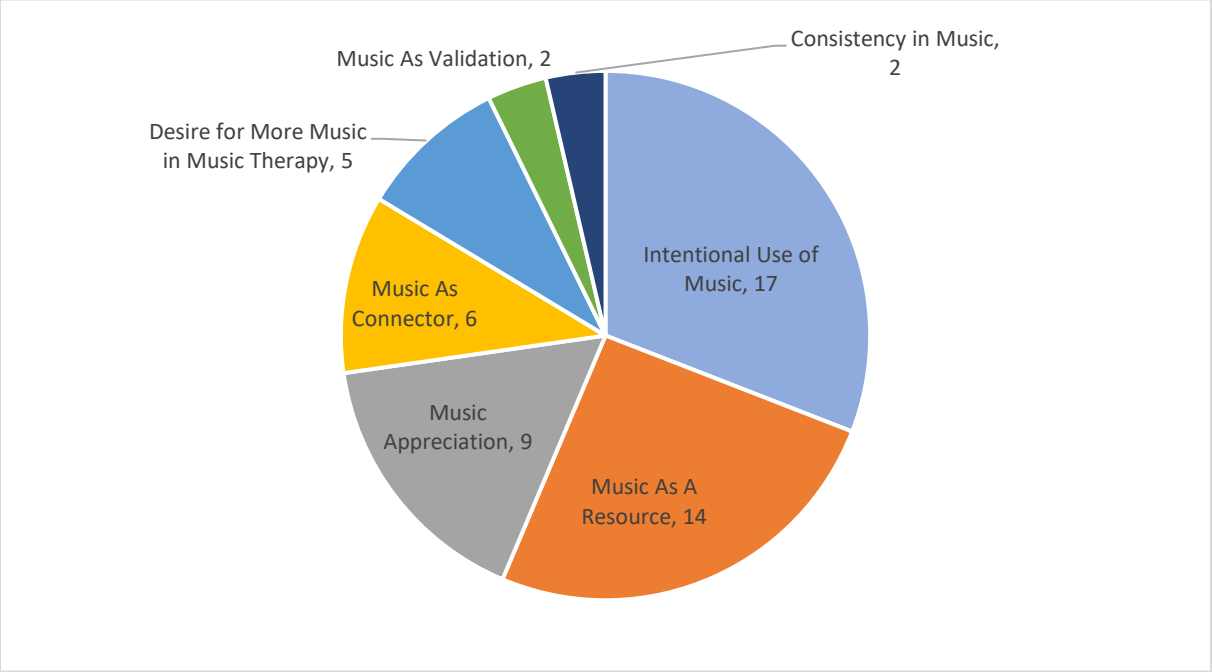
> It was great to actually get in touch with people that presented in, in some fashion, same fashion as, as I do and their experience with having a, a baby or a partner having a baby especially during the pandemic. It's hard for me to, to connect with people that are like cis-het situations.

### *Music Within and Beyond the Group*

The theme with the second greatest frequency throughout the narratives, music within and beyond the group occurs 55 times. Participants seemed to demonstrate a keen sense of awareness of the role music plays in their lives as well as how the music was present in the group. The subthemes identified within this theme are as follows: the intentional use of music, music as a resource, music appreciation, music as connector, the desire for more music in music therapy, music as validation, and consistency in music (See Figure 3).

**Figure 3**

*Subthemes for Music Within and Beyond the Group*




**Intentional Use of Music.** This was a topic that was explored throughout the group sessions and is reflected in the focus group and interviews. Participants explored lullabies to substitute ones in what is considered "traditional" in Western society that have dark content matter, including themes of sickness, death, and injury. Participants explored the importance of representation of race, culture, disability, gender, and sexuality within the music they share with their child. Cat describes this intentionality regarding gender and sexuality representation: "I've been wanting to increase my awareness and like practice of using songs that you know, like were said before, like weren't just like Mommy [Shark] Daddy [Shark], blah blah blah…" M describes the way the group allowed them to think of ways to use music in healing: "[it was] nice to explore like new music, and like ways to incorporate it into healing."

**Music as a Resource.** Participants described the impact of having resources to take away from the group, from singing songs weekly to having access to a collaborative playlist (See Appendix D) created by therapist and participants throughout the group, to ways to use music in their lives. X described:

> [I] felt really appreciative of the like stuff to take outside of the group as well, like the songs and things to do with him, were really helpful. [It's] always, always kind of hard to mobilize a toddler, to do anything at all, or go anywhere even during nap time.

**Music Appreciation**. Participants described the simple appreciation of music within their daily life. Cat shared in the focus group: "I love the, the music aspect of it, which was like fun and soothing at times, or, you know, offer different options like even away from this hour itself."

**Music as a Connector.** Participants highlighted music as being a way to connect with others. M described music as "an icebreaker" and "a fun way to connect with the group." X described it beautifully: "music is kind of a leveler like in general, just like music being, like - it kind of breaks some boundaries down for anyone and it's really cool to hear songs."

**Desire for More Music in Music Therapy.** When asked what they would want changed if they were to repeat the experience, participants unanimously shared that they would have preferred more music-making in the group sessions. DeShane said, "I would definitely say… more music experiences as a group that way, you know, we could like talk about it. And you know, sort of, cause I like to pick apart things."

**Music As Validation.** This subtheme was identified two times, and both were in the music therapist's reflexive journal. During a lyric analysis of the song, You're Enough by Sleeping At Last (2013), the group discussed the impact of hearing the lyrics repeat encouraging

statements: “Michelle shared how beautiful it was to hear ‘you’re enough’ repeated, and how it ‘could be cool’ to shift it to ‘I’m enough’, and shared how much ‘these words change us.’ Discussed speaking ‘you’re enough’ to your inner child.”

**Consistency in Music.** This subtheme was identified two times, and, as with music as validation, both were in the music therapist’s reflexive journal. One occurrence of the subtheme was identified in a journal entry from 4/8/2023 about the affirmation song I opened each group with, I Am Enough by Beautiful Chorus (2021). This is what I wrote: “I typed in the lyrics in the chat and encouraged [X] to tune into their body and breathing, and to join singing when they felt comfortable. [X] told me they felt that singing the repetitive affirmation song ‘felt meditative.’” The second occurrence of this subtheme was identified in my journal entry for another session on 4/29/2023, following a session involving song sharing and a discussion about music for bonding with baby: “[We] discussed the love for repetition and yearning for consistency in music as related to looking for consistency in parent-bond.”

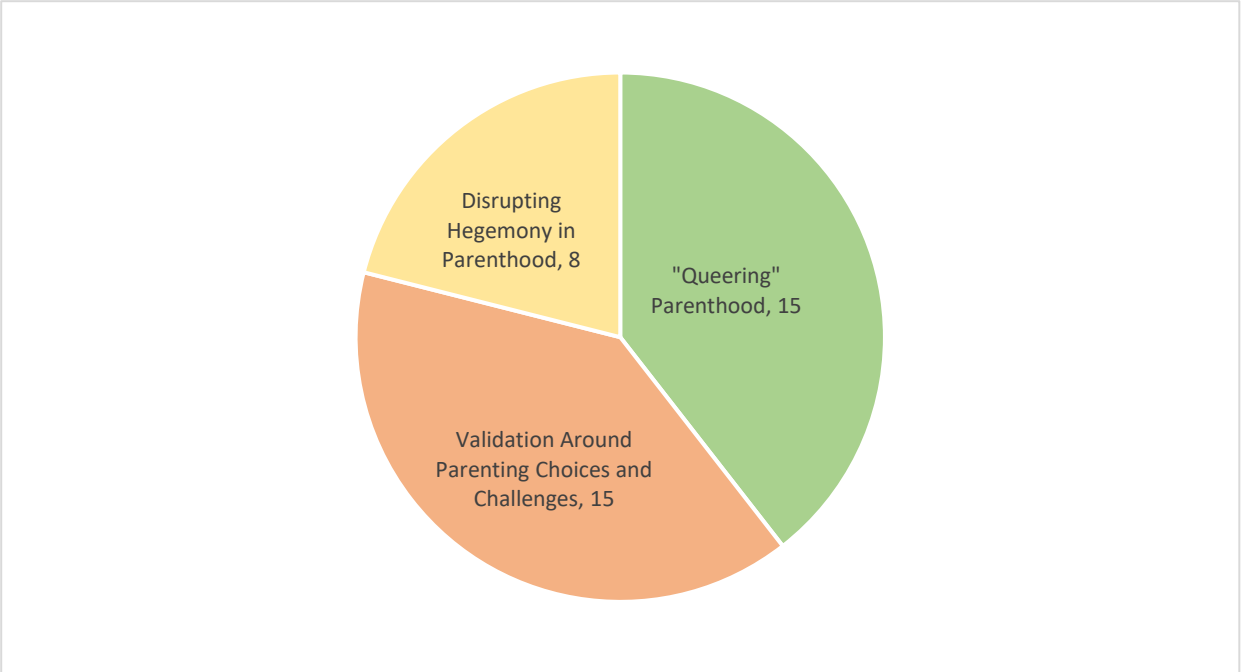
### *Expansiveness and Generativity in Parenthood*

Among the longing for community, shared experience, and challenges within the systems of society and one’s life, there was a sense of expansiveness, creativity, and ingenuity shared among the participants that pointed directly to queer parenthood. It seems that because LGBTQIA+ parents have to think carefully and radically imagine their reproductive journeys, that this gives way to attitudes of openness, imagination, reflection on values and desires, and reflexivity within all aspects of parenting. This theme was identified within 51 quotes across narratives and organized into the following subthemes: “Queering” Parenthood, Validation

Around Parenting Choices and Challenges, and Disrupting Hegemony in Parenthood, (See Figure 4).

**Figure 4**

*Subthemes for Expansiveness and Generativity in Parenthood*




**"Queering" Parenthood.** In activism, social, and academic spaces, queering, or to queer is to "challenge the dominance of heterosexist discourses" (Beemyn & Eliason, 1996, p. 165), or more broadly, "a distorting, a making the solid unstable" (Corber & Valocchi, 2003, p. 25). The art of queering across contexts is a beautiful, imaginative way of living life, because rendering normative ways of being as strange creates imaginative, innovative practices. bell hooks (2014) said it best:

> "Queer" not as being about who you're having sex with (that can be a dimension of it); but "queer" as being about the self that is at odds with everything around it and that has to invent and create and find a place to speak and to thrive and to live.

Participants are queering parenthood by being intentional about the language they use, such as referring to a nonbinary parent DeShane as "Maddy," as M and Cat who use interchangeable pronouns for their baby "until they tell us who they are," Michelle having intentional conversations about sexuality with her child, and X, a single parent, integrating chosen family with relatives into the circle of care surrounding a child.

**Validation Around Parenting Choices and Challenges.** Participants described having family and friends who "don't get it" and how refreshing it was to be surrounded by queer parents who validate their experiences. M expressed this sentiment, saying "defending me and my partner's parenting choices is exhausting." Michelle expressed this as well: "'Oh, yeah, like, I'm not alone' in having trouble talking to my relatives about, you know how to talk to or about my kids around sexuality or gender, reproduction, or any of like, you know, sexual health in general."

**Disrupting Hegemony in Parenthood.** A term attributed to the work of Antonio Gramsci (Gramsci et al., 1972), hegemony describes the cultivation of unquestioned norms of power as a means of coercion. The idea points to the way dominant power systems create social, political, and cultural norms that are so unquestioned that they easily remain in power. In a western white supremacist capitalist cis-heteropatriarchy, it is assumed that childbearing, adoption, and parenting are roles exclusively assigned to cisgender heterosexual couples who reproduce through penetrative sexual intercourse. Participants demonstrated a disruption of this hegemony within parenthood, challenging what parenthood is and who gets to be parents. M described wanting "to raise [their] child in a completely different way" than they were raised, highlighting child agency and autonomy. Michelle put it beautifully:

> I'm intentionally being radical and bucking the status quo and like yes, I will push, and I will fight, and I will advocate, and I will use my voice, and, like leverage, the power that I have in whatever it is to work for justice in an intersectional way.

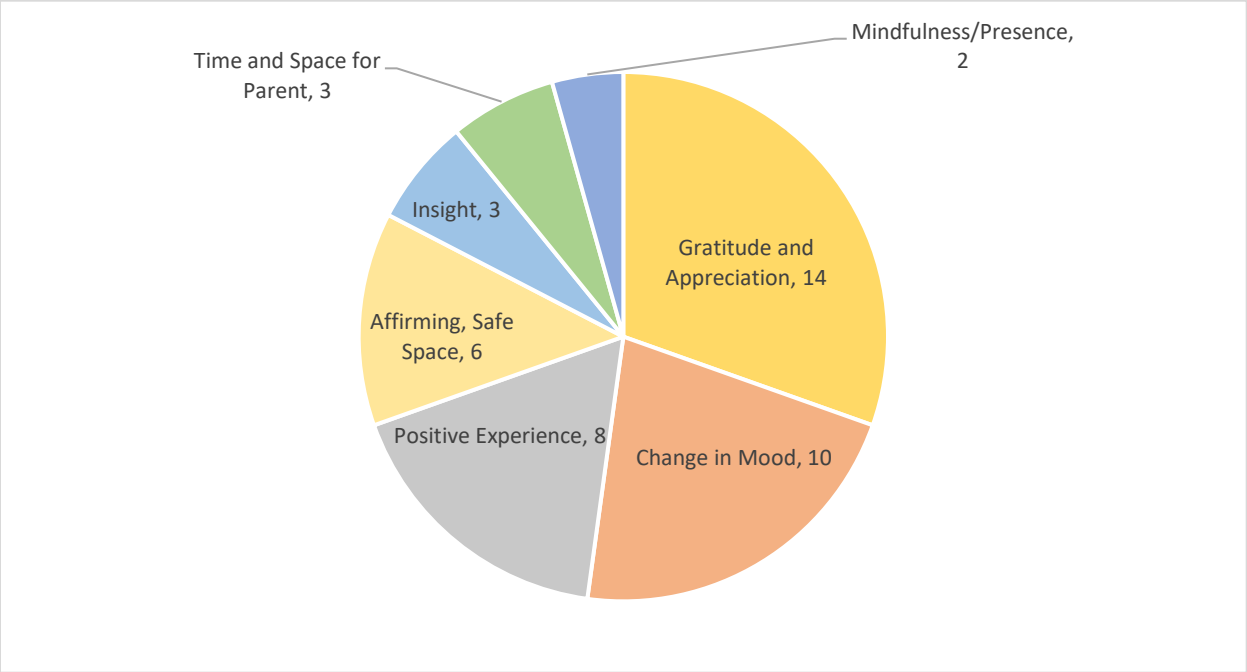
**Non Gestational Parenthood and Assisted Reproductive Technology.** Three of the five participants became parents through assisted reproductive technology, or the use of in vitro fertilization with or without sperm and/or egg donors. Two of the five are nongestational parents, meaning they did not carry the baby, and those same two do not share genetic material with their baby. DeShane described how impactful it was to connect with another non gestational parent, feeling "an instant connection with M."

### *Response to Experience*

This theme highlights participant indications of their responses to the experience of the 8-week music therapy group, which occurs across focus group and interview 46 times and categorized into the follow subthemes: gratitude and appreciation, change in mood throughout session and over time, positive experience, an affirming safe space, insight, relief, time and space for parent, and mindfulness/presence (See Figure 5).

**Figure 5**

*Subthemes for Response to Experience*




**Gratitude and Appreciation.** Participants shared a sense of gratitude for being included in this experience, and appreciation for the awareness and community that was created in the process. DeShane expressed gratitude for the inclusion criteria expanding from 12 months postpartum to 36 months postpartum, which meant they could participate, saying "I wanted to jump in on this in any way possible."

**Change in mood throughout session and over time**. Participants described varying changes in their mood and anxiety throughout sessions. Michelle said that she "felt a little better after feeling connected to others." DeShane shared that "it seemed like the more that we talked in session, the more that I would relax depending on… there were a couple of times where the, the mood didn't change because of the outside stressors." From the first to the last session, M shared:

> I noticed I felt, I'm trying to find the right word, I felt like, some relief. I found relief. I was gonna say, lighter… Yeah. I guess it would feel a little bit easier afterwards. Even if the circumstances hadn't really changed, just to have that space to feel safe and be heard.

**Positive Experience.** Participants shared having a positive experience in the music therapy group and with connecting with other participants DeShane shared:

> I think overall just being able to talk to somebody having a sounding board. and and just like. you know, figuring out, you know things outside of my own head. and and having somebody validate my feelings, and in my experience that you know it was, it was a good experience.

**Affirming, Safe Space.** These words were repeatedly used in the focus group and interviews. M described that parenting "in general is really hard" but that being a queer parent "adds an additional layer" and that "to have the space to be… seen and held gently and be accepted" was impactful.

**Insight.** One participant, DeShane, described several insights that came from their experience in the group. DeShane described having "better understanding" of anxiety and being able to communicate that to their wife in a way to better be cared for. They also described having more agency over their intrusive thoughts, saying they feel "more free" to let their son leave the house thinking of "the worst possible situation happening."

**Time and Space for Parent**. Participants highlighted their desire to make time and space for themselves as parents in a society that prioritizes the care and nurturing of the baby. Michelle shared that she "crave[s] the opportunity to carve out time for just [her] to support [her] growth

and healing." Cat shared that they appreciated the accessibility but also wished the sessions were in person so it would feel more like time and space for them as parents.

**Mindfulness/presence.** Participants discussed how the music therapy group brought about mindfulness and presence. X shared:

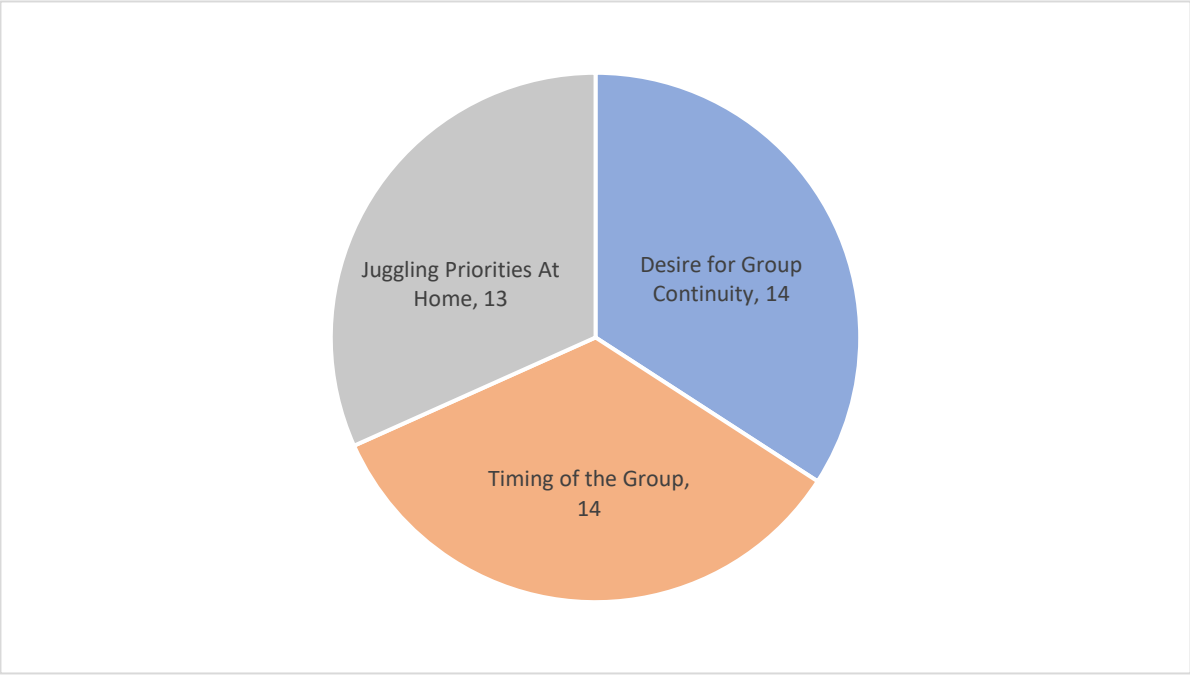
> It like gets me out of the like survival mode grind. And it's kind of like sometimes, like it is that deep. But it's kind of not that deep, you know. The present moment, it's very important as well and not just like zooming around and like remembering that you love things like music.

### *Attendance and Timing Challenges*

Occurring 41 times throughout the therapist journals, interviews, and focus group, participants and therapist highlight the challenges of finding a good meeting time for participants and their families and the inconsistency of attendance throughout the eight weeks. Participants attended an average of 3.4 weeks out of the eight, with a range of 2-5 weeks attended. The theme is broken down into the following subthemes: the desire for group continuity, timing of the group, and juggling priorities at home (See Figure 6).

**Figure 6**

*Subthemes for Attendance and Timing Challenges*




**Desire for Group Continuity**. Participants shared that the inconsistent attendance left them wanting for more consistency and continuity throughout the eight weeks. Cat shared that they wanted the group to have a similar camaraderie as depicted in the shows Working Mom and The Letdown, but that they "missed out on that feeling." Michelle said that "continuity and commitment would have really helped me."

**Timing of the Group**. Multiple participants described that the day and time the group occurred each week was not favorable with their families and lives. Participants filled out a poll with ideal scheduling prior to the start of the group, but it was still difficult to get a sense of a day and time that would work best for all. X pointed out that "it would be hard" to get a group of parents together, and Cat added "but it's really also the families and babies" and other schedules that need to come together.

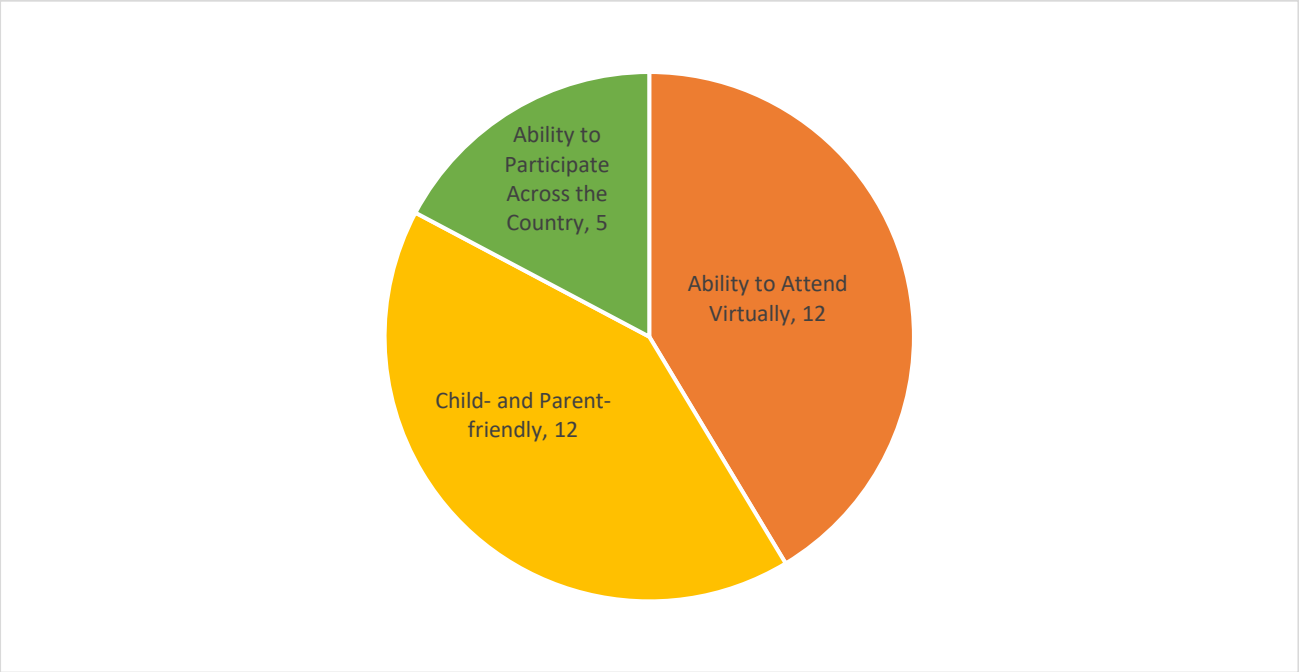
**Juggling Priorities at Home.** Participants described how balancing the baby, kids, partners, family, pets, house projects, work, and other commitments made it challenging to choose music therapy group over other things.

### *Accessibility*

The final theme identified throughout the narratives was accessibility, occurring 30 times. Participants found that despite attendance and timing challenges faced throughout the group, they were grateful for the accessible nature of the group across the following areas, which are the subthemes: the Ability to Attend Virtually, Child- and Parent-friendly, and Ability to Participate Across the Country (See Figure 7).

**Figure 7**

*Subthemes for Accessibility*




**Ability to Attend Virtually.** Participants described that the virtual format opened opportunities for them to attend while carrying for their families at home. X shared that they

"might have attended more" if they had to leave the house and Cat described that "it would be nice" to have it in person, but that it was "helpful" to have it virtually.

**Child- and Parent-friendly.** Participants described the group as "child-friendly," being able to care for their baby, turn their camera off to pump, and felt free to have their child roam around during the session. Cat described it as being "parent-friendly" in that there was "no judgement" for showing up late or needing to go "clean the poop off your phone."

**Ability to Participate Across the Country.** Three of the five participants attended the group from a state other than North Carolina, where the group was initially set to meet in person. Participants expressed gratitude for the ability to connect, as DeShane said, "with people out of state like Cat and M and their baby."

### Edinburgh Postnatal Depression Scale: Pre-treatment to Post-treatment

The Edinburgh Postnatal Depression Scale (EPDS) was administered upon the first session of music therapy a participant attended and following the last session, measuring change in postpartum mood over the course of the 8-weeks. Pre- and post-scores and the changes can be found below in Table 2.

**Table 2**

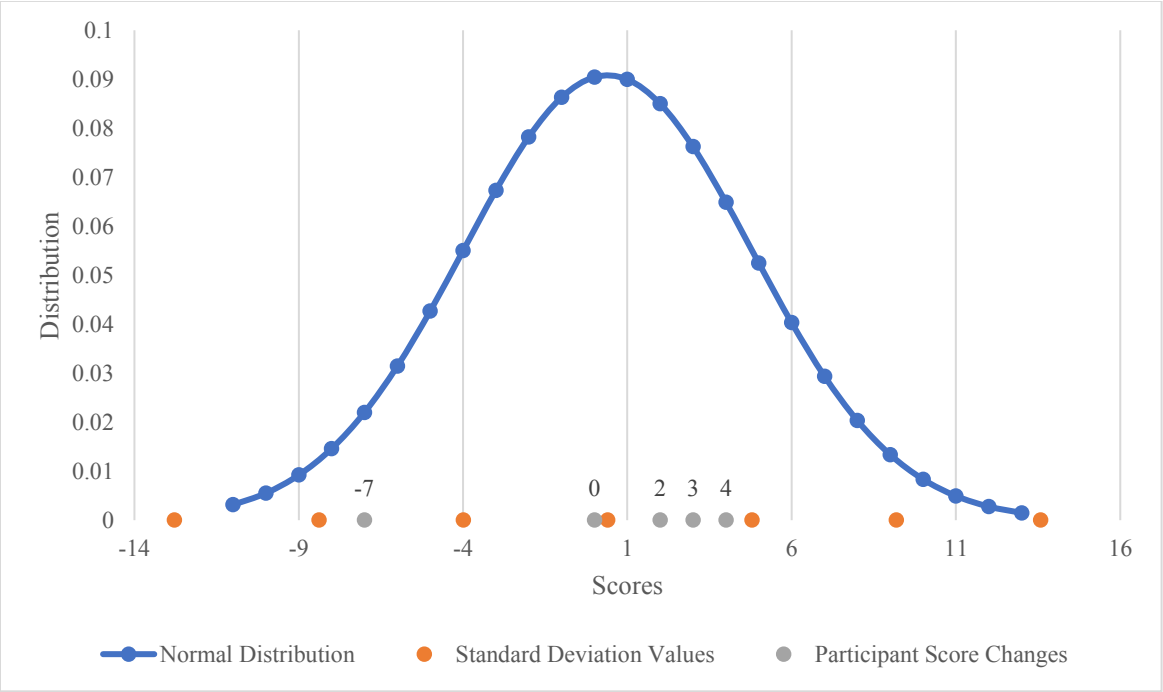
*Edinburgh Postnatal Depression Scale Scores and Changes*

| Pseudonym | Date of Pre | Pre-Score | Date of Post | Post-Score | Changes |
|---|---|---|---|---|---|
| Cat | 4/1/2023 | 14 | 6/3/2023 | 12 | -2 |
| X | 4/8/2023 | 17 | 5/20/2023 | 17 | 0 |
| M | 4/15/2023 | 22 | 6/2/2023 | 18 | -4 |
| Michelle | 4/22/2023 | 11 | 5/20/2023 | 8 | -3 |
| DeShane | 4/29/2023 | 18 | 6/12/2023 | 25 | +7 |

Changes in EPDS scores showed a range from -4 to +7 and a mean of +0.4 and a standard deviation of +4.39. The data shows an average increase in EPDS score, indicating higher levels of potential postpartum depression and anxiety, but because the sample size is so small, the average is skewed by an outlier. One participant, DeShane, had an increase in EPDS score of 7 points, while the other 4 participants had the following score changes, 0, -2, -3, -4. When I checked in with DeShane, they shared that the increase in their score is directly related to a major life event, as mentioned before, that was increasing their distress. I made sure DeShane had access to resources and safety planning. Despite the outlier, it appears that a decrease in Edinburgh Postnatal Depression Scale score may be associated with involvement in the 8-week music therapy group within the participant group. Nevertheless, given the sample size and inability to rule out other factors, the data cannot point to significant change in postpartum depression and anxiety. Figure 8 shows that all participant changes in EPDS scores lie within two standard deviations of the mean.

**Figure 8**

*Standard Deviation for EPDS Changes*




**Brief Mood Introspection Scale: Pre- to Post-session, Week-to-Week**

The Brief Mood Introspection Scale (BMIS) is scored here in four different ways, with the most basic covering overall pleasant to unpleasant mood. These same questions are scored to address arousal to calm, positive to tired, and negative to relaxed moods, all indicating more specific moods. Changes in the Pleasant-Unpleasant scale scores across weeks ranged from -2, or mood becoming less pleasant by two points, to +13, increasing in pleasant mood by 13, with a mean of +4.85 and a standard deviation of 4.69. Changes in the Arousal-Calm scores, which measure changes in from more aroused states to more calm states, had a range of -6 to +3, with a mean of -1.08 and a standard deviation of 3.12. Positive-Tired scores show an increase in mean score of +2.31, indicating a more positive mood from beginning to end of session on average, with a range of -2 to +8 and a standard deviation of 2.898. Finally, Negative-Relaxed scores

show a decrease in mean score of -2.08, indicating a less negative, more relaxed mood on average from a range of +2 to -8 and a standard deviation of 2.69. Changes in pre- to post-session scores within all four BMIS scales can be found in Table 3.

**Table 3**

*Brief Mood Introspection Scale Changes*

| Pseud. | Date | Pleasant-Unpleasant | Arousal-Calm | Pos-Tired | Neg-Relaxed |
|---|---|---|---|---|---|
| X | 4/8/2023 | 10 | -6 | 2 | -7 |
| X | 4/15/2023 | 4 | 3 | 2 | 2 |
| Cat | | 1 | -4 | -2 | -3 |
| M | | 0 | 2 | 2 | 0 |
| DeShane | 4/29/2023 | 13 | 0 | 6 | -2 |
| Cat | | 5 | -2 | 1 | -2 |
| Cat | 5/6/2023 | 3 | -1 | 2 | -2 |
| DeShane | | 7 | 3 | 8 | -1 |
| Michelle | | 3 | 1 | 2 | -1 |
| Michelle | 5/13/2023 | 3 | 1 | 2 | -1 |
| M | | 13 | -5 | 6 | -8 |
| Cat | | -2 | -1 | -2 | -1 |
| DeShane | | 3 | -5 | 1 | -1 |

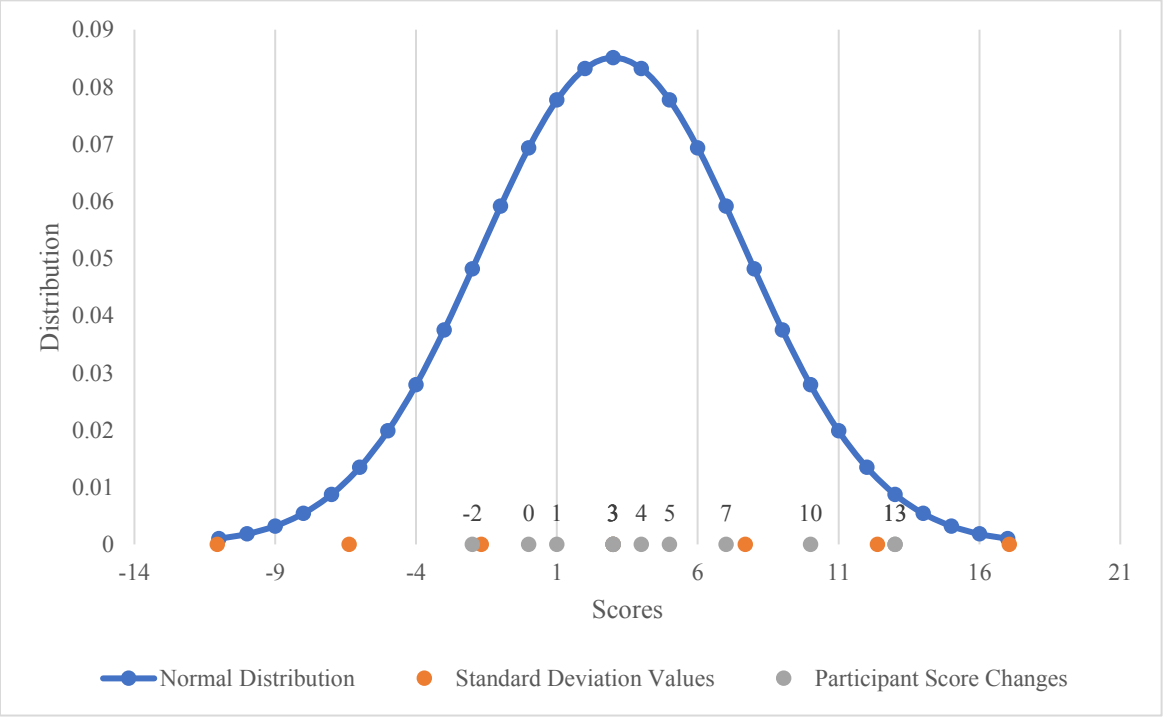
The score changes in the BMIS show the most significant change throughout sessions within the pleasant-unpleasant score (Mean=4.85), indicating that a moderate increase in pleasant mood may be associated with attending a music therapy group session. Scores showed minor change in the scores of arousal-calm, positive-tired, and negative-relaxed scales, with means of -1.08, +2.31, and -2.08. This indicates that engaging in a music therapy group may have contributed to participants becoming more calm and less stressed, more positive and less

tired, and more relaxed and less negative, but does not prove as significant as the general increase in pleasant mood.

Data from the changes in pleasant-unpleasant scores were examined on a bell curve. Except for one score that falls just out of range on the high end, all score changes lie within two standard deviations above the mean and within one standard deviation below the mean. This shows that except for a few higher score changes and with no significant decrease in score changes, most participants had similar amounts of increased changes in pleasant-unpleasant mood (See Figure 9).

**Figure 9**

*Standard Deviation for BMIS Pleasant-Unpleasant Changes*



## Integration of Data

The present research study utilized partially mixed concurrent mixed methods design in which themes were identified and analyzed from participant interviews, a focus group, and therapist reflexive journal entries. The themes were community and solidarity built upon shared experiences, music within and beyond the group, expansiveness and generativity in parenthood, response to experience, attendance and timing challenges, and accessibility, all with corresponding subthemes. The Edinburgh Postnatal Depression Scale (EPDS) was administered on the first session a participant attended and following the last session to capture overall change in postpartum mood over the time of the music therapy group meetings. The Brief Mood Introspection Scale was administered at the start and end of each music therapy session to capture more immediate changes in mood.

### *Themes*

The most predominant theme that occurred in 33% of the total content analyzed with 109 total quotes is community and solidarity built upon shared experience. This was most important to LGBTQIA+ parents struggling with postpartum mood and anxiety to find fellow LGBTQIA+ parents. That community building and support (27), the visibility and validation (22), connecting around those shared experiences (20), a sense of queer solidarity within parenthood (15), navigating family, healthcare, and relationships (15), and easing of social isolation (8) were all important elements that motivated participants to get involved in the group. Parenting can be challenging and isolating in and of itself, as is being queer and/or trans in a society built around cisnormativity and heteronormativity. The combination, met with lack of visibility and awareness creates a wide gap in community and mental health care for LGBTQIA+ parents. Nevertheless, participants demonstrated expansiveness and generativity in their parenthood (51

quotes, 15% of total quotes), “queering” their way through parenthood (15) and validating each other in their parenting choices and challenges (15), disrupting the hegemony in parenthood (8), validating nongestational parents and assisted reproductive technology among other means (6).

The second most predominantly occurring theme is music within and beyond the group, 17% of the analysis with 55 quotes, showing that while it was most significant to find LGBTQIA+ parent community and shared experiences, the music aspect of the group played a significant role in the experience. Participants came out of this experience with an awareness of the intentional use of music (17), music as a resource (14), greater sense of music appreciation (9), music as a connector (6) and validation (2) and bringer of consistency (2). Participants also expressed a desire for more music within the music therapy group (5), showing that this group craved connection in and to music specific to this context. With 46 total quotes and 14% of total quotes, the theme response to experience covers various reactions and takeaways from engaging in the group. Participants expressed gratitude and appreciation (14), indicated that their moods changed throughout session and over the course of the sessions (10), shared that they had a positive experience (8), that they felt this was an affirming safe space (6) set aside for parents (3), and that they gained insight (3), and increased mindfulness and presence (2).

With 41 quotes and 12% of theme makeup, attendance and timing challenges were the biggest drawback to the group experience. Participants were able to connect a lack of group continuity (14) with inconsistent attendance due to timing challenges (14) and participants juggling priorities at home (13). Despite the group being accessible (9 % with 30 quotes) in its virtual format (12) and parent- and child-friendly (12), some participants cited the time and day of the group as being challenging for their families despite the time and day being based on a doodle poll of participant preferences.

### *Scores in Context of Themes*

The BMIS captured more statistically significant data than the EPDS (See Tables 2 and 3), suggesting that the music therapy sessions may have had more significant impact on immediate mood and anxiety levels than over time, but this suggestion must be considered among a myriad of other factors. Participants shared that the community and solidarity, the music, and the expansiveness of queer parenthood found within the group were most impactful, which is reflected in the substantial changes in mood throughout the session as endorsed in the BMIS scores. The strong desire for group continuity and frustration with attendance challenges may be reflected in the minimal changes to EPDS scores.

### *Working Theory*

When participants showed up to the music therapy group, they demonstrated notable short-term improvements to their moods as indicated in the BMIS scores. However, there was no measurable significance in the EPDS scores, which were already limited due to sample size and an outlier. The themes and quotes from participants complete a picture of the strengths and challenges of this group. Participants attendance an average of 3.4 weeks total out of the eight offered. Were there more consistency in group attendance, it is likely that there would be more long-term improvements in postpartum mood and anxiety reflected in EPDS scores.

## Discussion

The present research study aimed at exploring the impact of an eight-week music therapy group for LGBTQIA+ parents with postpartum mood and anxiety disorders, highlighting the experiences of the participants. The sessions involved mindfulness-based singing, an opportunity to introduce themselves and to check in verbally among the group, song discussions, and the creation of a collaborative playlist of songs used for soothing and connecting with baby

and with themselves. The questions asked of participants during the semi-structured focus group and interviews aimed at highlighting elements of the group that were meaningful to participants and how mood and anxiety levels were impacted throughout the session and over time. The Edinburgh Postnatal Depression Scale was administered at the beginning of the first session participants attended group and following the last session to capture broadly how the eight-week music therapy group might impact perinatal mental health. The Brief Mood Introspection Scale was administered at the start and end of each music therapy group to capture more immediate shifts in mood and arousal state throughout the session. Using a concurrent partially mixed method design, the experiences of the participants have been prioritized over the pre- and post-test data as parts of an integrated whole.

**Community and Solidarity Built Around Shared Experiences**

Participants overwhelmingly highlighted the impact of finding community with fellow LGBTQIA+ parents, both as a primary desire for involvement in the group and as a primary takeaway from the group. This prevalence of this theme is consistent with and validates the emphasis on social support from family, chosen family, and friends for combatting mental health in queer and trans parents within existing literature (Alang & Fomotar, 2015; Ellis et al., 2015; Marsland et al, 2021).

**Music Within and Beyond the Group**

Participants indicated that the music experiences within the group and their increased awareness of music use within their lives were also significant to the experience and to facilitating connection and community. Fancourt and Perkins (2018) found that parents who engaged in singing groups experienced most rapid and significant changes in postpartum depression as compared to play and control groups. While this present study did not have a play

or control group to compare with, the prevalence of music within and beyond the group as a theme suggests that the singing and music discussion played a particular role in the overall impact of participant experiences. Further work by Perkins, Yorke, and Fancourt (2019) found that it was important for parents to have "me time" set aside from responsibilities and routines, a sentiment that was reflected in this present study.

**Expansiveness and Generativity in Parenthood**

Participants were bolstered in their sense of expansiveness and generativity within parenthood, encouraged to challenge the way parenthood is perceived as being solely for cisgender heterosexual couples who reproduce by way of penetrative sexual intercourse, and to generate expansive, creative ways of raising a family. The expansiveness and generativity cultivated in this group felt resonant of Boggan and colleagues (2017), who found that queer music therapy emphasizes the complexity and fluidity of sexual orientation; supports expression of unique conflicts due to oppression; empowers queer people to find strength in the diverse expressions of gender and sexuality; positively impact relationships; and emphasize common cause rather than commonality (p. 26). While Scrine's (2019) work was with LGBTQIA+ youth, their description of songwriting as an "after queer" methodology felt resonant: one which goes beyond viewing queer clients as subjects but as coconspirators who view the discourse of queerness as so much more than problems and solutions. Participants in this present study described how their queerness and their queering of parenting generated a more rich, imaginative way of raising children, similar to findings in McKee's (2022) study of gay fathers challenging of the "standard North American family."

### Attendance and Timing Challenges and Accessibility

Participants found that while the virtual format for the group increased accessibility, attendance and timing challenges were the biggest limitation to their overall experience and desire for group cohesiveness and continuity. Participants attended an average of 3.4 weeks out of eight. Similar attendance challenges were highlighted by Lara et al. (2010) in their longitudinal randomized controlled trial for group therapy with parents experiencing postpartum depression. The researchers had hoped to recruit and retain higher volumes of participants than they were able to and point to the unique challenges of postpartum depression and adjustment as barriers to such retention.

### Pre- and Post-Scores

The Edinburgh Postnatal Depression Scale was administered upon the first session a participant attended and following the last session to capture changes in mood and anxiety over the duration of the group meetings, eight weeks at most. The average score changes from pre- to post-treatment, +0.4, was heavily skewed by an outlier score change, which increased by seven points due to a participant experiencing a major life upheaval, while other scores decreased or stayed the same. Without the outlier, a general small trend towards decrease is scores may suggest that the music therapy group had a small impact on change in overall postpartum mental health, but ultimately the limited sample size and inability to rule out other factors renders this data insignificant. Pessagno and Hunker (2012) facilitated an eight-week psychotherapy group for parents who had recently given birth at a local hospital. Twenty-four participants were split into two groups based on whether their score indicated postpartum depression (10 or higher) or otherwise. Both groups saw significant decreases in EPDS score over the eight weeks and even after six months, contrary to the findings in this present music therapy study. Remarkably, all 24

participants attended all eight psychotherapy groups consistently, unlike in the present music therapy group study, where participants attended an average of 3.4 weeks out of 8.

The Brief Mood Introspection Scale was administered at the start and end of each music therapy session to capture more immediate and subtle changes in mood and anxiety. Ten score changes over five total sessions were captured using the scale's four scoring systems, showing an average increase in pleasant (versus unpleasant) mood of 4.85, an average decrease in arousal or anxious (versus calm) mood by 1.08, an average increase in positive (versus tired) mood by 2.31, and an average decrease in negative (versus relaxed) mood by 2.08. These findings are consistent with Friedman et al. (2010), who reported an increase in mood measured by an average of +0.8 on the Rogers Face Scale (Third World Congress on Pain for the International Association for the Study of Pain, 1981) pre- to post-session with similarly structured sessions in a perinatal intensive outpatient program. Findings in this present research were also consistent with the work of Reilly et al. (2019) in mother-baby units, who reported positive changes in mood as measured by increase in Quick Mood Scale (Woodruffe-Peacock et al., 1998) and Visual Analog Scale (Gift, 1998) from beginning to end of music therapy group sessions.

Examining the themes and pre- and posttests in context, participants experienced a marked improvement in postpartum mood and anxiety symptoms when they were able to overcome the attendance and timing challenges to attend music therapy sessions. Participants identified the factors that most improved their mood and anxiety were community and solidarity within LGBTQIA+ shared experiences and music within and beyond the group meeting space.

From the beginning of time, LGBTQIA+ people have brought expansive, generative, imaginative, and creative ways of being into their communities and into society that, in turn, benefit all people. LGBTQIA+ people bring this into parenthood by finding expansive,

generative ways of building families from reproduction to family dynamics and parenting styles. This research is motivated by the need to confront the vast unmet need in perinatal mental health care for LGBTQIA+ parents, and thus it would be incomplete without acknowledging the issues that complicate it. At the time I am writing this in August 2023, the LGBTQIA+ community in the United States where I reside has endured an onslaught of hateful, misinformed anti-LGBTQIA+ legislation proposals and many that have passed. The Human Rights Campaign has issued a national state of emergency for LGBTQIA+ Americans (HRC, n.d.). The American Civil Liberties Union is tracking 494 bills to date, 130 of which relate to healthcare (ACLU, 2023). At the time of writing this, my resident state of North Carolina moved to override the governor's vetoes on three bills that will directly harm queer and trans youth (Reed, 2023). Now more than ever it is imperative that both perinatal and family spaces embrace queer, trans, and gender-expansive families by being knowledgeable and accepting and to champion them. It is not enough to support the gay dads who adopt, or the lesbian couple who uses IVF. We must lovingly embrace trans and gender-expansive parents. Now more than ever music therapists need to passionately support and care for LGBTQIA+ clients and their families. We cannot simply address the psychosocial needs of clients without confronting what is causing the crisis.

**Limitations**

Findings in this study are not generalizable across settings, contexts, formats, or groups. Broader reaching studies with more resources and a greater geographical, sociocultural, and socioeconomic reach may be able to create generalizable findings within this context. The small sample size limits the breadth of diverse experiences and the reliability of trends particularly within the pre- and post-tests. This study captures the experiences of five participants who attended music therapy groups in a virtual context, and while these experiences may be valuable

in informing music therapy practice in a similar setting, other people in other groups may have completely different experiences. My preference for the group was that it would take place in person rather than in a virtual format, however participants largely found the accessibility helpful. I certainly felt that my use of music within the groups was limited, particularly because participants often had to split their attention between the group and the baby, family, pets, or other home activities. Ultimately, the most substantial limitation was the inconsistency of attendance due to timing challenges and juggling responsibilities. Looking back, I wish I had checked in with participants immediately to try and find a time that might work better. Finally, all five group participants were all experiencing mood and anxiety symptoms in the postpartum stage, so perinatal mood and anxiety disorders in the prenatal stage were not represented.

**Implications for Practice**

The present study suggests that a virtual music therapy group for LGBTQIA+ parents experiencing perinatal mood and anxiety disorders may have improved mental health outcomes. The group was initially planned in the in-person format but pivoted to virtual due to low recruitment. The virtual format allowed participants from other states to be involved, and participants reported that the increased accessibility was helpful. Music therapists have certainly become more aware of and experienced working in the virtual context in the wake of the COVID-19 pandemic and should consider how to adapt a music therapy group for the virtual context for postpartum mental health. Conversely, there were elements of music therapy that could not be adapted or utilized in the virtual format and should be handled with care and curiosity.

Participants gave the feedback that they would have preferred more active music experiences within the group, such as singing and songwriting, in addition to song discussion and

playlist creation, which I felt limited to do given the inconsistent attendance, commitments at home, and the virtual format. Music therapists should consider creative ways to meaningfully engage in immersive music experiences and not hold back despite split attention. Music therapists can explore the use of shared digital audio workstation platforms such as Sound Trap (https://www.soundtrap.com/musicmakers), where clients could engage in digital music-making and composing.

Perinatal mental health is a specialized area of practice that is not adequately addressed within even advanced music therapy or mental health counseling education. In interviewing music therapists who work in perinatal mental health contexts, Du (2016) found that music therapists should be knowledgeable of their limitations and know when to refer to a counselor or similar provider. Similarly, I recommend that music therapists interested in work within this area not only immerse themselves in existing literature but also seek additional training to appropriately address the gap in education and awareness. Postpartum Support International (https://www.postpartum.net) offers multi-tiered trainings on perinatal mental health for professionals as well as a variety of free webinars and resources. I recommend attending the two-day components of care and advanced psychotherapy workshops, as I have found this the most thorough, comprehensive, and useful among any counseling, birth worker, or music therapy training in this context.

Regardless of setting, music therapists should surround themselves with queer and trans perspectives within and beyond music therapy contexts. We must not only get and stay abreast of current concepts, terminology, and relevant areas of conversation, joy, and struggles. When working within perinatal contexts, music therapists must be knowledgeable of the expansive

ways that LGBTQIA+ people grow and raise families as well as issues that may exacerbate perinatal mood and anxiety for them.

### Recommendations for Further Research

More robust research is needed within music therapy in perinatal mental health contexts, from inpatient psychiatric units to intensive outpatient programming, to community and outpatient care. This research design may be replicated or adapted with proper acknowledgement and citation to fit various similar contexts. It would be beneficial to expand research to capture more thorough participant narratives, to reach more broad-scale demographic and geographic groups, and to focus within more localized communities. Researchers should consider the benefits of facilitating music therapy groups in person and virtually. Finally, music therapists and researchers should consider the language we use, the potential for inclusion, the risk of exclusion, and commit to curiosity as we learn and grow together.

## Conclusion

This study brought together two areas of music therapy that are not adequately addressed in literature and practice: perinatal mental health and the experiences of LGBTQIA+ individuals. What is abundantly clear is the importance of intentional spaces where queer and trans parents can find, support, and sustain each other. This need for queer solidarity is so much bigger than any clinical support or therapy context; healing happens as much, if not more, organically. Acknowledging this, music therapists are uniquely situated to cultivate creative means of connection and growth and must do this mindfully and reflexively in ways that sustain communities rather than profiting from them. The findings from the pre- and post-tests did not point definitively at significant changes in perinatal mental health for LGBTQIA+ parents in

a music therapy group, but there are certainly trends that can be further explored. There is so much to be curious about in music therapy and in perinatal mental health right now. I am excited for the conversations that this study will spark and for the research and practice that will follow.

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## Appendix A: Focus Group/Interview Questions

1. What was this experience like for you?
2. What role did the music play in your sense of connectedness to the group?
3. What role did the group play in your connectedness to the music or discussions?
4. What was it like to be in a group with other LGBTQIA+ parents?
5. Did you notice any changes in your mood/anxiety during the 8 weeks the group met?
6. Did you notice any changes in your mood/anxiety from beginning to end of sessions?
7. Do you feel you left with any resources/skills to apply in your life outside of the group? If yes, what?
8. What would you want changed about this experience if you were to repeat it?

## Appendix B: Edinburgh Postnatal Depression Scale (EPDS)

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- € Yes, all the time
- ✓ Yes, most of the time
- € No, not very often
- € No, not at all.

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions the same way.

**In the past 7 days:**

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all
2. I have looked forward with enjoyment to things
   - As much I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all
3. *I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never
4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often
5. *I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much

- No, not at all

6. *Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever
7. *I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all
8. *I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all
9. *I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never
10. *The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Administered/Reviewed by_____ Date_____

Postpartum depression is the most common complication of childbearing. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for ³perinatal´ depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders. Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center and from groups such as Postpartum Support International and Depression after Delivery.

**Scoring**

Questions 1, 2, & 4 (without an *): Are scored 0, 1, 2, or 3 with top box scored as 0 and the bottom box scored as 3.

Questions 3, 5-10 (marked with an *): Are reversed scored, with the top box scored as 3 and the bottom box scored as 0.

Maximum Score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

1 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item

Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

2 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002,

194-199

## Appendix C: Brief Mood Introspection Scale (BMIS)

Instructions: Circle the response on the scale below that indicates how well each adjective or phrase describes your present mood.

(definitely do not feel) (do not feel) (slightly feel) (definitely feel)

XX X V VV

Lively XX X V VV

Happy XX X V VV

Sad XX X V VV

Content XX X V VV

Gloomy XX X V VV

Jittery XX X V VV

Drowsy XX X V VV

Grouchy XX X V VV

Peppy XX X V VV

Nervous XX X V VV

Calm XX X V VV

Loving XX X V VV

Fed up XX X V VV

Active XX X V VV

For scoring info see Mayer's Brief Mood Introspection Scale BMIS): Technical and Scoring Manual (2nd edition) https://mypages.unh.edu/sites/default/files/jdmayer/files/bmis-technical_supplement_for_scoring.pdf

## Appendix D: Song List from Group Collaborative Playlist

1. I Am Enough – Beautiful Chorus
2. Bikeride (Bonus Track) – Vered
3. You Are Enough – Sleeping At Last
4. When You Smile – Vered
5. Lullaby – Sleeping At Last
6. You Matter to Me – Stephanie Leavell, Tucker Williams
7. What A Wonderful World – Stephanie
8. What My Body Needs – Sara Rogers
9. The Rainbow Connection – Sarah McLachlan
10. Hush – Kesang Marstrand
11. Better Place – Rachel Platten
12. When We Dreamed of You – Ryan Bauer-Walsh
13. til there was you – Christina Perri
14. just be – Christina Perri
15. all is found – Christina Perri
16. lullaby (goodnight my angel) – Christina Perri
17. Lullaby – The Chicks
18. Sweet Child O'Mine – Renee & Jeremy, Renee Stahl, Jeremy Toback
19. We Can Do Hard Things – Tish Melton
20. You're Gonna Be OK – Fearless Soul