Queer Clients' Experiences of Harm in Therapy

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Abstract

This thesis aimed to explore how queer clients experience harm in music therapy and how that harm impacted the therapeutic relationship and process. Upon completing an initial interest and demographic survey, four participants were selected to participate in semi-structured Zoom interviews. Interviews were transcribed and coded, resulting in seven themes: 1) therapist responses, 2) client responses, 3) qualities of the therapeutic relationship, 4) client perceptions of therapist, 5) impact on client and the therapeutic process, 6) barriers to accessing therapy, and 7) what builds safety and trust. Findings are discussed in relation to the research questions, and implications for clinical practice and suggestions for future research are also provided.

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Introduction

Motivations for Research

In my undergraduate music therapy education, I noticed that the curriculum lacked content about queer people's experiences, queer and non-Western understandings of sexuality and gender, and considerations of how heterosexism and cisgenderism play a role in therapy. My lived experience as a visibly queer person and my understanding of its relevance to every space that I am in made me concerned about how music therapists were being prepared to work with queer clients.

This was one of the reasons that I chose a graduate music therapy program that centered around sociocultural issues, although it ended up expanding and complexifying my understandings of therapy, health, and myself far beyond gender and sexuality. I began realizing how my previous conceptualizations of therapy as involving an expert and a layperson and client populations grouped together based on diagnosis were reductionistic and reinforced a power imbalance and a dichotomy separating the therapist and the client. Learning about critical race, queer, feminist, and disability theories and having some of my own internalized biases brought into my awareness made me realize the harm that I have been perpetuating in my work, in addition to in my personal life.

My journey of unlearning certainly hasn't been smooth and linear, nor has it reached some kind of destination. At times, I become defensive, and my attachment to my conceptualization of myself as the "good" white person (or "good" middle class person, etc.) keeps me complicit in the oppression of others. And at times, I am willing to move through those feelings, to withstand the discomfort of having my worldview destabilized and admit the ways that I have bought into lies I was taught about myself and others. Through this ongoing process, I

have started to form a new worldview, one that feels more grounded in reality and more attuned to how I move through the world.

Before this graduate program, I cared about social justice issues, I believed in examining the role of privilege and oppression in my life, and I was deeply passionate about providing the best therapy to my clients that I could. And yet, none of those attributes prevented me from enacting harm onto clients. In fact, none of them even helped me to recognize harm after the fact. What did help me to become more aware was: 1) reading the work of writers and theorists with different lived experiences and worldviews than my own, 2) deep and ongoing introspection into how my dominant identities have shaped the course of my life (just as my queerness impacts every space that I am in, so too does my whiteness, my neurotypicality, etc.), 3) sitting with and interrogating the feelings that arise when someone brings my attention to missteps that I have made, and 4) dialoging with peers who are in various places on a similar journey and with whom I have relationships of mutual accountability.

As I have begun moving into new understandings/questionings/wonderings of therapy and the world and dialoging about these with peers, I have become more aware of the contrast between those discussions and the discourse in music therapy research, education, and social media.

What I personally believe is needed in the music therapy literature is more content that helps guide music therapists to become more socioculturally aware, that sparks introspection and leaves readers with unsettling questions. Hadley's (2021) book, *Sociocultural Identities in Music Therapy*, is one example of this. In addition, because there is always resistance from those in the dominant group to critically examine our sociocultural location, there is a need for research that documents the harm that occurs in therapy to demonstrate the impossibility of being an ethical

therapist without such critical examination. And finally, given how demographically homogenous our field is and how heterogenous the clients we serve are, I believe that more literature is needed that centers clients' voices and experiences. Given my personal investment in queer experiences and the lack of literature and awareness around issues of gender and sexuality, I chose to explore these topics in my research.

Literature Review

Queerness

Very little research has been done in music therapy on queer clients. In addition, when reviewing the literature about queer identities and queer theory across disciplines, it is important to note the tendency for studies to focus only on issues of sexual orientation, excluding those related to gender identity and often reinforcing the gender binary and cisnormativity. Given that trans and nonbinary individuals experience greater systemic oppression than cisgender queer people, it is reasonable to assume that the issues discussed in the literature are even more extreme for trans and nonbinary people, and that there are unique gender-related barriers that the literature fails to capture.

Colin Lee (1996) was one of the first people in music therapy to explicitly talk about the relevance of queerness to practice. Queer theory has been introduced into the music therapy literature relatively recently (Bain et al., 2016; Boggan et al., 2017; Fent, 2019; Bain & Gumble, 2019; Harris, 2019; Hardy & Monypenny, 2019), but studies related to queer identities are still sparse. Bain et al. (2016) delineated key aspects of queer theory and how they relate to music therapy, outlined queer theory-informed therapeutic interventions for use with LGBTQ youth, and proposed a model of queer music therapy. Boggan et al. (2017) continued their work by exploring LGBTQ+-identified and allied music therapists' perspectives on queer music therapy

as a way of critically evaluating the model. They found the model's strengths to be the way it challenges ideas of fixed identities, requires engagement with larger systems of oppression, rejects the medicalization and pathologizing of LGBTQ+ identities, and focuses on common cause rather than commonality, meaning while LGBTQ+ folks may experience similar issues of oppression because of their sexual orientation or gender identity, they are no more homogenous of a group than their cisgender heterosexual counterparts. Harris (2019) examined the potential of queering the musical relationship in therapy, and Hardy and Monypenny (2019) shared an example of queering in action in a community music therapy group with transgender, nonbinary, gender creative, and questioning youth. While these last two articles are from the authors' perspectives and are not research, they offer useful reflections on practice and theory.

Ahessy (2011) and Wilson and Geist (2017) examined issues of curriculum and preparedness for working with queer clients. Ahessy (2011) found that two-thirds of music therapy university programs reported addressing LGB issues. However, Wilson and Geist (2017) found that nearly 40% of music therapy students had received no formal training related to LGBTQ issues, and that LGBT friends and family (93%) and LGBT media (91%) were the most common sources for knowledge about the LGBTQ community. When considering the emotional labor that marginalized groups are already tasked with in their daily lives and the narrow representations of LGBTQ people and experiences in media, these findings are concerning both in terms of how these future music therapists will engage with LGBTQ clients and how the onus of education is already falling on LGBTQ people at this stage. Furthermore, over 80% of respondents did not have a space in their clinical documentation for clients to self-identify their sexual orientation or gender, and yet a similar amount (75%) described their clinical approach as open and affirming. Making assumptions about a person rather than inviting them to share who

they are is in opposition to queer theory and is a direct violation of the best practices for working with LGBTQ clients developed by Whitehead-Pleaux et al. (2012). These best practices were significant for making LGBTQ issues more visible in music therapy literature and providing a very basic guide for practitioners. However, the authors did not solicit the experiences or opinions of queer clients themselves. In addition, their focus was on learning about how to interact with the "other" (in this case, the LGBTQIA+ community) rather than learning about oneself and how cisgenderism and heterosexism impact us all. Whitehead-Pleaux et al. (2013) used those best practices to design a survey studying music therapists' attitudes towards the LGBTQ community and found that more than half of respondents did not feel prepared to with LGBTQ communities, yet 61% said they did not seek supervision around LGBTQ issues. Additionally, 2% of respondents reported using reparative/conversion therapy in their practice. Given that conversion therapy has been found to be harmful and even abusive (Madgrigal-Borloz, 2020), has been condemned by major health professions and organizations (Bryne, 2016), and outlawed for youth in many states (*Conversion "Therapy" Laws*, n.d.), any number of music therapists employing it in their practice is extremely alarming.

Bains et al. (2019) discussed cisheteronormative values in music therapy and offered suggestions on how to make clinical and educational spaces more inclusive. The authors note that, "the approach…needs to focus less on *who are they?* and include more emphasis on *who am I* and perhaps also *what am I missing*?" (p. 8, emphasis in original), stressing the importance of the therapist or educator doing work on themselves rather than just focusing outward.

While these studies have played an important role into bringing queerness into the music therapy discourse, they lack the client's perspective and have not focused on queer clients' experiences of harm.

Harm

Curran et al. (2019) developed a model of factors potentially leading to harmful effects of psychotherapy based on clients' perspectives and experiences. Their findings are broken down into ten domains: contextual factors, pre-therapy factors, relationship factors, client factors, therapy processes, therapist factors, endings, what to do, adverse effects, and unhelpful therapist behaviors. Subthemes under unhelpful therapist behaviors included malpractice/boundary violations, devaluing or blaming the client, and involvement (too confrontational or too passive).

In the field of psychotherapy, Spengler et al. (2016) discussed microaggressions toward sexual minority clients, understanding microaggressions as "bias manifested as clinical errors because of how they weaken therapeutic alliance, decrease the effectiveness of treatment, decrease utilization intent, and cultivate feelings of shame, anger, and misunderstanding" (p. 360). They also discuss the "bias blind spot," as coined by Pronin et al. (2002), which describes an ability to recognize biases in others while being unable to recognize those same biases in self. It is important for music therapists to consider how we may be unable to accurately identify how our biases are showing up in our work, demonstrating the importance of supervision, particularly with supervisors or peers who are further along in their identity development and journey of unlearning.

Arora et al. (2022) interviewed queer and/or trans Black people, Indigenous people, and other people of color (QTBIPOC) about their experiences in therapy and determined that "an optimal therapy experience is contingent on the intentional dismantling of systemic oppression in therapy" (p. 498). Within this main finding, they identified the following six subcategories. First, therapy microskills encourage continued help-seeking despite cultural barriers, which speaks to the ability of empathy and active listening to improve therapeutic experiences even in the

absence of shared cultural understanding. Second, proximal stress leads to hesitation in the therapy room, meaning participants hesitated to disclose marginalized aspects of their identities due to fear of the therapist's reaction and ability to navigate those topics. Third, ignorant therapist reactions exemplify distal stress; whether subliminal microaggressions or overt aggressions, negative therapist reactions reinforce the distal stress that members of marginalized communities already experience daily in the world at large. Fourth, explicit validation of identity and experiences of oppression strengthens the therapeutic experience, and participants noted the responsibility of the therapist in bringing conversations about the impact of multiple axes of oppression to the forefront, rather than waiting for clients to initiate. Fifth, shared identity facilitates the therapeutic bond in terms of participants feeling understood and seen, emphasizing the need for more QTBIPOC therapists. Sixth, therapy must be decolonized and center nontraditional healing practices, which is broken down into: 1) expanding the scope of therapy beyond one-on-one counseling to include other mediums and settings, 2) decolonizing training and education to make clinicians more aware of the ways that psychology is entrenched in systems of oppression and to teach theories and understandings of healing from marginalized communities and how they can be incorporated into psychotherapy, and 3) prioritizing safety for marginalized group members in therapy, speaking to the ways that therapy should be more relevant to those whom the system most fails.

There is limited research within the field of music therapy about harm. Murakami and Goldschmidt (2018) and Murakami (2021) developed the Music Therapy and Harm Model (MTHM) to define harm and identify six potential sources harm within music therapy: the music presented, the music therapist, the therapeutic application of music, the therapeutic relationship, client-specific music associations, and ecological factors. Murakami states, "harm can occur

when the music therapist lacks self-awareness, knowledge, or judgment leading to non-musical decisions that compromise the client's safety" (p. 7), demonstrating the need for more studies to examine experiences of harm from the clients' perspective. In a model that is strikingly similar to Murakami's, Silverman et al. (2020) looked at music-induced harm, including how the identities and lived experiences of the deliverer and recipient of the music might impact the experience. Ironically, while these two articles are both about harm in music therapy, Silverman et al. enacted harm upon Murakami by requesting to see their pre-published work with the promise of citing them and then failing to do so, although when reviewing both articles it is clear that there is a significant overlap of ideas. That harm was further perpetuated by the ethics grievance processes of both the American Music Therapy Association (AMTA) and the Journal of Music Therapy (Murakami, 2021b, 2022).

While her study was not specifically on harm, Norris (2019) nevertheless discusses the risk of harm to Black clients in a vocal music therapy group for chronic pain due to the dominance of a white lens in music therapy discourse and the devaluing of Black aesthetics. She noted that, "the psychological wounds inflicted upon Black music therapy participants were relegated invisible because their lived realities continued to be unnamed and unacknowledged" (Norris, 2019, p. 2). While this is not addressing harm to queer clients, it is an important example of harm experienced by a group that is marginalized in society and underrepresented in the music therapy profession and demonstrates the need for harm against marginalized communities to be named and acknowledged in the literature.

In a study exploring sexism and cisgenderism in music therapy through microaggressions, McSorely (2020) found that harm as a result of gender microaggressions was enacted by all types of members of the discipline (i.e. educators, clinicians, students).

Participants discussed the qualities of the microaggressions they experienced, describing them as: 1) cumulative- marginalized people experience microaggressions throughout their lives, which accumulates and takes a toll, 2) intersectional- the sociocultural location of the participant and the enactor impacted how participants experienced the microaggression, 3) subtle- making them hard to detect and/or respond to, and 4) systemic- pervasive and situated in cultural context, causing music therapists "to unintentionally and unknowingly enact gender microaggressions, even when they were of a marginalized gender identity" (McSorely, 2020, p. 5). The impact of the microaggression incident included gender dysphoria, hurt, invalidation, tokenization, and visceral reactions. Participants coped with the incidents through various survival tactics, including avoidance, caregiving for the enactor, forgiveness, intellectualizing, minimizing, processing, self-protection, and vigilance. Participants also discussed the interpersonal dynamics of the microaggression incidents, noting the negative impact on the therapeutic relationship, the challenge of navigating professional boundaries (particularly when the enactor is a client), the role of power dynamics, and the response of the enactor, which ranged from remaining unaware of the incident to acknowledging their role in perpetuating oppression. McSorely found that the enactors seemed to be unaware of their microaggression in most instances, which the author points out, "demonstrates how our good intentions cannot always prevent us from enacting harm" (McSorely, 2020, p. 8).

Given the potential for harm in therapy and the evidence of harm towards queer clients in related professions, there is a clear need to examine queer clients' experiences of harm in music therapy. Moreover, because therapists may be unable or unwilling to recognize the harm they cause, it is necessary to solicit clients' perspectives on this issue.

Client Perspective

Outside of music therapy, recent studies that feature queer clients' perspectives of therapy have found that therapists over-emphasize clients' queer identities (attributing all of their issues to their queerness), underemphasize their queer identities (ignoring it, only focusing on other mental health issues), and/or overgeneralize the experiences of queer people, and that queer clients have to educate their therapists on things related to their LGBTQIA+ identities (Foy et al., 2019; Lloyd et al, 2021; McCullough et al., 2017; Mizock & Lundquist, 2016; Moradi & Budge, 2018; Quiñones et al., 2015; Shelton & Delgado-Romero, 2011).

Even when looking beyond research related to harm or queerness, very few studies in music therapy have centered the client's perspective. While not a peer-reviewed article, Hibben's (1999) book broke ground by featuring narratives from clients themselves about their experiences in music therapy. Since then, Abbot (2005) and Choi and Lee (2014) have explored clients' perceptions of the Bonny Method of Guided Imagery and Music, MacDonald (2015) explored clients' experiences in music therapy in an inpatient psychiatric facility, Venkatarangam (2021) examined clients' experiences of a receptive music intervention involving raga, and Lynch et al. (2021) examined clients' perspectives on active versus passive music therapy in an inpatient cancer setting.

Smetana et al. (2022) explored intersubjectivity and the experiences of both therapist and client during dyadic piano improvisations in music therapy, developing a framework for each person's understanding of the content, meaning, and relationship during the musical dialogue. Fairchild and Mraz (2018) are a music therapist and an 11-year-old client who collaboratively wrote about their experiences of working together through a strengths-based lens. This unique collaboration not only provides insight into the client's experience, but does so alongside the

therapists' perspective, allowing for a rich and holistic capturing of their engagement with each other.

Klyve (2019) discusses the importance of valuing clients' perspectives through the lens of epistemic justice, epistemic ignorance, and epistemic injustice, noting that, "dominantly situated knowers continue to misinterpret and misunderstand the world" (p. 5). Given that the majority of the music therapy profession is made up of dominantly situated therapists (white, cisgender, heterosexual, nondisabled, neurotypical), studies that examine these therapists' perspectives will continue to misinterpret clients' experiences.

The dearth of clients' voices in the music therapy literature is concerning, especially considering Murakami's (2021) findings that, "credentialed music therapists by themselves may not be able to recognize inadvertent harm they allow or cause. Still, they have the responsibility to listen to, reflect on, and make right the reasonable claims of harm brought to their attention" (p. 10). This study aims to contribute to this gap in knowledge by giving epistemic privilege to queer therapy clients so that music therapists can better reflect upon our practices and the ways that we may be enacting harm upon our clients, and to demonstrate a need for music therapy educators to better prepare students with the skills to be socioculturally reflexive.

Purpose Statement

The purpose of this qualitative inquiry was to explore queer clients' experiences of harm in therapy. Harm was defined as an experience related to clients' sociocultural identities with negative psychological and/or therapeutic effect(s). The research questions were:

1. How have queer clients experienced harm in therapy?
2. What was the therapist behavior/attitude that caused harm?

3. What was the effect of the harm on the client? On the therapeutic relationship and process?

Method

Research Design

Ontology and Epistemology. I believe in a subjective reality, as opposed to a singular objective truth. Subjectivism assumes that knowledge, meaning, and truth exist within human consciousness, and that human beings impose those meanings onto objects (Matney, 2019). Matney (2019) states that "general subjectivist research will therefore emphasize subjects' specific or collective meanings" (p. 16), which aligns well with the design of this study soliciting queer peoples' perspectives on their experiences. I believe that we come to know what we know through the lens of cisheteronormativity, as well as other systems of oppression. As a result, all of our therapeutic decisions, policies, and approaches are entrenched in this perspective. This is further perpetuated by the fact that most music therapists, and therefore, most music therapy researchers, are cisgender and heterosexual, positioning them to be less aware of and to benefit from cisheteronormativity.

In this study, I am operating from a queer standpoint epistemology, assuming that people develop different perspectives based on their unique sociocultural location in society. Queer people have unique knowledge and perspectives of the therapy process due to their experiences of living outside of the indoctrination of cisheteronormativity and as a marginalized group. I am soliciting the perspectives of queer people themselves in an effort to give epistemic privilege to a group whose voices have been historically unattended to.

Data Collection Procedures

Recruitment. Requests for participation were sent to various LGBTQ+ organizations and posted in the "LGBTQIA2+ Music Therapy Affinity Group" and "Trans & Nonbinary Music Therapists and Students" Facebook groups. All potential participants were then asked to complete a demographic survey confirming their eligibility for the study. Inclusion criteria were being an adult, self-identifying as queer/LGBTQIA+, and having had a previous harmful experience in therapy. Participants were excluded for having active symptoms of borderline personality disorder, schizophrenia, or psychosis.

Participants. Four participants met the inclusion criteria and were selected for participation. Due to the small number of responses, demographic diversity was limited (see Table 1).

Pre-interview Procedures. Once selected for participation, participants were sent an informed consent form (Appendix A) which they were asked to review and respond to with any questions. Once all questions were answered, they were asked to sign and return the informed consent form and provide the researcher with dates and times they were available for an interview.

Interview Procedures. Semi-structured interviews took place and were recorded via Zoom, guided by 8 pre-established questions designed to explore participants' experiences of harm in therapy, their emotional, psychosomatic, and behavioral responses to those experiences, and their overall experience of being queer as a therapy client (Appendix B). Additional questions arose organically with each respective participant. Each interview also provided the opportunity for participants to add final commentary.

Ethical Considerations

This research protocol 2022-062-56-A was approved by the SRU IRB on April 8, 2022. Due to the sensitive nature of the research topic, there was the potential for participation to cause emotional discomfort. Participants were informed of this risk in the informed consent form and were provided with contact information for an LGBTQIA+-affirming therapy practice.

To protect participants' anonymity, the interview recordings were kept on a password-protected external drive. No names or identifying information were used in the interview transcriptions or in this manuscript. Following the completion of the study, the recorded interviews will be deleted. The transcriptions of the interviews will be deleted one year after the conclusion of the study.

Location of the Researcher

Given the qualitative nature of this study, the subject matter, and the inevitable influence of the researcher on any type of research, it is important for me to name my own sociocultural location to situate this research in context. At the same time, I want to note that identities are not fixed, they can change and expand over time, and their nuance and complexity often cannot be captured through a label. At the time of writing this, I am a white, middle class, nondisabled, queer, butch, nonbinary person. I am a native English speaker and a citizen in my country of residence. All of these aspects of my personhood have shaped the design, implementation, and interpretation of this study. Furthermore, the relationship between my sociocultural locations and those of the participants likely impacted our ability to communicate comfortably and effectively with each other.

Data Analysis and Interpretation Procedures

The recorded interviews were transcribed verbatim, and transcriptions were sent to participants to check for accuracy and offer them an opportunity to change or add to anything

they had said. Transcripts were analyzed using qualitative content analysis (Ghetti & Keith, 2016). I began by reading through the full transcript twice without coding or making notes in an effort to "listen" to the participants fully before beginning to impose my interpretations on their words. I then analyzed the transcripts by identifying specific quotes that seemed particularly meaningful and assigning them a label. I used ATLAS.TI, a qualitative data analysis software, to code the data. This process continued cyclically; I revisited earlier coded transcripts and applied later developed codes. I also strove to be reflexive throughout the process, utilizing journaling and dialoguing with my supervisor about my personal reactions to the data and process. Once themes and subthemes were determined, I employed member-checking to determine if the participants felt that the interpretations accurately represented their original meanings. I also met regularly with my advisor throughout this process to enhance reflexivity and trustworthiness.

Table 1

Pseudonym	**Age**	**Pronouns**	**Gender Identity**	**Ability Status**	**Racial and Ethnic Identity**
1	29	She/her	Mostly woman/female with a little variance	Neurodivergent but not otherwise disabled	White Italian
2	29	She/her	Female/cis	Able-bodied	White
3	27	They/he	Transmasculine, nonbinary	Non-disabled	White
4	27	They/them	Nonbinary	Neurodivergent	Ashkenazi Jew

Results

The purpose of this study was to explore queer clients' experiences of harm in therapy. Transcripts were sent to participants to ensure accuracy. They were then coded and the codes were collated into themes. The themes that emerged in the data include 1) therapist responses, 2) client responses, 3) qualities of the therapeutic relationship, 4) client perceptions of therapist, 5) impact on client and the therapeutic process, 6) barriers to accessing therapy, and 7) what builds safety and trust.

Table 2: Themes and Subthemes

Themes	# of participants
Therapist responses	
Covert vs. overt responses	2/4
Responses to who the client is	4/4
Responses to feedback from the client about harmful incidents/dynamics	3/4
Client responses	
Emotional responses	4/4
Psychosomatic responses	3/4
Strategic responses	4/4
Qualities of the therapeutic relationship	
Toxic	1/4
Ineffective checking in	1/4
Limited rapport	4/4
Client self-protection	3/4
Therapy space replicates systems of privilege and oppression	3/4
Client perceptions of therapist	
Sociocultural/political location	3/4
Feelings towards the therapist	3/4
Lack of knowledge/tools	4/4
It didn't come across as like they cared	3/4

Good intentions	2/4
Impact on client and the therapeutic process	
Damage to the client	4/4
Loss of trust	3/4
Ineffective/inefficient therapy	3/4
Termination	4/4
Barriers to accessing therapy	
Having a choice in therapist	4/4
Additional layer of challenges	2/4
What builds safety and trust	
Self-Awareness	4/4
Knowledge	3/4
Skills	4/4

Therapist Responses

This theme captures the participants' depictions of their therapists' responses. It includes three subthemes: 1) covert vs. overt responses, 2) responses to who the client is, and 3) responses to feedback from the client about harmful incidents/dynamics.

Covert vs. Overt Responses. This subtheme reflects the different ways that therapists' lack of sociocultural reflexivity manifested as harm. Participant 1 shared, "I've had instances, again that have been overt and kind of like not okay, and then other things where it just sort of builds up after a while." Participant 2 stated, "it was nothing that-…-she said or did or anything…it's not necessarily something you can put your finger on."

Responses to Who the Client Is. This subtheme describes the ways that therapists responded to a client's identity. Ignoring/minimizing queerness was the most commonly described response, with 4 of 4 of the participants experiencing this. Participant 4 recalled how their therapist, "was trying really hard to address my other issues without addressing any of the

transness," and Participant 1 stated that their therapist was "not acknowledging, or pretending not to see, a part of [them]." Participants recounted several experiences of their identities and experiences being dismissed and invalidated, with 2 of the 4 participants having been laughed at by their therapist. When Participant 3 shared with their therapist that they think they might be trans, they recall their therapist's response as, "now come on, you know that's not true." Several participants described responses that pathologized their identities, as exemplified in Participant 4's statement that their therapist, "seemed really focused on like the harm that transitioning could cause." Other responses in this subtheme included universalizing experiences across all queer people (3 of 4) and misgendering (1 of 4).

Responses to Feedback from Client about Harmful Incident/Dynamic. This subtheme describes the ways that therapists responded when the client brought a harmful encounter or a power dynamic to their attention. Responses in this section included expressing understanding (1 of 4) and continued lack of awareness/understanding (3 of 4). After trying to bring a harmful incident to their therapist's attention, Participant 3 described their therapist's continued lack of understanding, stating, "I don't think she realized how much weight that sentence had."

Client Responses

This theme describes the ways that participants responded to harmful interactions with their therapists. It is broken down into three subthemes: 1) emotional responses, 2) psychosomatic responses, and 3) strategic responses.

Emotional Responses. Participants' emotional responses to incidents of harm can be grouped into two categories: reactions to the therapist and feeling a lack of belongingness. Reactions to the therapist included having high hopes, feeling mad, disappointed, defeated, betrayed, stunned, frustrated, and unsafe/fearful.

Lack of belongingness describes the ways that participants were made to feel othered, unaccepted, and alone. Participant 4 described this as, "I just kinda felt like she didn't know what to do with me." Participants discussed feeling unheard and unseen (2 of 4), and the exhaustion they felt from the familiarity of these issues (2 of 4). Participants described internalizing these feelings, with Participant 2 stating that they felt "a lot of guilt and shame," and assuming, "this is normal, this is what happens." Similarly, Participant 1 stated that they, "just always felt like a delinquent." A majority of participants (3 of 4) mentioned feeling unsupported due to their therapist being unequipped to hold and guide them through their experiences of queerness.

Psychosomatic Responses. This subtheme depicts the physical reactions that participants experienced in response to harm. They included feeling heaviness, having a visceral response, seeing red, having a sinking feeling, getting tension headaches, and experiencing cold hands.

Strategic Responses. This subtheme depicts the ways that participants chose to navigate through the harmful experience. All of the participants reported engaging in some form of advocacy. Two participants did this by attempting to bring the harmful experience to the therapist's attention, either directly or in a subtler manner, and two participants did it by educating their therapist. Community resources came up in two of the interviews as well, with Participant 2 describing how they leaned on their support system and sought out other queer people they knew who had worked with the same therapist, while Participant 4 mentioned part of their motivation for educating their therapist was to benefit the trans clients who came after them. Despite the fact that every participant engaged in some form of advocacy, a majority of them (3 of 4) also described being silenced by the power dynamic. For example, Participant 4 shared, "I clammed up and just kinda was like, ok, whatever."

Qualities of the Therapeutic Relationship

Given that this research was focused on experiences of harm, the qualities of the therapeutic relationship that came up were mostly negative. The subthemes include: 1) toxic, 2) ineffective checking in, 3) limited rapport, 4) client self-protection, and 5) therapy space replicates systems of privilege and oppression.

Toxic. While only one participant described their relationship with their therapist as toxic, it felt important to include given the potential for harm in toxic relationships and the contrast from what a therapeutic relationship is supposed to embody.

Ineffective Checking In. This subtheme describes how therapists were attempting to solicit feedback from their clients by checking in regularly, but the nature of the therapeutic relationship did not allow the clients to feel able to respond in a fully honest way.

Limited Rapport. All 4 participants reflected on how rapport was damaged or unable to be built due to the therapist's lack of sociocultural reflexivity. As Participant 1 put it, "if I'm telling you that this is a big piece of my existence and you're just like ignoring the crater in the room, like how am I supposed to feel super comfortable with you?" Participant 2 noted how not feeling safe to be their full self "kinda hinders the relationship." After the harmful incident occurred, Participant 3 said, "we, from that point on, really only talked about surface level stuff."

Client Self-Protection. All of the participants described feeling unable to safely engage in therapy with their whole selves. Half of the participants reported that they did not feel safe to be fully honest with their therapists. Participant 2 reported "holding back certain things," while Participant 4 stated that the harmful incident led them to "kinda just put a wall up."

Therapy Space Replicates Systems of Privilege and Oppression. This section describes the ways that participants had to deal with the same issues in therapy that they experience out in the world. Most commonly, participants felt that the onus fell on them to do the

work of educating their therapist. Participant 4 depicts this as, "she wanted me to do like all the work in making her understand me" and "she's getting the most benefit from this." Participant 1 echoed those sentiments, stating, "I have to be the one to explain, I have to be the one to be patient." Participant 4 also noted how gender discrimination played a role in their delayed autism diagnosis, and in the dynamics of having an older male therapist dismiss their need for accommodations.

Client Perceptions of Therapist

Sociocultural/Political Location. Participants described sensing whether their therapist was liberal or conservative (1 of 4), whether or not they were religious (2 of 4), and if they shared any of the same identity markers as the participants (2 of 4). 2 of 4 participants mentioned feeling unsure of whether or not their therapist was a safe person to share their queerness with; in the words of Participant 2, "I'm not sure how you're gonna receive what I'm about to say."

Feelings Towards Therapist. This subtheme represents participants' feelings towards their therapists. Three codes fell into this category: I really liked her (1/4), I hated her (2/4), and the therapist was terrible (1/4).

Lack of Knowledge/Tools. A majority of participants (3 of 4) described their therapist as being unaware or uneducated. Participant 1 recalled thinking, "you don't have any idea what I'm talking about," Participant 4 described their therapist as, "completely ignorant of queer identities," and Participant 3 said, "I don't think she had a personal understanding of gender expansive anything."

3 of 4 participants also found their therapists to be unequipped to support them, or as Participant 1 put it, "it didn't feel like I could be guided." Participant 2 depicted this as, "it seemed like she wasn't ready for that" and, "she didn't know how to respond."

Similarly, 3 of 4 participants reported that their therapists were unfamiliar with relevant language. Participant 3 described this experience as, "not even knowing like if they're gonna know certain language that you use that's like commonly understood amongst certain people" and Participant 4 said their therapist, "didn't even know basic terminology and stuff." The final code in this subtheme was they just don't get it, and was identified in 3 of the 4 interviews.

It Didn't Come Across as Like They Cared. This subtheme encapsulates participants' perception of their therapist as cold, detached, or uncaring, and was identified in 3 of 4 interviews.

Good Intentions. This subtheme included participants' sense that their therapists did not necessarily have malintent and there was a recognition of the therapist's attempts to be supportive and understanding. Participant 1 described their therapist as, "very open-minded, she did her best to try and hear me."

Impact on Client and the Therapeutic Process

Participants were asked how their harmful experiences had impacted their therapeutic outcomes. Their answers to that question, as well as their depictions of their various responses, demonstrated the impact that the harm had on the clients themselves and the therapeutic process.

Damage to client. 3 of the 4 participants explicitly stated that the experiences caused damage to them. 2 of 4 participants reported that the incident caused them to doubt themselves, with Participant 4 stating it, "made me feel like I wasn't like legitimate in seeking out my accommodations." Participant 2 recalled thinking "well there's something wrong with me" and "it took a year or something before I was like oh it's not me."

Loss of Trust. All participants reported a loss of trust in the therapeutic relationship, which was reflected in their need for self-protection discussed earlier. Participant 4 stated, "there

pretty much was no therapeutic relationship after that. The trust was just broken," and Participant 3 shared, "it was like the years of trust we had built just completely washed away by just that one sentence." Half of the participants specifically noted the fact that the breach of trust came from an unexpected source. Participant 3 illustrated this in the following statement: "I was like, if she could react like that after three years of building rapport and being so vulnerable with her, like it was kind of like I wondered what she could be capable of. Like what else could she say and how else could she respond to me in a way that could be even worse?"

Going beyond the specific therapeutic relationship in which harm occurred, 2 of 4 participants reported a loss of trust in and fear of the therapy process more generally. Participant 3 reported that they had not yet sought out a new therapist because of fear of another harmful response and stated, "I don't know like if I'll be able to like have that level of trust with a therapist again." In contrast, Participant 4 had found a new therapist that they were able to build trust with and feel affirmed by; however, their past harmful encounters and the difficulty of finding a therapist who understands their transness, "makes [them] hesitant to like do anything that might…challenge [their] current therapist at all."

Ineffective/Inefficient Therapy. Harmful encounters rendered therapy less effective and/or efficient for the majority of participants (3 of 4). Participant 2 noted that reaching their therapeutic outcomes "took a lot longer" and "that process was a lot more difficult." Participant 3 stated, "it definitely stopped a lot of my progress… I was on a very good like upward trajectory with her and then after that session it just kinda like plateaued." Participant 2 summarized this well, stating, "if I can't trust you and I can't say everything that I need to in this setting, then that's not effective therapy."

Termination. All 4 participants reported that they stopped working with the therapist due to the harm that had occurred.

Barriers to Accessing Therapy

This theme arose from the various challenges that participants had encountered in accessing therapy services, whether harmful or not.

Having a Choice in Therapist. This subtheme refers to the limited or lack of choice that participants had in choosing their own therapists as a result of contextual factors or financial/insurance barriers.

Participant 1 recalled being forced to work with a harmful therapist because they were a minor at the time, despite "arguing with [their] mom about the fact that [they] really don't like her." Participant 2 had sought out therapy services through the university they were attending, and that "it was still written in [the] rules of the college that they were not allowed to hire anyone who was openly gay/queer/trans/nonbinary/whatever." Half of the participants mentioned using the LGBTQ-friendly filter as a way to find therapists that are potentially safer, further limiting the pool of choices.

Participant 4 reported challenges in finding any therapist that accepts their insurance, stating, "there are doctors that take Medicaid but there's so few of them that they're so overbooked. They're so overbooked that they're not able to offer the same services that other places do, or they have a waiting list that's like 6 months to a year." Notably, this participant ended up having to pay out-of-pocket to find an affirming therapist. Participant 2 also discussed how finances limited their choice of therapist and said, "I didn't have a lot of money so I had to take like sliding scale therapists or like therapy interns."

Additional Layer of Challenges. This subtheme represents how the potential for harm makes accessing therapy that much more difficult for queer people. In the words of Participant 3, "a lot of people who aren't queer probably feel like therapy is a very vulnerable experience, which makes a lot of people fearful, but for me, adding in the layer of like hey is this person gonna freak out because I tell them I'm trans? Like, it's just another thing to deal with." Participant 4 brought up the fact that queer-specific services are even more impacted than general mental health services already are: "there are places to get additional help here, there are LGBT centers but they're so overwhelmed by need…that they can't provide long term therapy."

What Builds Safety and Trust

Participants were asked what they believe helps to establish and maintain safety and trust in a therapeutic relationship. The subthemes include: 1) self-awareness, 2) knowledge, and 3) skills. While I have divided these into these three subthemes, it should be noted that they are not necessarily linear or discreet; rather, they are intermingled and interactive. When engaging in culturally-sustaining therapeutic practice, these are three elements that have been cited in the literature (Lee & Park, 2013; Hadley & Norris, 2015).

Self-Awareness. One participant acknowledged the importance of the therapist practicing reflexivity, and two participants mentioned that the therapist needs to be able to hold their own emotions. All of the participants noted that the therapist needs to be at least as far along, if not further ahead, in their stages of identity development. Participant 2 said they wanted their therapist to "be a couple steps ahead of my…process before me," while Participant 4 said their therapist should be "able to answer questions." Half of the participants discussed the need for the therapist to take initiative in educating themselves and developing more self-awareness rather than relying on the client to provide that education. Participant 4 said, "making the effort to have

the knowledge base that will help you best with this client…it shows that…you care enough to do a little extra legwork instead of just applying like one size fits all therapy to everyone." Participant 1 said, "because of the education that she's given herself and has been given and the work that she does…I feel like I would be comfortable being guided by someone like that."

Knowledge. A majority of the participants (3 of 4) mentioned the need for therapists to be equipped with adequate culturally-relevant knowledge. Participant 1 said therapists needed to "understand certain dynamics that maybe aren't as talked about." Half of the participants felt that an important part of gaining knowledge was engaging with the culture. Participant 3 describes this as, "therapists who go out of their way to engage with trans, genderqueer, nonbinary, whatever it may be people" and "they follow some of the same TikTok pages that I follow…and I was like oh! You're cis and you're watching this? That's pretty cool." Participant 4 said, "there's something really valuable in working through where I am currently with someone who is the same gender as me and who's also very involved in the queer community." One participant also noted the importance of sensory friendly environments and connections to culturally-relevant resources.

Skills. Most of the skills that participants brought up were about navigating missteps. As Participant 1 said, "the more harm we do without being able to understand fully or acknowledge it, it just makes the potential for harm more….Try to acknowledge it and fix it." 2 of 4 participants felt that therapists need to be able to receive feedback and still hold therapeutic space. Participant 4 shared the challenges they've encountered around that, stating, "Cis people get really bent out of shape over being corrected about pronouns, like…Then if you correct them, they'll be like 'well I thought it said'- no, just like take your lump and move on." Participant 1 spoke about therapists needing to believe clients' experiences of harm: "[I need to know that]

they're doing their best to see where they hurt me if I tell them that they hurt me, and I know that's gonna be held." Half of the participants felt that therapists showing humanity is an important aspect of trust. Participant 3 described this as, "hearing a little bit about my therapist, keeping them human." Participant 1 offered the following guidance: "as therapists, you should be mindful of the fact that you're capable of doing harm and that it's gonna happen because you're a human being" and "when we see other human beings just being human beings…that makes me feel like, alright, this person is not gonna tell me that they're never gonna hurt me, they're never gonna harm me but like, they're gonna do their…best."

3 of 4 participants said they feel safer when their therapist treats them as normal. Participant 2 said they needed a therapist who, "isn't gonna blink at anything I would say," which Participant 3 echoed by stating that they lose a feeling of safety "if [they] even get a hint of a look or a double take." Participant 4 found a greater sense of safety and trust when working with therapists who allowed space for the queering of identities. They said, "knowing I'm not gonna be pushed in a box…being able to have a more fluid identity and not have that be pathologized." They also shared, "I feel like if I had tried different names with my previous cis therapists, they would've put that down as like attention seeking or like an attempt to differentiate from others or something. They wouldn't have seen it as an exploration, they would've pathologized it." Other skills that participants identified as trust-building were asking about previous therapy experiences and using correct name and pronouns.

Discussion

The purpose of this qualitative inquiry was to explore queer clients' experiences of harm in therapy. I will now discuss how the findings addressed my research questions: 1) In what ways have queer clients experienced harm in therapy? 2) What was the therapist behavior/attitude that

caused harm? 3) What was the effect of the harm on the client and on the therapeutic relationship and process? Included in each section are questions for therapists to sit with to encourage reflection on their practice.

Queer clients' experiences of harm in therapy

The findings show that queer clients have experienced harm in therapy in both covert and overt ways. They have experienced it in relation to their sexualities, their genders, and their neurotypes. Harm came from therapists that clients had worked with briefly and those with whom they had long standing relationships. It came from both liberal and conservative therapists, as well as those within and outside the queer community. These findings support McSorely's (2020) findings that harm can come from members located within the marginalized group. This raises important questions for therapists to reflect on, such as: Do I think of myself as someone who can perpetrate harm or do I assume that my intentions to do good prevent harm? What does it mean for my identity as a therapist to know that I cause harm? What feelings come up when I think about having harmed a person that I intended to help?

Therapist behavior/attitude that caused harm

As I was reflecting on the experiences that participants shared with me as well as my own, I found myself coming back to one of the subthemes of this study: therapy replicates systems of privilege and oppression. This subtheme relates to Arora et al.'s (2022) finding that ignorant therapist reactions exemplify distal stress, that is, stress related to discrimination and rejection. All of the codes related to therapist behaviors and attitudes represent classic forms of cisheterosexism that every queer person is likely to encounter in some aspect of their life: pathologizing, ignoring/minimizing queerness, dismissing and invalidating queerness and experiences of harm, misgendering, laughter, and assuming queer people are a monolith. These

behaviors and attitudes also align with the literature from other professions about queer clients' experiences of harm (Foy et al., 2019; Lloyd et al, 2021; McCullough et al., 2017; Mizock & Lundquist, 2016; Moradi & Budge, 2018; Quiñones et al., 2015; Shelton & Delgado-Romero, 2011).

Given the history of pathologizing queerness in psychiatry/psychology, it is not surprising that this legacy continues to have a presence in therapy. The most commonly mentioned form of harm was the therapist ignoring or minimizing the client's queerness. Queer people, especially trans and gender nonconforming people, have a long history of the world trying to make them hide, of being sent to institutions (carceral and/or psychiatric) to be kept out of public view, and being erased from history (Johnson, 2003; Sears, 2015; Heyam, 2022). When therapists refuse to acknowledge, work with, or take seriously their clients' queerness, they are reinforcing this history and sending the message to clients that their queerness is something worth hiding. Again, this raises important questions for therapists to reflect on, such as: What have I been taught to believe about queer people? About cishetero people? When have I responded to someone in a way that pathologized/minimized/invalidated their identity? When has someone unapologetically being themselves made me uncomfortable or felt like "too much" to me?

Effect of harm on the client and the therapeutic relationship and process

I found it particularly disheartening to learn about how participants had internalized the cisheterosexim of their therapists and located the problem within themselves, doubting the legitimacy of their needs and their right to be affirmed. In addition, the findings demonstrate that these therapy experiences were inefficient or ineffective for the majority of these participants. This makes sense given the damage to rapport that participants reported, considering rapport is one of the greatest factors of effective therapy, and it supports Arora et al.'s (2022) findings that

proximal stress leads to hesitation in the therapy room. Of particular concern in the findings were the ways in which these negative experiences have led queer folks to distrust and move away from therapy as a whole, radically removing access to what should be a resource for anyone in need. Reflexive questions that therapists need to ask themselves are: How do I respond when my missteps are brought to my attention? What feelings arise when harm I have caused is brought to my attention? How can I regulate those feelings so that I am able to stay present for the client/person I have harmed?

Implications for Clinical Practice

The findings from this study, in combination with the existing literature, demonstrate the importance of sociocultural reflexivity and the ability to navigate sociocultural missteps in therapy. Music therapy education and training should consider how to cultivate these skills. Hadley and Norris (2015) suggest the following strategies for increasing cultural sensitivity and awareness: examine the societal systems that perpetuate inequity and inequality, explore your cultural identity, explore your own intrapersonal communication, and stay engaged. The framework they use and the questions they pose is useful reading and can be adapted to specific aspects of cultural identity. Zeltzer (2016) discusses challenges and strategies for navigating missteps in music therapy supervision that can also apply to clinical practice. Hadley (2021) provides examples of different therapists' unlearning journeys and processes that can act as guides and spark further introspection. It is important to note that while this study centered around queerness, many of the same ideas and principles apply to other aspects of identity, and readers are encouraged to seek out resources specific to exploring those aspects and the ways they intersect with each other.

Given the gravity of the findings of this study, it is important for music therapists working with queer clients to seek out supervision with a supervisor who shares a concordant sexual and gender identity status and similar worldviews around sexuality and gender as the supervisee, or even more preferable, a supervisor who is more advanced in their sexual and gender identity development than the supervisee, similar to that outlined in regards to racial identity development in Norris and Hadley (2019). This would also be important for clients, to be able to seek out therapists who are more advanced or concordant in their sexual and gender identity development, in order to reduce the potential for harm in therapy.

As a way of beginning to develop sociocultural reflexivity and understanding our own sexual and gender identities, there are various strategies one could take. Based on my own experience as a queer nonbinary person and my journey of unlearning the cisheterosexism I have internalized, I am offering the following questions as starting points that may help others critically reflect on their own gender and sexuality.

- Knowing that anatomy doesn't equal gender, what makes me the gender that I am? How do I know this to be true?
- What roles, characteristics, aesthetics, body parts have I been taught are appropriate for or inherent to my gender? Which of these align with my sense of self? Which don't?
- When have I been rewarded for performing my gender in a certain way? When have I been punished or corrected for performing my gender in a certain way?
- How does my sexual identity show up in my work? In other areas of my life?

Limitations of the Study

Given that this study utilized an interpretivist design, the sample size was deliberately small. Thus, while the findings are not generalizable, it is hoped that they are transferrable.

While the small sample size was appropriate for this kind of research, as a result of the small number of responses to requests for participation, demographic diversity of the participants was limited, particularly with regard to race and age. Furthermore, shared location and experiences between the researcher, advisor, and participants may have limited the ways the data was understood and analyzed. I am aware that my own biases and worldview have inevitably influenced my interpretation and presentation of the data even though I took intentional steps to try to minimize these biases.

Future Research

Growing out of this research, there are a number of directions that future research could take. It would be interesting to explore discrepancies between clients' and therapists' perceptions of a therapy experience. This could illuminate important insights for all involved. While for this study I felt it was necessary to document the harm that queer folks experience, I also know that the experience of being queer is about so much more than harm and oppression. I would love to see research on positive therapy experiences for queer clients and what contributed to those positive experiences. I would also love to see more research exploring queer joy, queer love, and queer community. Participants mentioned engaging with other queer people to cope with harm and making themselves a resource for others by trying to prevent future harm. Future research could explore the role of community resources and support in the lives of queer people. Research could also examine queer community relationships as models for liberatory approaches to therapy practice.

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Appendix A

CONSENT TO PARTICPATE IN RESEARCH

QUEER CLIENTS' EXPEIRENCES OF HARM IN THERAPY

Susan Hadley, Ph.D, MT-BC; susan.hadley@sru.edu

Jess Neumann, MT-BC; jxg1093@sru.edu

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be an adult who identifies as queer/LGBTQIA+ and have had a harmful experience in therapy. Taking part in this research project is voluntary. You can opt out of participating at any point in the study.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to explore how therapists' lack of sociocultural reflexivity causes harm for their queer clients. If you choose to participate, you will be asked to participate in a semi-structured interview over Zoom. This will take approximately one hour.
- Potential risks or discomforts from this research include emotional discomfort from reliving harmful experiences. No other risks or discomforts are anticipated.
- There is no monetary incentive for participating in this study.
- Taking part in this research project is voluntary. You do not have to participate, and you can stop at any time.

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

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

The purpose of the study is to explore queer clients' experiences of harm in therapy. At this point in the research process, harm will be defined as an experience related to clients' sociocultural identities with negative psychological and/or therapeutic effect(s).

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be asked to participate in a one-on-one virtual interview over Zoom. We expect this initial interview to take about one hour and to only require one meeting. You will be asked to reflect on therapy experiences that you found harmful, including the relevant therapist qualities or behaviors and the effect that it had on you and on the therapeutic process. You will also have the opportunity to participate in an additional meeting

towards the end of the study to ensure that the researcher's interpretations of the data reflect the original meanings.

How Could You Benefit From This Study?

Although you will not directly benefit from being in this study, the results of this study may provide music therapists with insights and information about the causes and effects of harm for queer clients in therapy. There is no monetary incentive for participating.

What Risks Might Result From Being in This Study?

Potential risks or discomforts from this research include emotional discomfort from reliving harmful experiences. No other risks or discomforts are anticipated. Participants will be provided with counseling resources to mitigate this risk.

How Will We Protect Your Information?

To protect your privacy, we will not include information that could directly identify you and we will use pseudonyms instead. Similarly, if the results of this study are published or presented at a professional conference, information that could directly identify you will not be included and pseudonyms will be used.

We will protect the confidentiality of your research records by storing research data on a password protected external drive that will be kept in a locked cabinet. Your name and any other information that can directly identify you will be stored separately from the data collected as part of the project.

What Will Happen to the Information We Collect About You After the Study is Over?

We will not keep your research data to use for future research or other purposes. Your name and other information that can directly identify you will be kept secure and stored separately from the research data collected as part of the project. Research materials will be kept for 2 years and then destroyed.

How Will We Compensate You for Being Part of the Study?

There is no compensation for this study. It is completely voluntary.

What are the Costs to You to be Part of the Study?

There are no costs associated with participating in this research study.

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

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

Your Participation in this Research is Voluntary

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

withdraw before this study is completed, any data collected during your participation will be destroyed.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact Susan Hadley at susan.hadley@sru.edu and/or Jess Neumann at jxg1093@sru.edu

Contact Information for Questions about Your Rights as a Research Participant

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

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 008
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. Please print, sign, and return this document via email to co-researcher Jess Neumann. We will give you a copy of this document for your records. We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. A copy of this signed Consent Form has been given to me.

______________________________ ________________________________ ___________________

Printed Participant Name Signature of Participant Date

By signing below, I indicate that the participant has read and to the best of my knowledge understands the details contained in this document and have been given a copy.

______________________________ _________________________________ ____________________

Printed Name of Investigator Signature of Investigator Date

Audiotape/Videotape Release Form:

We request the use of audiotape/videotape material of you as part of our study. We specifically ask your consent to use this material during the study, as we deem proper. Regarding the use of your likeness in audiotape/videotape, please check one of the following boxes below:

☐ I do…

☐ I do not…

give unconditional permission for the investigators to utilize audiotapes/videotapes of me.

Print Name	Participant Signature	Date

APPENDIX B

Semi-structured Interview Questions

1. Describe an experience when your therapist enacted harm onto you as a result of their lack of sociocultural reflexivity.
    a. What was your emotional response?
    b. What was your physical/psychosomatic response?
    c. What was your outward response (to the therapist)?
    d. How did that experience affect the therapeutic relationship? Your therapeutic outcomes?
    e. How did your sociocultural location and your therapist's sociocultural location affect your experience?
2. What has been your overall experience of being queer as a therapy client?
3. What helps you gain trust in a therapeutic relationship?
4. Final or additional comments regarding experiences of harm in therapy
5. Additional participant questions