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A PILOT STUDY EVALUATING A TRAINING FOR MUSIC THERAPY STUDENTS ON CONSIDERATIONS FOR LGBTQ CLIENTS

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THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Music in the College of Fine Arts
at the University of Kentucky

By

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2021

ABSTRACT OF THESIS

A PILOT STUDY EVALUATING A TRAINING FOR MUSIC THERAPY STUDENTS ON CONSIDERATIONS FOR LGBTQ CLIENTS

Music therapists are expected to understand the influence of gender identity, gender expression, and sexual orientation on the therapeutic process, yet may not be receiving education that adequately prepares them to support LGBTQ clients. The purpose of this pilot study was to evaluate the impact of a one-hour educational training for music therapy students on considerations for working with LGBTQ clients. The presentation included information about terminology, discrimination, healthcare discrimination, music therapy research, musical considerations, and additional resources provided as a handout. The minority stress theory and queer theory informed the development of the presentation. Exploratory analysis revealed that participants ($N = 5$) demonstrated significant improvement in perceptions of their preparedness to support LGBTQ clients following the presentation, $Z = 2.03$, $p = .042$, $r = 0.91$, particularly regarding terminology and healthcare disparities. Although changes in knowledge did not reach statistical significance, measures of central tendency indicated some improvement following the presentation. Music therapy students made positive statements about knowledge gained from the training and expressed wanting to learn more about LGBTQ advocacy and discrimination in healthcare. Results suggest that a one-hour training may be useful for increasing music therapy students' perceptions of preparedness to work with LGBTQ clients.

KEYWORDS: Music Therapy, Education, Minority Stress, Queer Theory, LGBTQ

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04/27/2021

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In addition to the wonderful individuals who made this possible, I also want to acknowledge the many layers of privilege that allowed me to pursue higher education in music and a career in music therapy. Not everyone has access to instruments, lessons, family support, and resources necessary to pursue formal musical training, and I have been fortunate to have access to these opportunities. As we address ways that a global pandemic has exacerbated existing inequities and injustices, we will have opportunities to work toward imagining a more equitable future, both within the field of music therapy and beyond.

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CHAPTER 1. INTRODUCTION

People who identify as lesbian, gay, bisexual, transgender, questioning, or queer (LGBTQ) in the United States commonly experience stigma and discrimination, which can lead to both physical and psychological harm (Farr, 2018). The American Psychological Association defines heteronormativity as "the assumption that heterosexuality is the standard for defining normal sexual behavior" (American Psychological Association, 2020b, para. 1). When people hold beliefs that being heterosexual is normal, or what is considered acceptable, they may justify discrimination toward people who defy their expectations of sexuality and gender norms (Goodrich et al., n.d.). In additional to heteronormativity, attitudes about what is considered normal in terms of gender identity can also harm LGBTQ communities. The APA Dictionary of Psychology defines "cisgender" as "having or relating to a gender identity that corresponds to the culturally determined gender roles for one's birth sex" (American Psychological Association, 2020a, para. 1) The attitude that being cisgender is acceptable while being transgender is not is sometimes called cissexism (Whitman, Cissexism section, n.d.). People who hold cissexist attitudes may behave in ways that harm transgender people (Whitman, n.d.). Heterosexist and cissexisst attitudes can be expressed by individual people and can also be reflected by society more broadly. Most importantly, LGBTQ people can experience harm when these attitudes about sexuality and gender lead to discrimination (Frost et al., 2015).

The minority stress theory, introduced by Meyer (2003), suggests that individuals who represent minority identities are likely to experience health disparities as a result of the discrimination they experience. Frost and colleagues (2015) later expanded the

minority stress theory to include sexual and gender minority identities. The minority stress theory highlights ways that experiences of discrimination can negatively impact the health of LGBTQ people (Meyer, 2003). Queer theory, a term that cultural theorist Gloria Anzaldúa is often credited as first using, emerged in the 1990's as a critical theory that challenges heteronormativity and encourages a critical examination of ways that people understand and define sexuality and gender binaries (Illinois Library, 2020; Duke University Press, n.d). Queer theory suggests that sexuality and gender identities are fluid, and challenges norms related to the ways these identities are negotiated in society (Oxford Reference, 2020). In the context of music therapy, queer theory may be particularly useful in exploring ways to dismantle heterosexist and cissexist attitudes while normalizing diverse sexual orientations, gender identities, and gender expressions (Bain et al., 2016; Baines et al., 2019, Boggan et al., 2017). In other words, queer theory may challenge clinicians to evaluate attitudes surrounding sexuality and gender to build more affirmative practices.

When considered together, both the minority stress theory and queer theory may help music therapists increase their understanding of ways that discrimination affects the health of LGBTQ people, ways that their own attitudes surrounding sexuality and gender impact their clinical practice, and ways that music therapy practice can be inclusive and affirming to LGBTQ people. For this pilot study, I reviewed a wide range of interdisciplinary research. Much of the research investigated ways that discrimination harms LGBTQ people was based on the minority stress theory. Several of the articles I included in my literature review and my training described music therapy approaches based on queer theory, which all offered specific suggestions about creating inclusive

clinical practices. Both theories were presented in the training presentation to provide participants with theoretical frameworks to guide their understanding.

Although LGBTQ communities and allies have made extensive progress toward increased legal protections and visibility in the United States, many LGBTQ people continue to experience discrimination (Human Rights Campaign, 2018b). The American Music Therapy Association (AMTA) includes sexual orientation, gender identity, and gender expression as factors that professional music therapists should consider in the role of treatment (American Music Therapy Association, 2013). Music therapists are likely to work with LGBTQ clients in a variety of settings (Whitehead-Pleaux et al., 2013). Some music therapy scholars have provided guidelines for best practices for supporting LGBTQ clients and colleagues (Whitehead-Pleaux et al., 2012) and approaches to music therapy practice based on queer theory (Bain et al., 2016; Baines et al., 2019). Nonetheless, music therapy students appear to lack educational training that specifically addresses their ability to support LGBTQ clients (Steward, 2019).

A lack of education on LGBTQ topics may limit music therapists' ability to implement best practices for working with clients representing diverse sexual orientations and gender identities (Whitehead-Pleaux et al., 2013). This lack of education raises concerns for the potential for music therapists to perpetuate harm toward LGBTQ people through discriminatory practices and policies, even if done so unintentionally. For these reasons, I chose to conduct a pilot evaluation of the impact of a one-hour educational training delivered to current, pre-professional music therapy students on considerations for working with LGBTQ clients. In response to safety guidelines during the COVID-19 pandemic, I adapted the training and data collection to be delivered virtually. Current

music therapy students participated in the training presentation and completed pre- and post-tests about perceptions of their preparedness to support LGBTQ clients and general knowledge of LGBTQ topics that relate to music therapy practice. Participants additionally completed a brief written survey after the training to share their input about the training.

Self-Introduction

My interest in pursuing this research was ignited by a realization during my internship in an acute medical setting: the medical charts of patients clearly indicated assigned sex at birth, but did not provide an option for patients to indicate their gender identity. I wondered what it would feel like to be misgendered or called by the wrong name by staff members while hospitalized. I began to explore research on LGBTQ discrimination within healthcare to understand more about how I could advocate for my LGBTQ clients. As music therapists, we are uniquely positioned to validate clients who represent diverse identities through the therapeutic relationship and through the music itself. Music is powerful in its unique ability to validate complex experiences and emotions, and to celebrate diverse identities and cultures. At the same time, music that perpetuates heterosexist or cissexist attitudes may harm LGBTQ individuals.

As an advocate of the LGBTQ community, I hope to present information as objectively as possible, but understand that my own biases and experiences are likely to shape my approach to this research. While I acknowledge my own sexual fluidity and stigma I have felt surrounding aspects of my sexuality within certain communities, I also recognize the relative privilege I experience as a cisgender woman in a long-term heterosexual relationship. Despite my best efforts to approach this research respectfully

and inclusively, I also realize that some information in my thesis may become outdated. As LGBTQ people continue to share their lived experiences, research on LGBTQ experiences continues to emerge, and the culture and terminology surrounding sexuality and gender continues to evolve, I look forward to opportunities to learn and grow. I am motivated to use this information to become a better music therapist, but also to become better equipped to advocate for my friends, family, and neighbors.

Purpose

The primary purpose of this pilot study was to evaluate the impact of a one-hour, web-based educational training on music therapy students' perceptions of preparedness and knowledge of considerations for working with lesbian, gay, bisexual, transgender, and questioning (LGBTQ) clients. My specific questions were:

1. To what extent will music therapy students' perceptions of preparedness for working with LGBTQ clients change after participating in a one-hour training?
2. To what extent will music therapy students' knowledge of considerations for working with LGBTQ clients change after participating in a one-hour training?

A secondary purpose was to collect written feedback about the training itself to improve this and future educational and research opportunities regarding LGBTQ education in music therapy. I gathered this information to understand what participants found helpful and to identify ways I may improve the content of future trainings. Participants completed an open-ended feedback questionnaire after the training, which answered the following secondary research questions:

1. What information will music therapy students report finding most useful about a training on considerations for working with LGBTQ clients?

2. What will students report wanting to know more about after a one-hour training about considerations for working with LGBTQ clients?

3. What aspects of a one-hour training on considerations for working with LGBTQ clients will students report wanting to change?

4. What additional feedback will students provide about a training on considerations for working with LGBTQ clients?

Operational Definitions

The following key definitions are provided to guide your understanding of this thesis. Most of these definitions come from two different glossaries—the LGBTQIA+ Glossary of Terms for Health Care Teams, which is published by the Fenway Institute, and the UC Davis LGBTQIA Resource Center Glossary. It is important to understand that definitions of LGBTQ terms can vary between resources, that language surrounding sexuality and gender can change over time, and that individual preferences of language usage may vary (Gold, 2019). It is also important to understand that this is not an exhaustive list of terms. There are many other relevant and important terms related to LGBTQ identities.

Asexual: "Describes a person who experiences little or no sexual attraction to others. Asexual people may still engage in sexual activity" (National LGBTQIA+ Health Education Center, 2020, para. 6).

Assigned sex at birth: "Refers to the sex that is assigned to an infant, most often based on the infant's anatomical and other biological characteristics" (National LGBTQIA+ Health Education Center, 2020, para. 7).

Bisexual: "A sexual orientation that describes a person who is emotionally and physically attracted to women/females and men/males. Some people define bisexuality as attraction to all genders" (National LGBTQIA+ Health Education Center, 2020, para. 11).

Cisgender: A person whose gender identity is consistent in a traditional sense with their sex assigned at birth; for example, a person assigned female sex at birth whose gender

identity is woman/female. (National LGBTQIA+ Health Education Center, 2020, para. 12).

Cissexism: "The pervasive system of discrimination and exclusion founded on the belief that there are, and should be, only two genders and that one's gender or most aspects of it, are inevitably tied to assigned sex. This system oppresses people whose gender and/or gender expression falls outside of cis-normative constructs" (UC Davis, 2020, para. 26).

Gay: "A sexual orientation describing people who are primarily emotionally and physically attracted to people of the same sex and/or gender as themselves. Commonly used to describe men who are primarily attracted to men, but can also describe women attracted to women" (National LGBTQIA+ Health Education Center, 2020, para. 19).

Gender-affirmation: "The process of making social, legal, and/or medical changes to recognize, accept, and express one's gender identity. Social changes can include changing one's pronouns, name, clothing, and hairstyle. Legal changes can include changing one's name, sex designation, and gender markers on legal documents. Medical changes can include receiving gender-affirming hormones and/or surgeries" (National LGBTQIA+ Health Education Center, 2020, para. 21).

Gender expression: "The way a person communicates their gender to the world through mannerisms, clothing, speech, behavior, etc. Gender expression varies depending on culture, context, and historical period" (National LGBTQIA+ Health Education Center, 2020, para. 28).

Gender identity: "A person's inner sense of being a boy/man/male, girl/woman/female, another gender, or no gender" (National LGBTQIA+ Health Education Center, 2020, para. 30).

Health equity: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Robert Wood Johnson Foundation, 2017, para. 1).

Heteronormativity: "Attitudes and behaviors that incorrectly assume gender is binary, ignoring genders besides women and men, and that people should and will align with conventional expectations of society for gender identity, gender expression, and sexual and romantic attraction" (UC Davis, 2020, para. 50).

Heterosexism: "The assumption that all people are or should be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of lesbian, gay, bisexual and queer people while it gives advantages to heterosexual people. It is often a subtle form of oppression, which reinforces realities of silence and erasure" (UC Davis, 2020, para. 51).

Intersex: "Describes a group of congenital conditions in which the reproductive organs, genitals, and/or other sexual anatomy do not develop according to traditional expectations for females or males" (National LGBTQIA+ Health Education Center, 2020, para. 38).

Lesbian: "A sexual orientation that describes a woman who is emotionally and physically attracted to other women" (National LGBTQIA+ Health Education Center, 2020, para. 39).

Microaggression: "Brief and subtle behaviors, whether intentional or not, that communicate hostile, derogatory, or negative messages of commonly oppressed

identities. These actions cause harm through the invalidation of the target person's identity and may reinforce stereotypes" (UC Davis, 2020, para. 65).

Minority stress: "Chronic stress faced by members of stigmatized minority groups. Minority stress is caused by external, objective events and conditions, expectations of such events, the internalization of societal attitudes, and/or concealment of one's sexual orientation" (National LGBTQIA+ Health Education Center, 2020, para. 41).

Non-binary: "A gender identity and experience that embraces a full universe of expressions and ways of being that resonate for an individual, moving beyond the male/female gender binary" (UC Davis, 2020, par. 77).

Queer: "An umbrella term describing people who think of their sexual orientation or gender identity as outside of societal norms. Some people view the term *queer* as more fluid and inclusive than traditional categories for sexual orientation and gender identity" (National LGBTQIA+ Health Education Center, 2020, para. 52).

Queer theory: "An approach to literary and cultural study that rejects traditional categories of gender and sexuality" (Oxford Reference, 2020, para. 1).

Questioning: "Describes a person who is unsure about, or is exploring their sexual orientation and/or gender identity" (National LGBTQIA+ Health Education Center, 2020, para. 53).

Sexual Minority: "The term sexual minority includes a variety of gender and sexual identities and expressions that differ from cultural norms. Usually, sexual minorities are comprised of lesbian, gay, bisexual and transgender individuals" (Rodrigues et al., 2017, para. 1).

Sexual orientation: "An enduring emotional, romantic, sexual or affectional attraction or non-attraction to other people. Sexual orientation can be fluid and people use a variety of labels to describe their sexual orientation" (UC Davis, 2020, para. 102).

Transgender: "Describes a person whose gender identity and sex assigned at birth do not correspond based on traditional expectations; for example, a person assigned female sex at birth who identifies as a man; or a person assigned male sex at birth who identifies as a woman. Transgender can also include people with gender identities outside the girl/woman and boy/man gender binary structure; for example, people who are gender fluid or non-binary. Sometimes abbreviated as *trans*." (National LGBTQIA+ Health Education Center, 2020, para. 64).

CHAPTER 2. REVIEW OF LITERATURE

In this review of literature, I first provide some context for the terminology I chose to use in this thesis. I then provide demographic information about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) people in the United States, followed by information about ways that stigma and various forms of discrimination can contribute to negative health outcomes for LGBTQ communities. I also include information specific to LGBTQ youth, transgender communities, and LGBTQ Black people, Indigenous people, and People of Color (BIPOC). Next, I provide information about the barriers to high-quality, equitable healthcare for LGBTQ communities, discrimination that occurs within healthcare, and the impacts of these experiences. I review literature that explores protective factors and suggestions for improving healthcare for LGBTQ people based on existing multi-disciplinary research. I then review research in music therapy that explores considerations for LGBTQ communities and education on LGBTQ topics in music therapy. I also include information about the significance of music in LGBTQ communities, quotes from LGBTQ musicians, and the importance of safe and affirmative music spaces. Finally, I explain why this collective body of literature highlights a need for expanded education in music therapy on working with LGBTQ clients.

Societal attitudes, legislation, culture, and research surrounding LGBTQ issues has changed rapidly in recent years. For this reason, it was important for the literature included in this thesis to be as recent as possible to reflect the most current understanding of the needs of LGBTQ people. Most literature included in this literature review was written within the past six years (2015-2021). Readers should be aware that language and culture surrounding sexuality and gender is always evolving (Gold, 2019).

Use of Terminology in this Literature Review

Language is powerful. It is important to acknowledge that language surrounding LGBTQ topics can vary in literature and in cultures, and evolves over time (Gold, 2019). At times, there will be inconsistencies in the acronyms used in this thesis as a consequence of this evolving language. People sometimes expand the LGBTQ acronym to include additional subgroups, such as "I" for intersex, "A" for asexual, and a "+" to more broadly include a wide range of identities that are not heterosexual or cisgender. The "Q" in the LGBTQ acronym may stand for either questioning, queer, or both (Grinberg, 2019). Other times, researchers may adapt the LGBTQ acronym to reflect subgroups that were included in research studies. For example, a research study that specifically includes lesbian, gay, and bisexual participants may use the acronym LGB. In this literature review, I will use the LGBTQ acronym as a default because it appeared most commonly in the literature that I reviewed. Additionally, I intend to list subgroups as they are represented in the literature that I present. For example, including intersex (I) or asexual (A) as part of the LGBTQ acronym would be inappropriate when referring to research that does not specifically include people who identify as asexual or intersex. The healthcare needs of people who are asexual and intersex, along with other underrepresented LGBTQ+ subgroups, are deserving of further research. Finally, there are sometimes differences in terminology between researchers. I have done my best to present literature in a way that does not alter the meaning intended by the authors, but that has resulted in some inconsistencies in language.

The term *queer* appears in this thesis, but only when it is used by the author, a person identifying as queer, or when discussing queer theory. My intention in making this

choice was not to express a preference for one term over another, but to help distinguish research based on the minority stress theory from queer theory. The term *non-binary* is used by some people who do not feel their gender identity is represented by strictly male/female binary. The term *gender nonconforming* is sometimes used by someone who expresses their gender outside of traditional norms (Gold, 2019). Although this thesis does not address in detail the needs of people who identify as non-binary or gender non-conforming, I hope that some of the information encourages a deeper reflection on the relevance of diverse gender identities and expressions to music therapy practice. Language can be used, either intentionally or unintentionally, to perpetuate stigma toward LGBTQ people and to reinforce heteronormative and cisnormative attitudes (National LGBTQ+ Health Education Center, 2020). In summary, my intentions behind choices I made with language are to increase clarity, relay research findings accurately, and demonstrate respect based on my understanding of terminology that is embraced by LGBTQ communities. I acknowledge, however, the challenges in using language appropriately and consistently surrounding LGBTQ identities in ways that does not perpetuate harm.

Demographics of LGBTQ People in the United States

People who use language in a manner that reinforces negative attitudes toward LGBTQ identities can perpetuate harm and stigma toward LGBTQ people (UC Davis, 2018). Additionally, harm can arise if we fail to acknowledge that diverse LGBTQ people exist in our communities. Demographic information may be useful for highlighting that people of all ages, ethnicities, and backgrounds identify as part of the LGBTQ community in the United States. It is important, however, to consider the

likelihood of underreporting (Jones, 2021; Silva, 2017). Overall, the number of Americans who identify as lesbian, gay, bisexual, or transgender (LGBT) has increased in recent years (Jones, 2021). Gallup predicts that the percentage of people who identify as LGBT will continue to grow over time (Jones, 2021). According to a recent Gallup poll that interviewed 15,000 participants, 5.6% of U.S adults identify as LGBT, which has increased from 3.2% in 2012 and 4.5% in 2017 (Newport, 2018). Over half of adults who identify as LGBT identify as bisexual, making bisexual adults the largest subgroup of the LGBTQ community (Jones, 2021). The percentage of adults in Generation Z (born 1997–2002) who identify as LGBT is the highest at 15.9%, and this percentage decreases with each subsequent older generation (Dimock, 2019; Jones, 2021). For example, 3.8% of Generation X respondents (born 1965–1980) and 2% of Baby Boomer respondents (born 1946–1964) identified as LGBT (Jones, 2021). The women surveyed in the Gallup poll were more likely to self-identify as LGBT compared to men (Jones, 2021). Lower numbers of older adults who identify as LGBT may reflect underreporting that may be linked to stigma (Jones, 2021).

Differences between numbers of people who identify as LGBT within various demographic factors may reflect ways that perceptions of stigma surrounding being LGBTQ can vary depending on these factors (Newport, 2018). For example, higher numbers of millennials (born 1981–1996) and Generation Z adults identifying as LGBT may reflect overall increased acceptance of LGBT identities among young people (Jones, 2021). Additionally, it is important to consider that data from surveys and research studies are typically dependent on self-report measures, which can have limitations. Self-report measures of sexual orientation may differ from an individual's actual behavior or

feelings of attraction (Newport, 2018; Silva, 2017). Asking people to self-report their sexual orientation may lead to underreporting because of stigma, privacy concerns, fear of consequences, and disparities between lived experiences and self-identification (Silva, 2017). It is important, however, to provide individuals with the opportunity to self-identify their sexual orientation and gender since there are no singular definitions of LGBTQ identities.

The increase in people coming out as LGBTQ may highlight overall growing acceptance of LGBTQ people (Brown, 2017);however, an individual's perception of stigma surrounding LGBTQ identities may influence their choice to identify as LGBTQ (Silva, 2017). For this reason, it is important to consider the likelihood that more LGBTQ people are living in the United States than data currently suggest (Jones, 2021). Demographic information about LGBTQ people may be helpful for understanding patterns about people who identify as LGBTQ, but should be interpreted cautiously considering the limitations that stigma and self-report measures can present.

Discrimination of LGBTQ People and Impacts on Health

Considering that LGBTQ people of all ages and ethnicities can face discrimination within our society. It is therefore important to consider the impact of this stress on the health of people who identify as LGBTQ. Researchers continue to find that discrimination and victimization create physical and psychological health challenges for LGBTQ people (Farr, 2018; Kassing et al., 2021; Walch et al., 2016). LGBTQ people can experience discrimination and stigma on a variety of levels, including within interpersonal interactions, within communities, through broader structural and systemic experiences, and through internalized stigma— all of which can be damaging to

an individual's health and wellbeing (Farr, 2018; Human Rights Campaign, 2018a). LGBTQ people who report experiencing high levels of trauma tend to experience poor physical and mental health outcomes, including higher rates of anxiety, depression, drug abuse, and suicidality (Kassing et al, 2021). In this section, I will first provide information about various forms of discrimination. I will then provide additional examples of how these various types of discrimination can contribute negatively to health outcomes and lead to physical and mental health disparities for LGBTQ People.

Discrimination can occur either intentionally or unintentionally, but all forms of discrimination can be harmful to LGBTQ people (Seelman et al., 2017). People who demonstrate negative attitudes toward LGBTQ people are sometimes referred to as being "homophobic" or "transphobic" (Forshee, n.d.). Herek (2016) argues that the term "stigma" may be more appropriate than "phobia" when addressing negative attitudes toward LGBTQ people, because it more accurately reflects the structural and systemic roots of these negative attitudes. On an interpersonal level, the process of coming out as LGBTQ to one's family members is often challenging, and experiencing family rejection can contribute to negative health outcomes (Farr, 2018). People who come out as LGBTQ may also face negative attitudes from others within their religious communities, peers at school, or colleagues. A 2017 survey found that the majority of LGBTQ people have experienced slurs or offensive comments related to being LGBTQ (Robert Wood Johnson, 2017b). LGBTQ people may also internalize negative attitudes or stigma surrounding same-sex attraction or defying gender norms and expectations, which can also increase stress and negatively affect one's health (Farr, 2018). These are examples of ways that LGBTQ people can experience increased stress as a consequence of stigma

surrounding same-sex relationships and transgender identities, which can be expressed by individuals in a variety of contexts and internalized by LGBTQ people over time.

LGBTQ people can also experience systemic and structural discrimination. In other words, discrimination does not only occur between individual people but can be reflected in laws and policies that discriminate against LGBTQ people. For example, policies that limit a transgender person's access to appropriate bathrooms is a form of systemic discrimination (Ronan, 2021). More recently, legislation has been proposed that would limit access of transgender youth to participate in school sports (Ronan, 2021). To provide another example, approximately 20% of LGBTQ people report experiencing discrimination when applying for jobs (Robert Wood Johnson, 2017b). Additionally, about 20% of LGBTQ people state knowing other LGBTQ people who have experienced being treated unfairly by the police or courts because of their identity (Robert Wood Johnson, 2017b). These are examples of ways that harm toward the LGBTQ community can be perpetuated through laws, policies, and systems that do not support the needs, rights, and humanity of LGBTQ people.

Some forms of discrimination are unintentional, yet still have the potential to harm LGBTQ people. Microaggressions can occur when an individual makes statements or behaves in a way that perpetuates heteronormativity and cisgender normativity (Lubsen, n.d.). In other words, microaggressions toward LGBTQ people can occur when a person either knowingly or unknowingly behaves in a way that implies that being straight or cisgender is normal and acceptable. Microaggressions may occur when an individual uses disrespectful terminology, or makes assumptions about a person's identity (Lubsen, n.d.).

To provide a more extreme example, blatant victimization occurs when an individual intentionally targets and harms an individual based on their sexual orientation or gender identity (Seelman, Woodford, & Nicolazzo, 2017). People who hold negative attitudes toward LGBTQ people may intentionally try to harm LGBTQ people in the form of hate crimes. Data from FBI reporting in 2020 revealed increased rates of bias-motivated hate crimes toward LGBTQ people (Ronan, 2020). Black transgender women have been particularly vulnerable to hate crimes in recent years (Ronan, 2020). The Human Rights Campaign identified at least 44 known transgender or gender nonconforming individuals in 2020 who were victims of fatal violence (Human Rights Campaign, 2020a). The majority of these victims were Black and Latinx women (Human Rights Campaign, 2020a). I have intentionally capitalized "Black" to acknowledge Black culture (Coleman, 2020). I have also written the gender-neutral term "Latinx" as it appears on the Human Rights Campaign source that I referenced. It is important to note, however, that according to a 2020 Pew Research survey, only about 3% of adults in the United States who identify as Hispanic or Latino use the term Latinx (Noe-Bustamante, 2020).

Seelman et al. (2017) examined the impact of victimization of LGBTQ college students and found that both blatant victimization and microaggressions are correlated with decreased self-esteem and increased anxiety symptoms. This finding highlights that discrimination and victimization in all forms, whether caused intentionally or unintentionally, can be damaging to the health and wellbeing of LGBTQ people. In addition to mental health disparities, LGBTQ people can face negative physical health consequences. In one large survey, Conron and colleagues (2010) found that individuals

who identified as lesbian, gay, or bisexual were more likely to report activity limitation, smoking, drug use, and asthma compared to heterosexual individuals. Additionally, respondents who identified as lesbian or bisexual were more likely to report multiple risks for cardiovascular disease (Conron et al., 2010).

To summarize, increasing numbers of people are identifying is LGBTQ (Jones, 2021). It is important to acknowledge that negative attitudes toward LGBTQ identities can be demonstrated through various ways, such as interpersonally or systemically, and people who hold negative attitudes about LGBTQ identities may express these attitudes either intentionally or unintentionally. Most importantly, all forms of discrimination and negative bias can harm LGBTQ people. The following sections will examine some of the concerns for discrimination specific to transgender people, LGBTQ youth, LGBTQ Black people, Indigenous people, and People of Color. While this is not a complete list, it provides some key information about LGBTQ communities that may be particularly vulnerable to discrimination.

Transgender Discrimination

When discussing the impacts of discrimination on the health of LGBTQ people, it is important to acknowledge that transgender people face heightened discrimination. Transgender people are frequently targeted in acts of bias-motivated violence, and transgender women of color are at heightened risk for experiencing acts of violence (Human Rights Campaign, 2018b). In a survey of transgender teens across ten states, 27% of respondents reported feeling unsafe going to or from school (Johns et al., 2019). Compared to cisgender students, transgender respondents were more likely to experience violent discrimination, substance use, and suicidal risks (Johns et al., 2019). Compared to

lesbian, gay, and bisexual people, transgender people are even more likely to experience negative comments about their gender identity (Robert Wood Johnson Foundation, 2017b).

Transgender people are also more likely to be targets of hate crimes, although inconsistent reporting may limit our understanding of the true extent of this violence (Ronan, 2020). At this time, law enforcement agencies are not required to report hate crimes to the FBI, which contributes to a lack of reliable data (Human Rights Campaign, 2018b). In other words, it is likely that hate crimes toward transgender people are far more prevalent than current data would suggest.

In addition to physical health risks, discrimination toward transgender people can also contribute to psychological distress. In a report published by the UCLA Williams Institute (2019), Herman and colleagues found that the prevalence of suicidal thoughts and suicidal attempts for transgender adults is much higher compared to the general population of adults, which the authors state is linked to minority stress. Among participants who had experienced four encounters of discrimination or violence, 98% had thought about suicide that year (Herman et al., 2019). As this body of data suggests, the transgender community is experiencing significant harm. The current pandemic may be exacerbating some of already concerning health disparities experienced by transgender people. Later in this thesis, I will describe some more specific concerns for the health of LGBTQ people related to the COVID-19 pandemic.

LGBTQ Youth

Young LGBTQ people can face a multitude of challenges, particularly when they lack family or social support (Ryan, Huebner, Diaz, & Sanchez, 2009). A Human Rights

Campaign (2018a) survey found that 95% of LGBTQ youth reported having trouble sleeping at night, 67% reported hearing family members make negative remarks about LGBTQ people, and only 26% reported always feeling safe in their classrooms. Children and adolescents who represent gender non-conforming identities and minority sexual orientations are at an increased risk of experiencing various forms of family abuse, which may lead to negative outcomes later in life (Baams, 2018).

Perhaps most alarming is the risk of suicide for LGBTQ youth. In a 2020 National Survey on LGBTQ Youth Mental Health, which surveyed 40,000 LGBTQ young people between the ages of 13 and 24, 40% of respondents had serious thoughts of attempting suicide in the past year (The Trevor Project, 2020). This rate was closer to 50% for transgender and non-binary respondents (The Trevor Project, 2020). Additionally concerning, 20% of respondents reported having experienced homelessness, 61% of transgender or non-binary respondents have been denied access to the appropriate bathroom, and 10% reported having undergone conversion therapy (The Trevor Project, 2020). Furthermore, 86% of respondents indicated feeling that recent political events have negatively impacted their wellbeing.

Overall, these recent data reveal that many LGBTQ young people are continuing to experience discrimination in a wide variety of forms that is harmful to their physical and psychological health. It is important to note, however, that individual differences can greatly impact the experiences of LGBTQ adolescents (Birkett et al, 2014). In other words, many factors other than sexual orientation, gender identity, and expression also contribute to an adolescent's experiences and health outcomes. This data, however, does

raise important concerns about vulnerabilities of LGBTQ youth linked to experiences of discrimination.

LGBTQ Black People, Indigenous People, and People of Color

Black people, Indigenous people, and People of Color (BIPOC) are likely to experience even greater discrimination compared to white LGBTQ people. The Williams Institute (2021) released a detailed report that provides information about Black LGBT adults in the United States, making comparisons to Black non-LGBT individuals. Among the findings, Black LGBT women are less likely to have earned a college degree compared to non-LGBT Black women (Choi et al., 2021). Black LGBT adults are more likely to experience unemployment and to live in low-income households when compared to Black non-LGBT adults (Choi et al., 2021). In one study, Black women who identified as sexual minorities reported higher frequency, greater scope, and broader bases of discrimination compared to white sexual minority participants (Calabrese, Meyer, Overstreet, Haile, & Hansen, 2014). In other words, participants experienced discrimination more often and more intensely, and as a direct consequence of representing multiple minoritized identities. A 2017 survey found that compared to white LGBTQ people, LGBTQ people of color are far less likely to be contacted by a political representative, suggesting that LGBTQ people of color may be missing opportunities to engage civically or politically (Roberts Woods Johnson Foundation, 2017b). Overall, LGBTQ people of color face higher rates of discrimination compared to white LGBTQ individuals (Whitfield et al., 2014).

Indigenous communities have distinct views and culture surrounding LGBTQ identities. For example, many tribal languages possess vocabulary to describe genders

other than strictly male or female (Zotigh, 2020, para. 1). For example, the term "two spirit," which became a term in the pan-Indian vocabulary in 1990, encompasses a broad range of LGBTQ identities and includes variations on gender expression (Zotigh, 2020, para. 1). Two spirit people are considered to have a special standing in society, and their identities were often viewed as coming from dreams or visions that called on them to be leaders in their communities (Zotigh, 2020, para. 1). Some of the tribes that have historically honored and celebrated two-spirit people include the Lakota, Mohave, Crow, and Cheyenne tribes (Indian Health Service, n.d.). Many two-spirit traditions died away in response to violence and negative attitudes of white colonizers, yet many of these traditions are being revived in North America (Indian Health Service, n.d.).

Although many indigenous tribes have historically celebrated LGBTQ identities, indigenous LGBTQ people may still face unique challenges. Logie & Lys (2015) interviewed LGBTQ youth in Canada's Northwest Territories, which included indigenous participants. Many youth participants reported feeling that stigma was perpetuated in secondary schools, that same-sex relationships were stigmatized, and that there is a need for sexual and gender diversity to be integrated into education and services at school. Overall, more research is needed about the prevalence and impacts of discrimination on LGBTQ indigenous communities.

It is also important to acknowledge significant contributions and historic leadership of BIPOC in addressing intersections of oppression in the fight for social justice. The 1977 Combahee River Collective Statement, written by a collective of Black feminists, described fighting "racial, sexual, heterosexual, and class oppression," which they referred to as multiple interlocking forms of oppression (para. 1). To address these

layers of oppression, the collective called for using an "integrated analysis and practice" (para. 1). In summary, the statement set a precedent for recognizing the complex overlap between multiple forms of oppression. Today, this is often referred to as an intersectional approach to social justice, originally coined by law professor Dr. Kimberle Crenshaw, which Crenshaw described in a 2020 interview with Time Magazine as "basically a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other (Steinmetz, 2020, para. 2). The Combahee River Collective statement also acknowledged the leadership of Black women activists throughout history, such as Sojourner Truth and Harriet Tubman, who have historically recognized intersections of sexual and racial identity in their activism (Combahee River Collective, 1977, para. 3). The Combahee River Collective (1977) stated "Although we are feminists and Lesbians, we feel solidarity with progressive Black men and do not advocate the fractionalization that white women who are separatists demand" (para. 12). Additionally, the collective stated "We realize that the liberation of all oppressed peoples necessitates the destruction of the political-economic systems of capitalism and imperialism as well as patriarchy" (para. 13).

Black queer feminism centers the experiences of Black LGBTQIA+ people in the fight against structural oppression such as racism, sexism, classism, and heterosexism (Sullivan, 2019). Activists, writers, educators, and artists have been leaders in Black queer feminist discourse for decades now, both within and outside of academia (Sullivan, 2019). The Black Lives Matter movement, founded in 2013 by Alicia Garza, Patrisse Cullors, and Opal Tometti, was formed not only to fight for racial justice, but also to "affirm the lives of Black queer and trans folks, disabled folks, Black-undocumented

folks, folks with records, women and all Black lives along the gender spectrum" (Garza, 2014, para. 10; Sullivan, 2019). This vision exemplifies ways that an intersectional approach to social justice, which has often been led by queer Black women (Sullivan, 2019), considers the many layers of marginalized identities to envision a more just and equitable existence.

To conclude, a discussion of the experiences of LGBTQ people should consider intersections of racial and ethnic identity, and a recognition that racism impacts the experiences of LGBTQ BIPOC. Researchers have highlighted ways that LGBTQ BIPOC are likely to experience higher rates of discrimination and economic disparities, which are concerning for the health and wellbeing of LGBTQ BIPOC. Additionally, work toward dismantling heterosexism and cissexism should acknowledge the leadership of Black queer activist women who have historically led anti-oppressive, intersectional movements. BIPOC have often led the way in creating and sustaining intersectional social justice movements. Additionally, we should consider ways indigenous communities have historically embraced and celebrated two-spirit identities, which contrasts dramatically with Western society's dominant heteronormative and cissexist attitudes toward variations of sexuality and gender.

LGBTQ Discrimination and Inequity in Healthcare

So far, I have provided more broad information about the impacts of discrimination on the health of LGBTQ communities along with information specific to transgender communities, young people, and BIPOC. Now, I will now present information that specifically relates to discrimination within healthcare settings. Financial barriers to healthcare represent one source of health disparities of LGBTQ people.

Compared to individuals who identify as straight, LGBTQ people are more likely to face financial barriers to accessing healthcare (Dahlhamer et al., 2016). These financial barriers may lead to individuals choosing to delay seeking healthcare or not receiving healthcare services at all (Dahlhamer et al., 2016). Among subgroups, bisexual women appear to face the most financial barriers to accessing healthcare (Dahlhamer et al., 2016).

In addition to financial barriers which may limit access to healthcare, LGBTQ people commonly report experiencing discrimination when they do access care. According to the 2019 Health Equality Index, a yearly report published by the Human Rights Campaign (2018a), 56% of lesbian, gay, or bisexual (LGB) patients surveyed report experiencing discrimination in healthcare settings. This percentage was higher (70%) for transgender or gender non-conforming patients (Human Rights Campaign, 2018a). Discrimination in healthcare settings can occur when staff are not properly trained, when bathrooms do not adequately serve the needs of transgender or non-binary people, when policies are not inclusive to all people regardless of sexual orientation and gender identity, and when staff members demonstrate negative attitudes toward LGBT people (National LGBT Health Education Center, 2020). In response to structural stigma and perceived stigma, LGBTQ individuals often avoid disclosing relevant health information to healthcare providers, which can further exacerbate the health disparities (Herek, 2016). In other words, when healthcare providers do not demonstrate an understanding or respect of LGBTQ identities, patients may not feel safe sharing certain information with providers. This lack of trust and understanding between a patient and provider can diminish the quality of healthcare.

To understand why LGBTQ individuals experience discrimination in healthcare, it may be helpful to understand how same-sex attraction has been addressed in healthcare in the past. Historically, healthcare institutions have either ignored or stigmatized patients who represent sexual or gender minority identities (Herek, 2016). In previous versions of the Diagnostic and Statistical Manual (DSM), "homosexuality" was diagnosed as a mental disorder, which the American Psychological Association decided to remove in 1973 (Drescher, 2015). This marked an important step toward destigmatizing same-sex attraction (Drescher, 2015), but LGBTQ people continued to report negative experiences in healthcare settings decades later (Human Rights Campaign, 2018a). In the most recent edition (DSM-5),"Gender Dysphoria" is listed as a pathology which is described as "the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics (Mayo Clinic, 2019). People who are transgender or gender non-conforming may not necessarily experience gender dysphoria if they do not experience these feelings of discomfort (Mayo Clinic, 2019). This history demonstrates that heteronormativity and cisgender normativity are pervasive within healthcare institutions. Although some steps have been made toward dismantling stigma in structural ways, such as the removal of homosexuality as a mental disorder, there is still a long way to go in establishing equity and inclusion within healthcare settings (Human Rights Campaign, 2018a).

Barriers to healthcare for LGBTQ people can arise despite positive attitudes and intentions from healthcare professionals. In a recent European study, researchers found that healthcare professionals often assume that patients are heterosexual, cisgender, and non-intersex (McGlynn et al., 2019). Additionally, the researchers found that despite

healthcare professionals viewing themselves as "LGBTI friendly", they also made incorrect assumptions that LGBTI people did not experience significant problems in healthcare (McGlynn et al., 2019). These assumptions, which might be described as microaggressions, can negatively impact the healthcare experience.

In one qualitative study of LGBTQ cancer patients, a cisgender gay man shared, "When I talked to the nurse about my dissatisfaction with how they treated my partner, the nurse apologized and said that he assumed that we were just friends because my partner is both African-American and younger than me" (Kamen et al., 2019, p. 2529). In the same study, a white cisgender lesbian described, "When I was crying in her office, a well-meaning oncology social worker suggested I go to a makeup class called 'Look Good, Feel Better.' I told her 'I'm a kind of butch lesbian. I just don't understand that stuff." (Kamen et al., 2019, p. 2529). These quotes exemplify ways heteronormative and cisnormative attitudes can lead to incorrect assumptions from healthcare providers and staff, which can negatively impact the healthcare experiences of LGBTQ people. This quote exemplifies ways that even with good intentions, microaggressions that occur within healthcare settings profoundly harm the perception of care that is being provided. Dismantling heterosexist and cissexist attitudes within healthcare is a complex systemic issue that requires structural changes, along with increased education on negative bias, microaggressions, and healthcare considerations for LGBTQ patients.

Transgender Discrimination in Healthcare

In addition to the harm that discrimination causes for transgender individuals, healthcare represents one important area that transgender people may experience challenges. Transgender individuals often face profound challenges in terms of accessing

healthcare services, and experiencing discrimination when receiving healthcare. Approximately 30% of transgender people report not having a regular doctor (Robert Woods Johnson Foundation, 2017b). Many transgender people delay seeking medical care or refuse to seek medical care altogether because of fear of discrimination (Grant et al., 2010). In a 2010 survey of transgender and gender non-confirming people, 19% of respondents reported being denied healthcare services by providers (Grant et al., 2010). Additionally, 50% of respondents reported needing to provide education to their medical providers about transgender healthcare (Grant et al., 2010). One of the more concerning findings of the survey was that 41% of transgender and gender non-conforming respondents reported attempting suicide (Grant et al., 2010).

In one qualitative study on experiences of LGBTQ patients with cancer, one participant stated:

> Prior to [transition] I lived as a lesbian female for 50 years and never once experienced any hostility of discrimination by any health care provider. I was never denied care, interrogated, distrusted, or treated with overt hostility and rejection. Transitioning changed all that. (Kamen et al., 2019, p. 2528).

This statement highlights ways that even within LGBTQ communities, transgender people may experience higher rates of negative attitudes, even from healthcare professionals. Considering the tremendous challenges that the transgender community already faces due to discrimination in society, it is concerning that transgender people are additionally facing such challenges within healthcare settings.

Transgender people may also face barriers to accessing gender-affirming healthcare services. COVID-19 has presented additional challenges to receiving gender-

affirming care since many procedures that are categorized as non-emergency have been delayed (Woulfe & Wald, 2020). Economic challenges experienced by transgender people also contribute to challenges with accessing gender-affirmative care (Woulfe & Wald, 2020). Transgender and non-binary people of color are even more likely to be living in poverty, which further exacerbates barriers to gender-affirming healthcare services.

LGBTQ Youth and Discrimination in Healthcare

In addition to some of the broader challenges specific to LGBTQ youth already discussed, LGBTQ youth can also experience some specific challenges within healthcare. Conversion therapy, sometimes called "reparative therapy" is a practice that attempts to change the sexual orientation or gender identity of an individual (The Trevor Project, 2015). Despite contraindications from the American Psychological Association, conversion therapy for minors continues to be legal in some states, including Kentucky, where the present study took place. According to the Williams Institute, approximately 698,000 adults have received conversion therapy, and approximately 16,000 minors are likely to receive conversion therapy before the age of 18 in states where conversion therapy continues to be legal (Mallory et al., 2019). Even in states that have banned conversion therapy, the law typically does not apply to religious and spiritual advisors who are not licensed mental healthcare providers (Mallory et al., 2019). In addition to concerns surrounding conversion therapy, a 2020 survey published by the Trevor Project revealed that 46% of LGBTQ youth report not being able to access mental health services despite wanting help.

At the time of editing this thesis, Kentucky Senator Rand Paul compared gender affirmation surgery to the violent act of genital mutilation, and additionally criticized policies that allow transgender student athletes to participate in athletic programs in correspondence with their gender (Diamond & Schmidt, 2021). These statements were directed at Rachel Levine, a transgender woman and health official awaiting confirmation as Biden's choice for assistant health secretary. These problematic statements from lawmakers, and specifically cisgender men in positions of power, are extremely concerning because they convey to young transgender people that their healthcare is not understood or respected. By the time this thesis is complete, further developments in legislation that impact LGBTQ communities are likely, particularly surrounding the Equality Act, which would extend non-discrimination laws to LGBTQ people more broadly (Human Rights Campaign, 2021).

Paths Toward Healthcare Equity

Collectively, the research presented demonstrates that discrimination and inequities within the healthcare system remain a significant problem for LGBTQ communities. There are, however, paths toward increased inclusion and equity. Herek (2016) argues that addressing healthcare inequities requires us to "dismantle structural stigma by changing institutional policies and practices" (p. 398). Researchers and advocates of the LGBTQ community have already identified some specific ways that policy changes can improve the healthcare experience. In a survey given to LGBTQ individuals about healthcare experiences, respondents reported feeling safer in healthcare settings where staff used gender neutral language or displayed the Human Rights Campaign logo to indicate being inclusive of LGBTQ patients (Quinn et al.,

2015). Some respondents indicated feeling that the inclusion of gender identity and sexual orientation would improve the inclusivity of intake forms (Quinn et al., 2015). For young LGBTQ people, outcomes can be improved by fostering inclusive, identity-affirming environments (Hadland, Yehia, & Makadon, 2016). Furthermore, developmentally-appropriate confidentiality can help to maintain a respectful and effective relationship between youth patients and providers (Hadland et al., 2016). These are all examples of specific steps and actions that healthcare institutions can take toward becoming more inclusive, affirming, and equitable.

To summarize, there is existing data about ways we can create more inclusivity and equity within healthcare for LGBTQ people. As research continues to highlight specific steps to mitigate harm and improve the quality of healthcare for LGBTQ communities, healthcare providers will continue to face the responsibility of receiving education in this area, building more inclusive and equitable practices and policies, and advocating for systemic change.

COVID-19 and LGBTQ Communities

The COVID-19 pandemic has exacerbated existing inequities that were present before the pandemic, while creating new and unprecedented challenges as well. I have already touched on some of these challenges in previous sections. While many people are quarantined during the COVID-19 pandemic, there is concern for young LGBTQ people who may be isolated or quarantined with family members who are disapproving of their identities (Fish et al., 2020). Adults may be facing a variety of challenges as well. According to a 2020 survey by the Movement Advancement Project, the pandemic has impacted LGBTQ households economically at significantly higher rates compared to

non-LGBTQ households. Barriers to healthcare have also impacted LGBTQ households at higher rates compared to non-LGBTQ households (Movement Advancement Project, 2020). Compared to 19% of non-LGBTQ households, 38% of LGBTQ households have experienced challenges to accessing healthcare for serious medical problems (Movement Advancement Project, 2020). Healthcare providers should consider ways that COVID-19 has disproportionately impacted LGBTQ communities, which has consequences for both physical and psychological health. As the long-term impact of COVID-19 on LGBTQ communities becomes more known over time, and particularly on BIPOC who are also disproportionately impacted by the pandemic, it will be critical to consider how to advocate for the health and wellbeing of these communities. Given the devastating economic impact of COVID-19, which has disproportionately affected LGBTQ communities and BIPOC, access to affordable care will be critical.

A Brief Overview of Recent Progress Toward LGBTQ Equality in the United States

In recent years, tremendous strides have been made toward establishing legal equality and protections for LGBTQ Americans. Following the abolishment of the *Don't Ask, Don't Tell* policy in 2010, Americans who are openly gay may now serve in the military. The 2015 Supreme Court ruling ("Obergefell v. Hodges," 2015) legalized same-sex marriage nationally, which was a significant victory toward LGBTQ equality in the United States. Recently, the Supreme Court once again ruled in favor of LGBTQ equality when it determined that employers legally cannot fire individuals on the basis of being gay or transgender (Totenberg, 2020). In addition to progress toward legal equality, diverse representations of LGBTQ people in entertainment has expanded in recent years, which is associated with an overall increase in positive attitudes toward

LGBTQ people (Ellis, 2019). LGBTQ people and allies have worked tirelessly to establish legal rights and media representation over the years, often in the face of opposition from those who seek to reinforce "traditional", or heteronormative, relationships and gender norms (Human Rights Campaign, 2020b). LGBTQ people and allies have worked tirelessly to establish legal rights and media representation over the years, often in the face of opposition from those who seek to reinforce heteronormative (i.e. "traditional") relationships and gender norms (Human Rights Campaign, 2020b). LGBTQ people and allies continue to advocate for equality, both on the state and federal level to address forms of systemic discrimination (Human Rights Campaign, 2020b)

Protective Factors and Healthy Development

In addition to legislation and media representation, social support provides protection against discrimination and stigma for LGBTQ communities. Research in this area tends to focus on LGBTQ youth, but may also translate in many ways to adults. Researchers have found that psychological distress tends to decrease over time as LGBTQ adolescents transition into adulthood (Birkett et al., 2014). A variety of factors may serve as a buffer from the negative impacts of discrimination, such as support from family members, social support of friends, and community support (Snapp et al., 2015). Within schools, organizations like gay-straight alliances appear to decrease instances of LGBTQ victimization (Marx & Kettrey, 2016). In a 2020 survey published by the Trevor Project, transgender and non-binary respondents were half as likely to report having attempted suicide compared to those who did not have their pronouns respected. By understanding some of the important ways that LGBTQ youth can experience protections

from minority stress, people working with youth in various capacities may be able to offer support by advocating or facilitating opportunities for positive social support.

Although researchers frequently point to alarming health disparities of LGBTQ people, it is important to acknowledge that most young lesbian and gay individuals express feeling content with their lives and identity (Savin-Williams & Cohen, 2015). Savin-Williams and Cohen (2015) suggest that at times, researchers have failed to consider more dimensional aspects of sexuality and healthy development of young people. Research on LGBTQ health also tends to place sexuality in distinct categories rather than considering sexuality as occurring on a spectrum (Savin-Williams & Cohen, 2015). Therefore, it may be important to recognize that not all people fall distinctly in a single category of a static sexual orientation or gender identity (Diamond, 2016). Additionally, varying levels of privilege and lived experiences shape the degree to which people are impacted by experiences of discrimination. In summary, although minority stress can create very real challenges for LGBTQ communities, it is important to consider all aspects of an individual's identity and avoid making assumptions based solely on sexual orientation or gender identity.

Best Practices in Psychology

Because music therapy research on best practices with LGBTQ clients is somewhat limited, guidelines established by the American Psychological Association (APA) may provide music therapists with considerations for working with LGBTQ clients. The APA's "Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients" (American Psychological Association, 2015) provides an overview of important terminology, guidelines for practice, and an appendix listing organizations that

advocate for the lesbian, gay, and bisexual community. Some of the guidelines relate to understanding the impact of stigma and discrimination on LGB clients, understanding that same-sex attraction is not a mental illness, understanding how one's own perceptions of lesbian, gay, and bisexual persons may impact therapy, understanding ways that sexual orientation can impact family relationships, understanding how age impacts experiences of LGB people, and understanding the impact of HIV/AIDS. These represent only a portion of the guidelines provided by APA, and music therapists may benefit from further exploring these guidelines since they reflect best understood psychological practices with lesbian, gay, and bisexual clients.

To address needs of transgender and gender non-conforming individuals, the APA published an article entitled "Guidelines for Psychological Practice with Transgender and Gender Non-Conforming People" (American Psychological Association, 2015). Many of the guidelines are similar to those provided in the LGB guidelines document, but focus specifically on guidelines for providing affirmative care to transgender and gender non-conforming people (American Psychological Association, 2015). For example, in the category of "Foundational Knowledge and Awareness", APA states that "psychologists understand that gender is a non-binary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth" (p. 834). APA also guides psychologists to understand that "gender identity and sexual orientation are distinct but interrelated constructs (835). In other words, it is important not to conflate gender identity with sexual orientation, but to understand that these identities may be connected and impact identity development (American Psychological Association, 2015).

The APA additionally suggests that clinicians be aware that research on LGBT populations can reflect bias and should be approached with caution (American Psychological Association, 2012). As with any research, it is important to be mindful of the limitations of the research designs. While the minority stress model provides a valuable framework for understanding the impact of discrimination and stigma on the health of LGBTQ individuals, there is a need for expanded research designs that account for differences between subgroups and lived experiences of participants (Frost, 2017). Considering the many complex factors that shape a person's identity and experiences, research on LGBTQ communities can have many limitations, particularly when subgroup differences are not considered.

The Significance of Music in LGBTQ Communities

While music therapists should consider the negative impact of discrimination on LGBTQ communities, they should also consider the significance and positive role that music plays in providing opportunities for self-expression, community, and resistance. LGBTQ artists who have made significant contributions to music throughout history. Furthermore, LGBTQ artists have often used music as a vehicle to explore topics related to sexuality and gender. While some contemporary artists may come to mind, there are also earlier musicians who exemplify this exploration through music. In jazz musician Ma Rainey's 1928 song, "Prove It On Me Blues," Rainey sings "Went out last night with a crowd of my friends/ They must've been women, 'cause I don't like no men/ It's true I wear a collar and a tie…" (Sommer, 2019, para. 3). Considering the gender norms at the time, and lack of protections for LGBTQ people, it is remarkable to see these thoughts expressed openly in song.

In 1984, Bronski Beat released, “Smalltown Boy,” which explored the challenges of being LGBTQ and experiencing harassment in a small town. The song went to No. 3 on the U.K singles chart. (Sommer, 2019, para. 8). While many current pop artists today openly discuss LGBTQ themes in music, this would have been less common in 1984 and even more complex considering stigma and fear surrounding the AIDS crisis. The song explores the experience of being LGBTQ in a small town, not feeling understood by one’s family, and feeling compelled to move to a place that might offer more support:

> You leave in the morning with everything you own in a little black case
> Alone on a platform, the wind and the rain on a sad and lonely face
> Mother will never understand why you had to leave
> But the answers you seek will never be found at home
> The love that you need will never be found at home

These are only a few examples of lesser known contributions from LGBTQ musicians who explored their own identity through the music they shared. Many popular musical artists who have come out as LGBTQ/queer have publicly discussed experiences related to their identities as LGBTQ people. In a 2019 interview with British GQ, pop singer Sam Smith described the process of understanding their identity as non-binary person stating:

> Ever since I was a little boy, ever since I was a little human, I didn’t feel comfortable being a man really. I never really did. Some days I’ve got my manly side and some days I’ve got my womanly side, but it’s when I’m in the middle of that switch that I get really, really depressed and sad. Because I don’t know who I

> am or where I am or what I'm doing and I feel very misunderstood by myself. I realised that's because I don't fit into either (Levesley, 2019, para. 19).

This quote provides an example of how well-known musicians sometimes use their public platform to share personal stories about exploring and understanding their own identities, and emotions that surround that process. LGBTQ artists sometimes also use their music to send affirmative and uplifting messages to their LGBTQ audiences. Janelle Monáe, who identified as a queer Black woman at the time of a 2018 article promoting her album *Dirty Computer*, stated:

> I want young girls, young boys, nonbinary, gay, straight, queer people who are having a hard time dealing with their sexuality, dealing with feeling ostracized or bullied for just being their unique selves, to know that I see you. This album is for you. Be proud. (Spanos, 2028, para. 10).

This quote provides an example of a queer musician reaching out directly to fans to offer support during the publicity process. LGBTQ musicians may also provide leadership and inspiration for younger generations of artists. In an interview with Rolling Stone, accomplished singer-songwriter Brandi Carlile (2021) described the influence of the Indigo Girls on her music and identity, describing:

> The Indigo Girls have always maintained a sense of dignity, pride, activism. They've overcome every time, and for a queer person like me, I realized that my path would have been so much more rife with rejection and parody if the Indigo Girls hadn't taken those hits for me. I feel a big responsibility to evangelize about how much of the way they have paved, and how important their music-making still is to this day (para. 14).

Although sexuality and gender may impact a musician's creative work, it does not necessarily mean that a musician wants to be defined entirely by their sexuality or gender. In a 2018 Billboard interview, transgender pop singer-songwriter Kim Petras described how despite feeling proud of her identify as a trans women, she wants her music rather than her identity to draw in listeners, describing:

> I just hate the idea of using my identity as a tool. It made me the person I am and that's a big part of me, but I think music is about your feelings and your fantasies and it goes deeper than your gender or your sexuality (Daw, 2018, para. 3).

Of course, these are only voices of three individuals. There are countless articles, interviews, and books that explore contributions of LGBTQ musicians who all have their own unique and valuable perspectives. Overall, it is important to recognize that LGBTQ musicians have significantly shaped the landscape of popular music. Sexuality and gender represent some, but not all aspects, of a person's identity. Musicians and artists may choose to explore aspects of their sexuality and gender within the music they create or as part of a public discourse, but they also represent complex and diverse individuals who decide for themselves how and what they want to share about their identities.

In addition to the significant contributions of LGBTQ musicians, it is also important to consider the significance of LGBTQ/queer music spaces and the importance of what they provide. Gay nightclubs have often served as a safe community space for LGBTQ people (Hardy & Whitehead-Pleaux, 2017). Of course, these spaces no longer become safe when they become targets of hate crimes. In 2016, a shooter used an assault rifle to open fire on the crowd at Pulse nightclub, a gay nightclub in Orlando, Florida. The attack killed 49 people and injured 50 more (Curry, 2016, para. 2). The club's owner

shared in an interview, “It was a safe, fun place to come be who you are. It’s as simple as that. It was supposed to be a safe place” (Curry, 2016, para. 3). The COVID-19 pandemic has also presented challenges to LGBTQ music spaces since many clubs and performance venues are shut down to meet safety guidelines. In a Rolling Stone article about drag shows adapting to the pandemic, drag performer Puddin’ stated “Drag is like the church of our community. It’s a safe haven. The fact that people are missing that right now is really hurting us” (Spanos, 2020, para. 11). These quotes illustrate how the importance of community music spaces are significant for the safety they can provide to be one’s authentic self.

As the COVID-19 pandemic continues to limit access to many clubs, performance halls, and various other community music spaces, it is important to considering how these closures may be impacting LGBTQ communities who rely on these spaces for safety and community. While there may not be a perfect solution for replacing what these spaces provide, music therapists should consider the importance of safe community music spaces for LGBTQ communities and work to provide a safe and affirmative environment within the context of music therapy practice.

Music Therapy with LGBTQ Clients

Professional Competencies

The American Music Therapy Association (AMTA) provides several professional guidelines that relate to providing music therapy services that are inclusive and respectful to the LGBTQ community. AMTA’s Code of Ethics states that music therapists must provide quality care regardless of sexual orientation, gender identity, or gender expression, among other factors (American Music Therapy Association, 2019).

Additionally AMTA's Professional Competencies (2013) regarding the therapeutic relationship (B.9.5) states:

> Demonstrate awareness of the influence of race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation on the therapeutic process.

In other words, in addition to simply avoiding discrimination of LGBTQ people, music therapists are expected to demonstrate an understanding of ways that gender, gender identity, or expression, and sexual orientation influence the therapeutic process. Despite this professional expectation set forth by AMTA, there appears to be a need for increased education on LGBTQ topics in music therapy programs that would better prepare music therapy students to demonstrate meet these professional expectations (Steward, 2019).

LGBTQ Voices and Music Therapy Education

In the process of exploring this topic, I have developed an understanding of the importance of including voices from the LGBTQ community who have been directly impacted by discrimination, and who have led the way in fighting for the dignity and inclusion of themselves, their colleagues, and clients in the field of music therapy. Robinson & Oswanski (2020) co-authored a chapter entitled LGBTQ+ Music Therapy within the book *Music Therapy in a Multicultural Context*. In the opening section, Beth Robinson shares experiences as a self-identified gender queer pansexual person during her music therapy education, stating:

> Remembering back to my life as a young queer music therapy student in the 1990's, I can honestly say that I did not feel seen or supported by my professors or supervisors. Nor did I have any education on working with LGBTQ+ clients.

> There was no education or discussion about LGBTQ+ culture, topics, history, or people in the music therapy curriculum. It was as if we would never meet or work with an LGBTQ+ person in a clinical setting. Or, if we did, that their sexuality and gender were not important (p. 76).

This first-hand account of a music therapy education devoid of any discussion about LGBTQ identities makes several valid and important points. First, it highlights that ignoring the existence of LGBTQ people is problematic when we know that LGBTQ people of all ages exist throughout the United States (Jones, 2021). Second, it highlights the importance of recognizing the significant contributions of LGBTQ musicians in popular music and acknowledging the significance of music in LGBTQ culture (Robinson & Oswanski, 2020). Finally, it highlights the harm that we can perpetuate if we fail to acknowledge LGBTQ identities in music therapy. Although decades have passed since the 1990's and LGBTQ topics are hopefully being incorporated into music therapy curriculum as our body of research grows, there is still a need for increased education on LGBTQ topics in music therapy (Whitehead-Pleaux, 2013; Steward, 2019).

Literature and Recommendations in Music Therapy

A 2012 article entitled "Lesbian, Gay, Bisexual, Transgender, and Questioning: Best Practices in Music therapy", Whitehead-Pleaux and colleagues provided guidelines for working with LGBTQ clients and colleagues. The authors of the article, who represented members of the LGBTQ community and allies, consulted a variety of interdisciplinary resources to create the guidelines. The following list highlights some of the recommendations, which I have paraphrased. The entire list of recommendations is far more extensive and divided into a number of categories, some of which relate to

clinical practice, and others that relate to research, education, policies, and considerations for the workplace. I have altered the language of some of these recommendations slightly to reflect more updated language surrounding LGBTQ topics. For example, I have updated “gender re-assignment surgery” to “gender affirmation surgery”, and have eliminated the word “preferred” when discussing appropriate pronouns based on one’s gender identity.

- Use forms that allow clients to identify their gender identity and sexual orientation.
- Avoid making assumptions about gender identity and sexual orientation.
- Use gender neutral language when possible to avoid making heteronormative assumptions.
- Demonstrate awareness of some of the common challenges and risks that LGBTQ people face, and create a supportive and inclusive environment for LGBTQ clients.
- Demonstrate respect for transgender clients by using the correct name and pronoun.
- Demonstrate an understanding that people who choose to transition do so in a wide variety of ways, including gender affirmation surgery, hormone treatments, or no medical interventions at all.
- Understand the distinction between gender identity and sexual identity, and recognize that people who are transgender can represent a variety of sexual orientations.
- Demonstrate sensitivity to the discrimination that transgender people typically face, including in healthcare, employment, and housing.
- Provide or guide LGBTQ clients toward supportive resources and community organizations when appropriate.
- Be aware of the biases and limitations that can impact research related to LGBTQ populations.
- Learn about LGBTQ musicians and LGBTQ culture in music.

Whitehead-Pleaux and colleagues (2012) included a category about LGBTQ curriculum in music therapy. The researchers recommended that music therapy educators and clinicians integrate educational content that prepares students to provide high quality services to LGBTQ clients (Whitehead-Pleaux et al., 2012). The researchers recommended including education on harmful practices like conversion therapy, challenges faced by LGBTQ communities, and LGBTQ musicians and history (Whitehead-Pleaux et al., 2012).

In a 2013 study, Whitehead-Pleaux and colleagues surveyed music therapists to investigate current attitudes toward working with the LGBTQ community. The majority of respondents (57%) reported having no training in working with LGBTQ clients, and among those that did, 59% reported feeling ill-prepared to work with LGBTQ communities. Most music therapists surveyed reported feeling comfortable working with LGBTQ clients, and most reported knowing individuals who identify as LGBTQ. More than half reported using an open and affirmative approach to working with LGBTQ clients. The researchers found that despite the likelihood that music therapists in all settings will encounter LGBTQ individuals, between 10% and 17% of respondents reported not expecting to encounter LGBTQ clients in particular settings. While the survey found that the music therapy community tends to be accepting and willing to work with LGBTQ people, the results also highlight some inaccurate assumptions about the likelihood of encountering LGBTQ people in a variety of settings (Whitehead-Pleaux et al., 2013). Considering the many changes in legislation, research, and culture since 2013, an updated version of this study may provide more currently relevant data. Still, it does highlight a need for increased education on working with LGBTQ communities.

Queer Theory and Music Therapy

Queer theory challenges traditional assumptions and attitudes about sexuality and gender. Music therapists and music therapy scholars have looked to queer theory to guide them in finding ways that music therapy can be more inclusive to LGBTQ communities. Bain, Grzanka, & Crowe (2016) proposed a "queer music therapy" by exploring ways that queer theory can guide music therapy practices with LGBTQ clients. Bain et al. (2016) define queer theory as "a field of critical theory that challenges heteronormative ideologies by arguing that sexual identities are fluid rather than fixed" (p. 24). Queer theory challenges the concept of a gay/straight binary, and acknowledges the fluid nature of identity (Bain et al., 2016). This concept of sexual fluidity has been reinforced by various researchers, including Lisa Diamond who has demonstrated ways that sexuality can be fluid across the lifespan (Diamond, 2016). Bain et al. (2016) argue that music has the potential to be oppressive by reinforcing heteronormative attitudes, but also has the potential to support and empower LGBTQ communities, and particularly youth, by validating lived experiences and supporting identity development. Adolescents often use music to explore and affirm their identity, suggesting that music therapy may be effective for LGBTQ adolescents who are struggling to be accepted because of their sexual orientation or gender identity (Bain et al., 2016).

In addition to establishing a queer music therapy, Bain et al. provided specific suggestions for clinical practice and music therapy experiences based on queer music therapy. For example, music therapists can intentionally manipulate the language in familiar songs to affirm LGBTQ identities (Bain et al., 2016). A music therapist may adapt lyrics to be gender neutral, change the names or pronouns of characters in a song,

or adapt the lyrics to make a song's narrative more inclusive or relevant to the client's identity. The researchers also described using a "musical autobiography assessment," in which the music therapist prompts the client to brainstorm songs "representative of their past, present, and expected future" (p. 27). For another experience, the authors suggested that music therapists facilitate critical lyric analysis and discussion in group settings. In the context of engaging with an LGBTQ music group, this experience could encourage participants to verbally process their own thoughts and emotions related to experiences related to gender and sexual orientation (Bain et al., 2016). Music therapists can refer to this queer music therapy approach to provide a safe space for identity exploration, recognize the oppression that LGBTQ communities experience, and celebrate differences (Bain et al., 2016).

To build on this queer music therapy approach, Boggan, Grzanka, and Bain (2017) collected qualitative data from semi-structured interviews of twelve music therapists who identified as LGBTQ+. The researchers described that the queer music therapy model can serve group settings by creating affirming spaces for LGBTQ people (Boggan et al., 2017). One music therapist shared that using critical lyric analysis within her LGBTQ+ student group allowed the clients to explore personal experiences and challenges related to being LGBTQ+ (Boggan et al., 2017). One participant stated the importance of clarifying her role as a music therapist, stating "the medicalization of queer identity can be dangerous, especially if you go in as a therapist and your typical model is that the locus of the problem is within the client and the locus of the solution is within you" (p. 383). In other words, music therapists working with LGBTQ/queer clients should understand the ways that same sex attraction and variations on gender identity

have historically been perceived negatively within the medical community. Framing music therapy as a "treatment", or implying that a client's queer identity is problematic, could be damaging to the therapeutic process. Considering the negative impacts of conversion therapy (The Trevor Project, 2015), the history of LGBTQ/queer identities being viewed as pathological (Drescher, 2015), along with the frequency of negative healthcare experiences (Human Rights Campaign, 2018a), it is important for music therapists to be mindful of how they frame the therapeutic relationship. For this reason, I have chosen to use the language "working with LGBTQ clients" instead of "treating" LGBTQ clients to minimize medicalized language that could potentially harm the therapeutic relationship.

Diversity in the Profession

Boggan et al. (2017) suggest that the high level of privilege and lack of diversity among music therapists currently limits music therapy's intersectionality and inclusivity. This lack of diversity is highlighted by the American Music Therapy Association (2019b) Member Survey and Workforce Analysis, which shows that approximately 87% of music therapists identify as female, and 85% identified as white. The relative lack of racial diversity is further highlighted by less than 2% of respondents identifying as Black or African American. Sexual orientation was not included among the demographic variables in the survey. Considering the important role of sexual orientation on the lived experiences and identities of music therapists, it may be worth exploring whether sexual orientation would be valuable to include on similar surveys in the future.

LGBTQ Education in Music Therapy

At this time, limited research exists that specifically investigates LGBTQ topics in music therapy education. Through a queer theoretical perspective, Baines (2019) and colleagues collaborated to explore "ways educators might work effectively to make music therapy courses and programs welcoming of queer bodies and identities" (p. 2). The authors state that when educators do not include queer content, heteronormativity and cisgender normativity continue to be reinforced. Incorporating queer content in music therapy education provides students with opportunities to explore the ways that inequality and social norms impact the lives of queer people (Baines et al., 2019). The authors recommend that music therapy educators reflect on ways that their own biases may impact teaching spaces (Baines et al., 2019). Additionally, the authors suggest using a "curious and questioning" approach (p. 8). This suggestion reflects an attitude of approaching gender and sexuality with an open mind and willingness to evaluate preconceptions and biases. In summary, music therapy educators should be proactive in reflecting on their own identities and attitudes toward LGBTQ communities, how such lenses influence their teaching practices, and how they might better represent LGBTQ/queer identities in educational content.

In a review of literature on queer theory and music therapy education, Steward (2019) recommend that a unit on LGBTQ+ topics be incorporated into the educational requirements for music therapy students. Based on a review of music therapy research and queer theory, Steward (2019, p. 27) additionally proposed that AMTA implement the following competencies that do not currently exist:

1.1 Recognize the multiple communities within the LGBTQ+ community at large

1.2 Be knowledgeable of the difference between gender and sexuality

1.3 Recognize the fluidity of both gender and sexuality

1.4 Be knowledgeable of current political and social discriminations towards the LGBTQ+ community

1.5 Be knowledgeable of current laws and regulations impacting the LGBTQ+ community

1.6 Recognize implicit biases in regard to the LGBTQ+ community

Because research on LGBTQ topics in music therapy education is limited, research in related fields may help guide research in this area and may help guide music therapy educators about ways to increase students' competency and feelings of preparedness for working with LGBTQ clients. Overall, there appears to be a need for increased education in working with LGBTQ patients in a variety of healthcare practices. In a survey of medical students in the United Kingdom, most respondents reported having overall positive attitudes toward LGBTQ patients, but not having received training that specifically informs practices with LGBTQ patients (Parameshwaran, Cockbain, Hillyard, & Price, 2017). In the survey, 84% of respondents reported feeling that their education of LGBTQ healthcare topics was inadequate, including using appropriate terminology, identifying resources for support, and placement of transgender patients (Parameshwaran et al., 2017). In another study, Strong and Folse (2014) collected responses from 58 nursing students, assessing the students' attitudes toward the LGBTQ patient population using a modified version of the Attitudes Toward Lesbians and Gay Men (ATLG) scale. Based on results from a pre- and post-test, Strong and Folse (2014) concluded that a brief educational intervention can improve the attitudes and understanding of LGBTQ patients among nursing students. These two studies are

consistent with the findings of Whitehead-Pleaux et al. (2013), which suggests that music therapists are generally reporting positive attitudes and intentions toward LGBTQ communities, but may lacking training that specifically addresses considerations for LGBTQ clients. Overall, this research highlights a need for healthcare providers to receive more education that prepares them to support and advocate for LGBTQ patients. Considering that music therapists are likely to work in settings with other healthcare providers and staff members who may be lacking training on LGBTQ topics, increased LGBTQ education in music therapy may help music therapists to be leaders in advocating for more inclusive practices within the facilities they work.

Rationale for Present Pilot Study

Researchers have demonstrated that LGBTQ individuals are vulnerable to the impacts of discrimination that occurs on a variety of levels. In healthcare settings, discrimination and barriers to necessary care can contribute to health disparities for LGBTQ individuals. As healthcare professionals, music therapists may perpetuate harm toward LGBTQ clients, even if done so unintentionally. Existing music therapy research provides guidelines for best practices for supporting LGBTQ clients and suggestions for clinical practice based on queer theory. While these guidelines are helpful, there is a need to understand how music therapy students may benefit from increased educational content that specifically addresses the needs of diverse LGBTQ people.

The purpose of this pilot study was to evaluate the impact of a one-hour educational training presentation for music therapy students on considerations for working with LGBTQ clients. Specifically, the following research questions were addressed:

1. To what extent will music therapy students' perceptions of preparedness for working with LGBTQ clients change after participating in a one-hour training?

2. To what extent will music therapy students' knowledge of considerations for working with LGBTQ clients change after participating in a one-hour training?

A secondary purpose was to collect written feedback about the training itself, in hopes that the information gathered may improve future educational trainings or help guide future research on LGBTQ education in music therapy. Participants completed an open-ended feedback questionnaire after the training presentation and interpreted qualitatively to answer the following secondary research questions:

1. What information will music therapy students report finding most useful about the training?

2. What will students report wanting to know more about this topic?

3. What aspects of the training will students report wanting to change?

4. What additional feedback will students provide about the training?

CHAPTER 3. METHODS

I received approval from the University of Kentucky Institutional Review Board (IRB) prior to conducting this pilot study (see Appendix A). Originally, the IRB approved the study to be conducted in-person on campus at the University of Kentucky. In response to the COVID-19 pandemic and recommendations for social distancing, I modified the research procedures and training presentation to take place entirely online, which was approved by the IRB.

Participants

I recruited participants for this pilot study using convenience-sampling, targeting current music therapy students from two large universities in the southeastern United States that I live close to. Criterion sampling was also used (Creswell, 2013). My criteria required that participants had to be at least 18 years old, currently enrolled in an accredited university music therapy program, a pre-professional music therapy student, and not yet board-certified as music therapists. Students were eligible to participate regardless of whether they had started or completed their internships but were only included if they had not yet earned the MT-BC credential. I contacted via email a music therapy program director and music therapy professor at two universities, both of whom I knew previously, and invited them to share the invitation for both the educational training and research study with their students via email and social media (see Appendix B). I notified the program director, assistant professor, and students that participation in the training presentation did not require participation in the research study.

Instrumentation

I designed a questionnaire that included four sections: (a) demographic information and two questions about music therapy background/current educational status (b) a multi-item questionnaire measuring current perceptions of preparedness for working with LGBTQ clients using a Likert-type scale; (c) a pre-test that comprised of open-ended questions designed to test participants' current level of knowledge of considerations for working with LGBTQ clients; (d) post-tests delivered after the training, which contained a perceptions of preparedness and knowledge questionnaire identical to those delivered in the pre-tests; and (e) a questionnaire containing four open-ended questions asking for participants' feedback about the training (see Appendices C–F)

Demographic information and educational background. This section consisted of three multiple-choice questions that included gender identity, sexual orientation, and racial identity, and a write-in question for age. Additionally, the form contained a write-in option for gender identity, sexual orientation, and racial identity to provide participants with the option to self-identify these items if the options provided were insufficient. The educational background questions asked participants to state if they are currently enrolled as a music therapy student in an AMTA-approved program and if they had earned the MT-BC credential. These two questions served to ensure that participants were eligible to participate in the pilot study. Only current pre-professional students were eligible to participate.

Perceptions of preparedness pre-test and post-test. This section contained multiple choice items to assess participants' perceptions of their own preparedness to

demonstrate various skills related to clinical work with LGBTQ clients. These items were drawn and adapted from a variety of resources, including existing research on music therapy with LGBTQ clients, current clinical recommendations from APA, research on health disparities and healthcare needs of LGBTQ people, reputable advocacy organizations, and a University of Kentucky webinar training on LGBTQ healthcare.

Knowledge pre-test and post-test. This section contained open write-in questions designed to assess participant's general knowledge of considerations for working with LGBTQ clients. This included questions about professional expectations, considerations for communicating respectfully, music therapy research, transgender topics, and considerations for choosing music. These questions were also drawn from many of the same resources as described previously in the questionnaire on perceptions. I decided to ask for written responses in the knowledge tests, with the intention of encouraging participants to engage more deeply in the subject matter.

Procedures

Informed Consent

When participants arrived at the web-based training, the research assistant provided an overview of the informed consent information (see Appendix G), answered any questions, then provided a link to the online pre-tests. The first section of the pre-test questionnaire included the informed consent information and prompted participants to check "yes" to indicate consent. Since some students who participated are in the music therapy program directed by the researcher's faculty adviser, steps were taken to minimize the potential for undue influence in recruiting potential participants. Specifically, neither I nor the faculty advisor were present in the meeting while the research assistant reviewed informed consent and answered questions. Only participants

who met eligibility requirements and indicated consent to participate were included in the study.

Educational Training

The one-hour training was guided by an overall goal of improving participants understanding of considerations for working with LGBTQ clients based on existing research in music therapy and related health professions, along with recommendations from established advocacy organizations. The rationale for the training was supported by AMTA's Professional Competency 9.5, which includes "gender identity, gender expression, and sexual orientation" among the factors that music therapists should be aware of influencing the therapeutic process. This rationale was presented at the beginning of the training presentation, followed by an exercise that encouraged attendees to reflect on how their understanding of LGBTQ people originated and changed over time, which was adapted from the The Safe Zone Project (2019) curriculum.

The training was delivered as lecture and was approximately 50 minutes in length. The presentation was aided by PowerPoint slides providing key information and visual aids. I designed the PowerPoint based on the assertion-evidence presentation style (Garner & Alley, 2013). I adapted the presentation from one I had presented twice previously, which focused on supporting LGBTQ clients within hospital settings. To make information more relevant to a wide variety of settings, I decreased some content that specifically applied to hospital settings, added information relevant to COVID-19, and added more information including national and regional resources supporting LGBTQ people. Following the lecture, participants were invited to ask questions or make

comments for approximately five minutes. The following represents more information about content delivered in the training:

Terminology. The first portion of the training focused on current terminology. I provided some key definitions provided by LGBTQ advocacy organizations, explained the differences between sex and gender, described gender pronouns, and discussed the LGBTQ acronym and expansions of the LGBTQ acronym.

LGBTQ Discrimination. I presented information about how discrimination impacts the health of LGBTQ people through the lens of the minority stress framework. This included an explanation of different forms of discrimination. I provided specific examples of microaggressions experienced by LGBTQ people that music therapists should consider in order to avoid perpetuating discrimination. I additionally described instances of blatant discrimination and hate crimes experienced by LGBTQ communities.

LGBGTQ Discrimination in Healthcare. In this section, I presented information about ways that LGBTQ people experience discrimination within healthcare and about the impacts of healthcare inequities. This included direct quotes of LGBTQ people who described negative experiences during healthcare, barriers to reproductive healthcare, barriers to transgender care, historic context of discrimination in healthcare, and connections to the COVID-19 pandemic.

Music Therapy with LGBTQ Clients. In this section, I presented information from existing music therapy research on working with LGBTQ populations. I also provided considerations for selecting music that affirms and normalizes diverse sexual orientations and gender identities. Many of these suggestions were derived from suggestions of Bain et al. (2016) based on a queer theory framework. Finally, I described

some additional resources, some of which are specific to Kentucky, for LGBTQ education, advocacy, and inclusive healthcare.

Conclusion. Following the training, I invited attendees to ask questions and engage in discussion for approximately five minutes. Next, the research assistant provided each attendee with a share-drive link to a handout of additional resources that may be helpful for further education on LGBTQ topics, musical resources for therapists, and resources for clients who may benefit additional services and support.

Questionnaire

The research assistant provided attendees of the training with links to the pre-tests and post-tests. Participants were allowed approximately 15 minutes to complete the pre-test, which included the informed consent document, demographics and education questionnaire, perceptions of preparedness questionnaire, and knowledge questionnaire. Next, the research assistant invited me to enter the meeting and deliver the training. Following the training, the research assistant provided participants with a link to the online post-tests that included the perceptions of preparedness and knowledge-based questions identical to those delivered in the pre-test. Additionally, the post-test contained a brief, open-ended feedback questionnaire asking for feedback about the training (Appendix H).

Data Collection

The research assistant and I individually graded participant responses in the knowledge-based pre- and post-tests independently using a detailed answer key designed by myself. Next, we identified and resolved any discrepancies in our scores based on our best understanding of the material presented in the training, along with our own

knowledge of the subject matter. The questionnaires were not linked to pre-tests and post-tests, so neither I nor the research assistant had knowledge linking specific participants to the questionnaires. Individual questions from the knowledge-based tests were worth a total of 2 points each, and participants could earn one point for two-part questions in which one part was correct. The perceptions of preparedness questions, presented as a Likert-type scale, were adapted to a numeric 0-4 scale (0 = Strongly Disagree, 1 = Disagree, 2 = Neither Agree nor Disagree, 3 = Agree, 4 = Strongly Disagree). I analyzed and interpreted the quantitative data collected from the pilot study. Finally, I analyzed the written responses collected in the "feedback" section of the post-test perceptions and presented this as qualitative descriptive data.

Data Analysis

Quantitative

For this pilot study, the primary researcher conducted exploratory statistical analysis using a non-parametric Wilcoxon signed ranks test and examined measures of central tendency as well as visual display of the data. Data from the knowledge and perceptions pre- and post-tests were reported using descriptive statistics.

Qualitative

To answer the secondary research questions related to feedback on the training, I collected written responses from the feedback questionnaire and analyzed them thematically through a process of open coding with a member of my thesis committee. Dr. Vasil and I independently analyzed responses to the feedback questions. First, we created a table for open coding, which identified key topics that emerged within each feedback comment. Next, we identified common themes that emerged in participants' responses.

CHAPTER 4. RESULTS

I evaluated the impact of a one-hour educational training for music therapy students on considerations for working with LGBTQ clients. Before the training, participants completed a pre-test that included a demographic and educational questionnaire, a perceptions of preparedness pre-test, and a knowledge-based pre-test. After the training, participants completed a perceptions post-test and knowledge post-test that were both identical to the pre-tests, and additionally completed an open-ended feedback questionnaire that prompted participants to reflect on their perceptions of the training. Results from the perceptions and knowledge portions of the pre- and post-tests are based on a non-parametric quantitative analysis. Results from the feedback questionnaire are based on qualitative analysis.

Participants

Five attendees of the training ($N = 5$) consented to participate in the pilot study, all of whom were eligible to participate as pre-professional music therapy students who are currently enrolled in an AMTA-approved music therapy program at the time of the pilot study. All five participants submitted the pre-test, post-test, and a completed feedback questionnaire.

Demographic Information

All participants ($N = 5$) identified as being white and female. No participants identified as being transgender. Four participants identified as being between 20 and 29, and one participant did not list their age. Participants varied with regards to their sexual orientation. See Table 1 for a complete breakdown of demographic variables

Table 1

Demographic Variables

Demographic Variables	*n*	%
Race/Ethnicity		
White	5	100%
Age		
20–29	4	80%
Gender		
Female	5	100%
Identifying as Transgender		
No	5	100%
Sexual Orientation		
Straight	2	40%
Mostly Straight	2	40%
Pansexual	1	20%

Quantitative Analysis

Primary Research Question 1

To what extent will music therapy students' perceptions of preparedness for working with LGBTQ clients change after participating in a one-hour training?

Participants completed an 11-question perceptions questionnaire that asked participants to reflect on feelings of preparedness to demonstrate specific skills related to working with LGBTQ clients (see Appendix D). Questions were presented as a Likert-type scale, asking participants to choose between "Strongly Disagree," "Disagree," "Neither Agree nor Disagree," "Agree," and "Strongly Agree" for each item. To translate responses into quantitative data, I converted each response to an ordinal score (0, 1, 2, 3, or 4). Results from a Wilcoxon signed-rank test indicated that post-training perceptions of preparedness scores (M = 39.00, Mdn = 39.00) following the delivery of the

educational training were significantly higher than pre-training scores (M = 27.40, Mdn = 27.00), Z = 2.032, p = .042, r = 0.91.

All participants (N = 5) scored higher on the post-tests compared to the pre-tests. Changes between pre- and post-tests for each participant demonstrate improvements between overall scores, and most individual questions (see Figures 2–6). In each line graph, a line that is parallel to the line or below it indicates no change in score from pre-test to post-test. Within the perceptions of preparedness tests, two individual questions reached statistical significance in terms of improvement between the pre- and post-test. Results for the question "I feel prepared to use appropriate terminology when discussing LGBTQ topics" indicated that post-test perceptions of preparedness scores (M = 3.80, Mdn = 4.00) were significantly higher than pre-test scores (M = 3.00, Mdn = 3.00), Z = 2.00, p = .046, r = .89. Results for the question "I feel prepared to demonstrate an understanding of healthcare disparities experienced by LGBTQ people" indicated that post-training perceptions of preparedness scores (M = 3.40, Mdn = 3.00) were significantly higher than pre-training scores (M = 1.80, Mdn = 2.00), Z = 2.07, p = .038, r = .93.

Table 2

Comparison of Perceptions of Preparedness Total Scores

	Mdn	*M*	*SD*	*R*	*p*	*r*
Pre-test	27.00 (61.36%)	27.40 (62.27%)	3.05	7.00	.042	0.91
Post-test	39.00 (88.64%)	39.00 (88.64%)	0.76	9.00		

Note. The p values and effect sizes (r) are the results of the Wilcoxon signed rank tests. Perceptions tests were scored out of a total of 44 possible points. * $p < .05$.

Figure 1

Perceptions Score Comparison

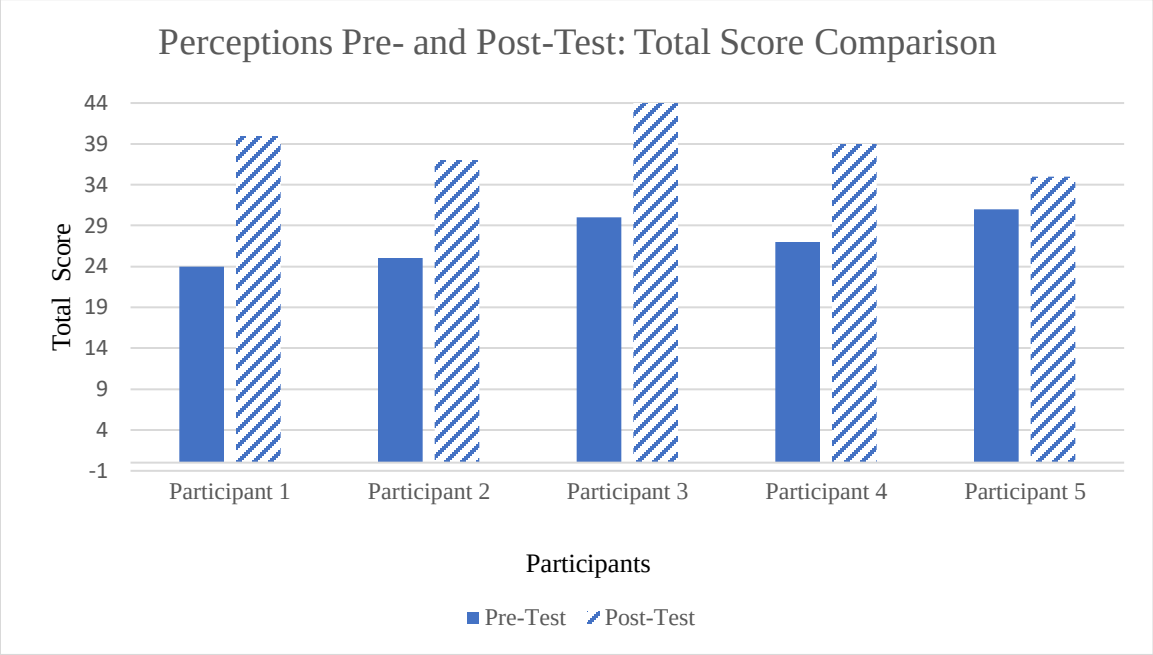

Figure 2

Participant 1 Perceptions Scores

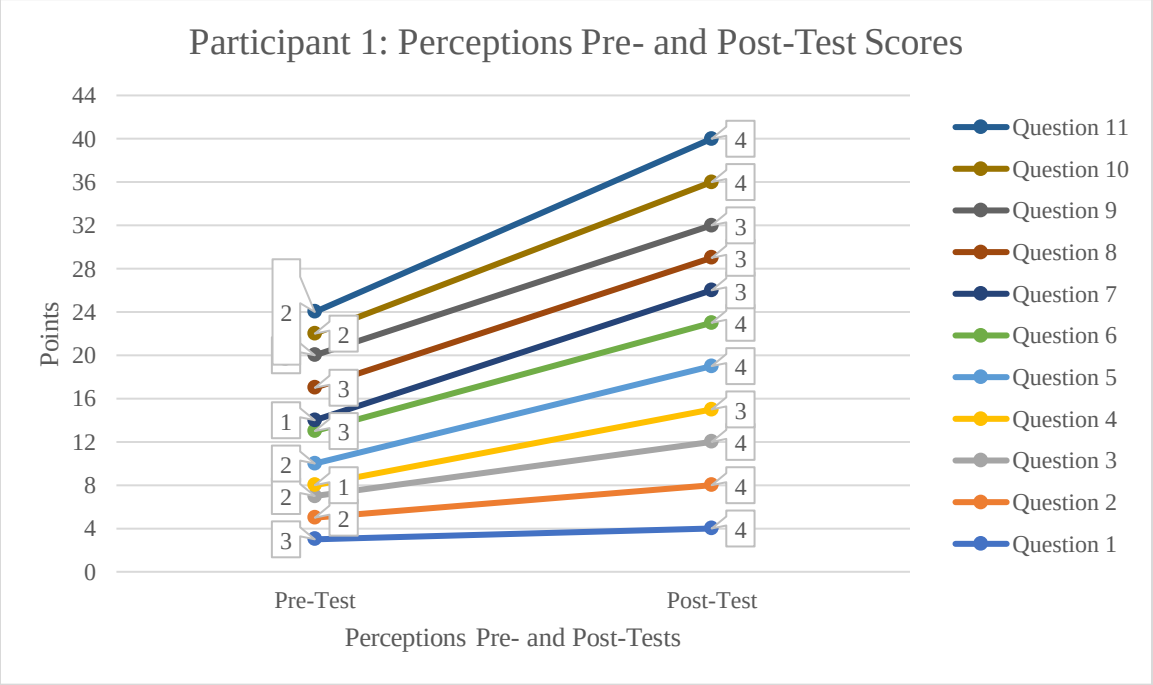

Figure 3

Participant 2 Perceptions Scores

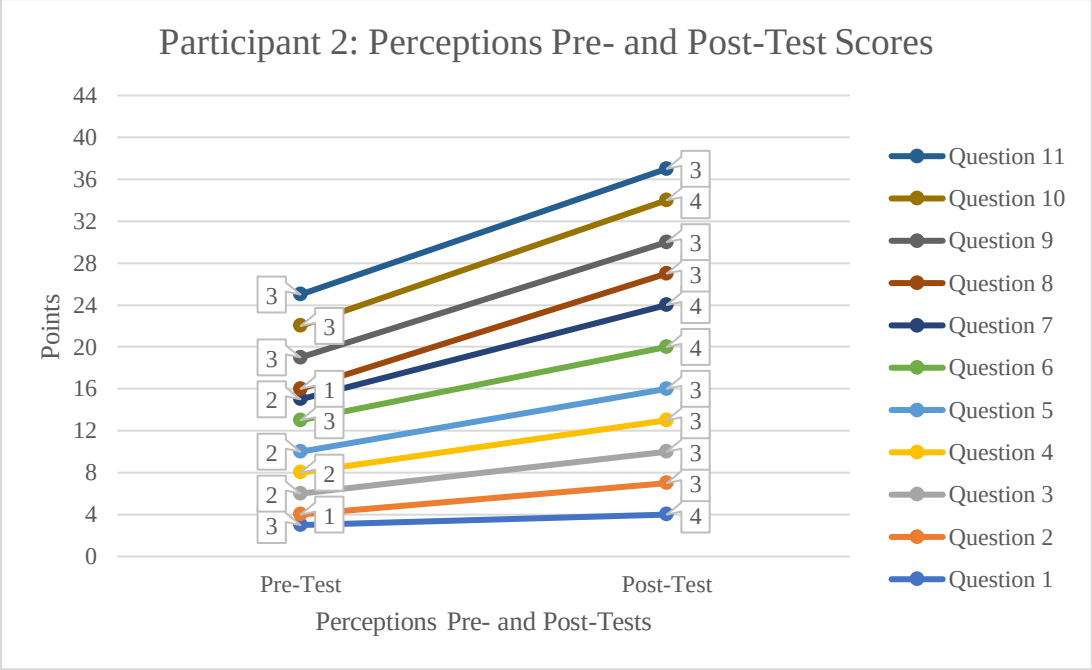

Figure 4

Participant 3 Perceptions Scores

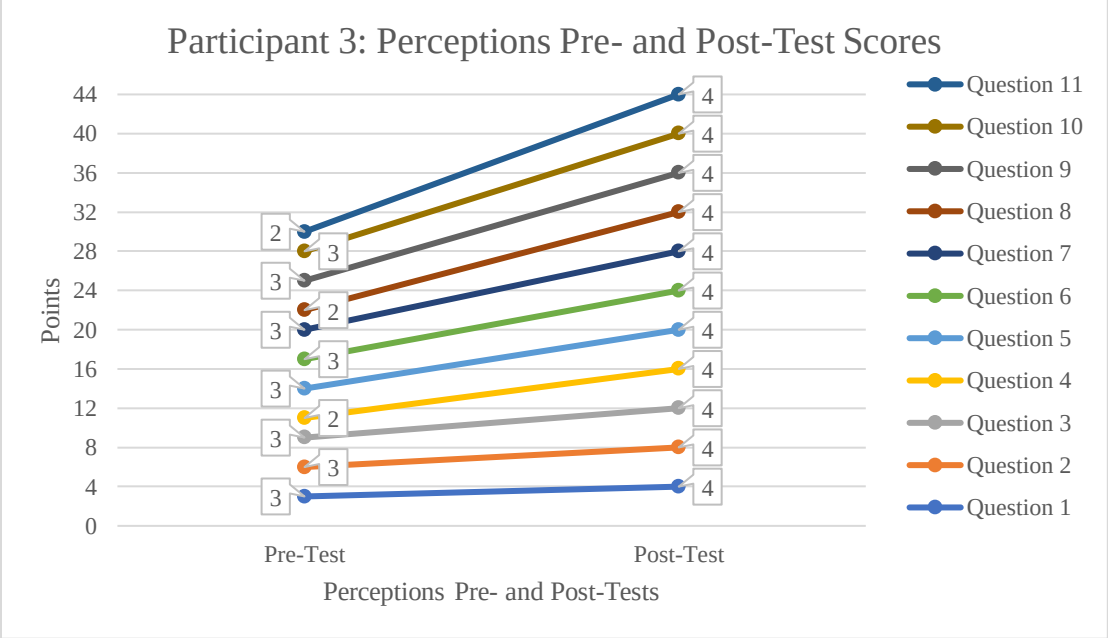

Figure 5

Participant 4 Perceptions Scores

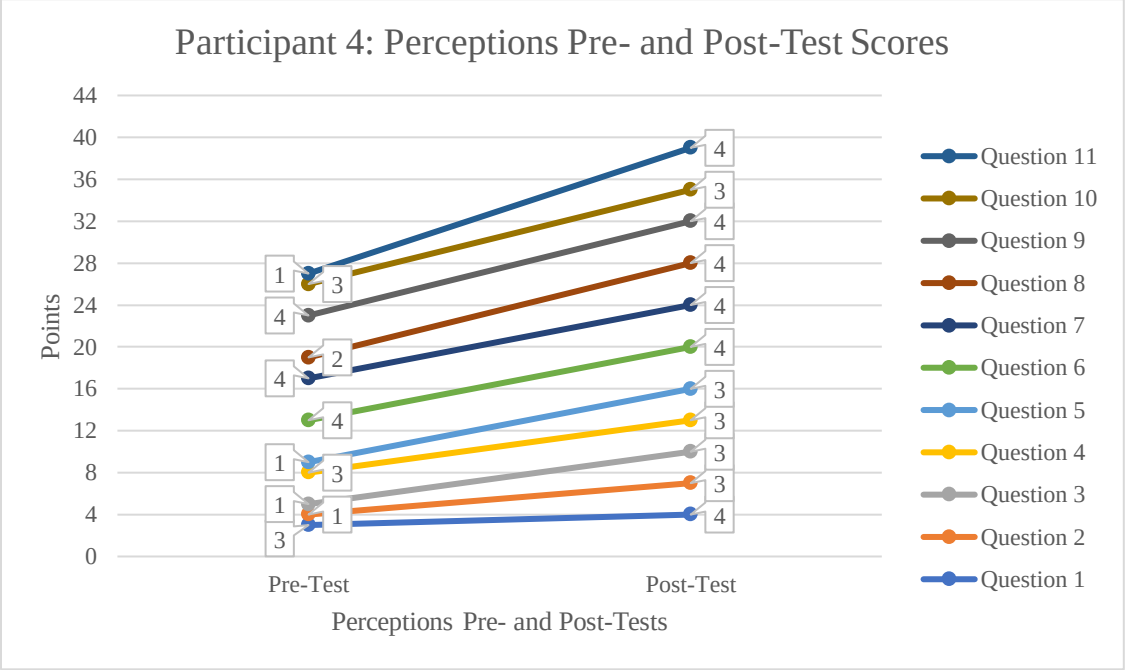

Figure 6

Participant 5 Perceptions Scores

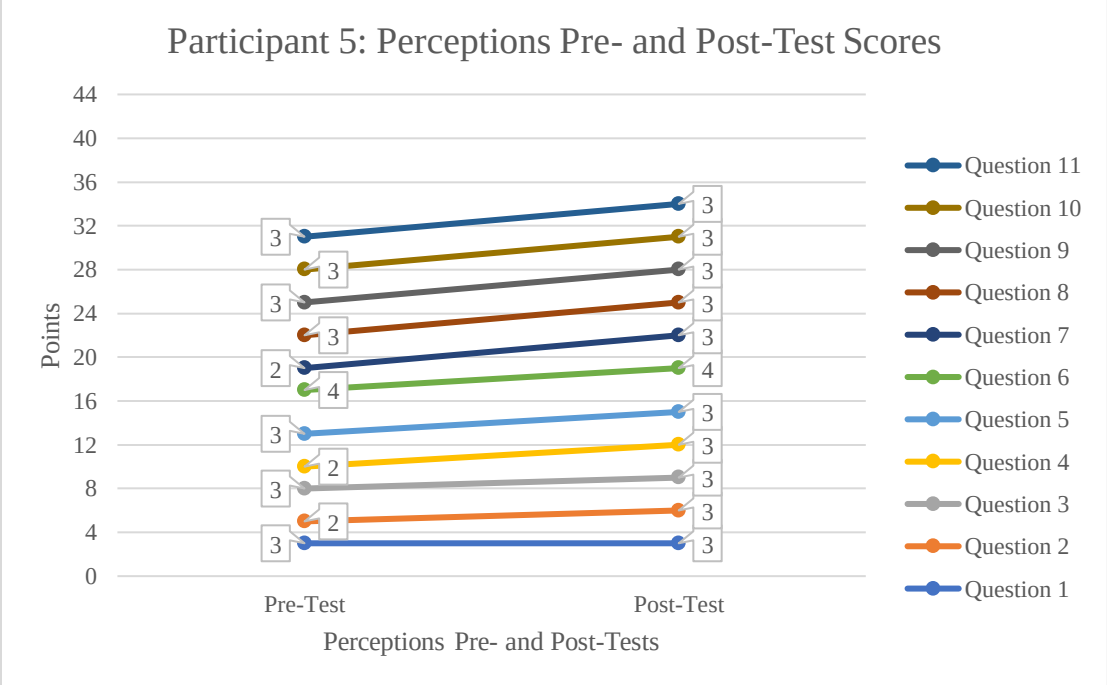

Table 3

Reponses to Perceptions of Preparedness Questions

	Pre-test					Post-test				
I feel prepared to…	*Mdn*	*M*	*SD*	*Min*	*Max*	*Mdn*	*M*	*SD*	*Min*	*Max*
Use appropriate terminology when discussing LGBTQ topics. *	3.00	3.00	0.00	3.00	3.00	4.00	3.80	0.45	3.00	4.00
Demonstrate an understanding of healthcare disparities experienced by LGBTQ people. *	2.00	1.80	0.84	1.00	3.00	3.00	3.40	0.55	3.00	4.00
Discuss the impact of microaggressions with LGBTQ clients.	2.00	2.20	0.84	1.00	3.00	3.00	3.40	0.55	3.00	4.00
Choose music that validates LGBTQ identities and does not perpetuate stigma.	2.00	2.00	0.71	1.00	3.00	3.00	3.20	0.45	3.00	4.00
Demonstrate an understanding of topics related to transgender identities.	2.00	2.20	0.84	1.00	3.00	3.00	3.40	0.55	3.00	4.00
Normalize and validate a wide range of sexual orientations, gender identities, and gender expressions.	3.00	3.40	0.55	3.00	4.00	4.00	4.00	0.00	4.00	4.00

Table 3 (Continued)

	Pre-test					Post-test				
I feel prepared to…	*Mdn*	*M*	*SD*	*Min*	*Max*	*Mdn*	*M*	*SD*	*Min*	*Max*
Support a client who is in the coming out process.	2.00	2.40	1.14	1.00	4.00	4.00	3.60	0.55	3.00	4.00
Consider the role of my own sexual orientation in the therapeutic process.	2.00	2.20	0.84	1.00	3.00	3.00	3.40	0.55	3.00	4.00
Consider the role of my own gender identity in the therapeutic process.	3.00	3.20	0.45	3.00	4.00	3.00	3.40	0.55	3.00	4.00
Guide clients to resources and organizations that support LGBTQ people.	3.00	2.80	0.45	2.00	3.00	4.00	3.60	0.55	3.00	4.00
Refer clients to healthcare professionals who provide affirmative services to LGBTQ patients.	2.00	2.20	0.84	1.00	3.00	4.00	3.60	0.55	3.00	4.00

Note. Scores range from 0 (Strongly Disagree) to 4 (Strongly Agree). Higher scores indicate stronger feelings of preparedness for each item. Results are rounded to nearest one hundredth. *$p < .05$ and statistically significant.

Primary Research Question 2

To what extent will music therapy students' knowledge of considerations for working with LGBTQ clients change after participating in a one-hour training?

Participants completed a 9-item knowledge-based pre- and post-test (see Appendix E). Each question prompted participants to provide a written response to questions related to knowledge of LGBTQ topics relevant to music therapy. Overall, change between the knowledge-based pre- and post-test did not reach statistical significance. For this reason, definitive conclusions cannot be drawn from the results. Results from the knowledge-based pre-test and post-test did, however, indicate an overall increase in the average of total scores when comparing the post-tests to pre-test scores. Furthermore, a small sample size limited the power. Four participants (80%) demonstrated an overall improvement scores on the knowledge-based test following the delivery of the educational training (see Figures 7–12). In each line graph, a line that is parallel to the line or below it indicates no change in score from pre-test to post-test. The total mean scores of knowledge test increased from 48% on the pre-test, to 80% on the post-test. Among individual knowledge-based questions, no changes in individual questions reached statistical significance.

Table 4

Comparison of Total Knowledge Scores

	Mdn	*M*	*SD*	*R*	*p*	*r*
Pre-test	7.00 (39%)	8.60 (48%)	4.39	11.00		
					.08	0.78
Post-test	15.00 (83%)	14.40 (80%)	1.34	3.00		

Note. The *p* values and effect sizes (*r*) are the results of the Wilcoxon signed rank tests. The knowledge-based test was scored out of a total possible 18 points. Results are rounded to nearest hundredth.

Figure 7

Knowledge Pre- and Post-Test Total Score Comparison

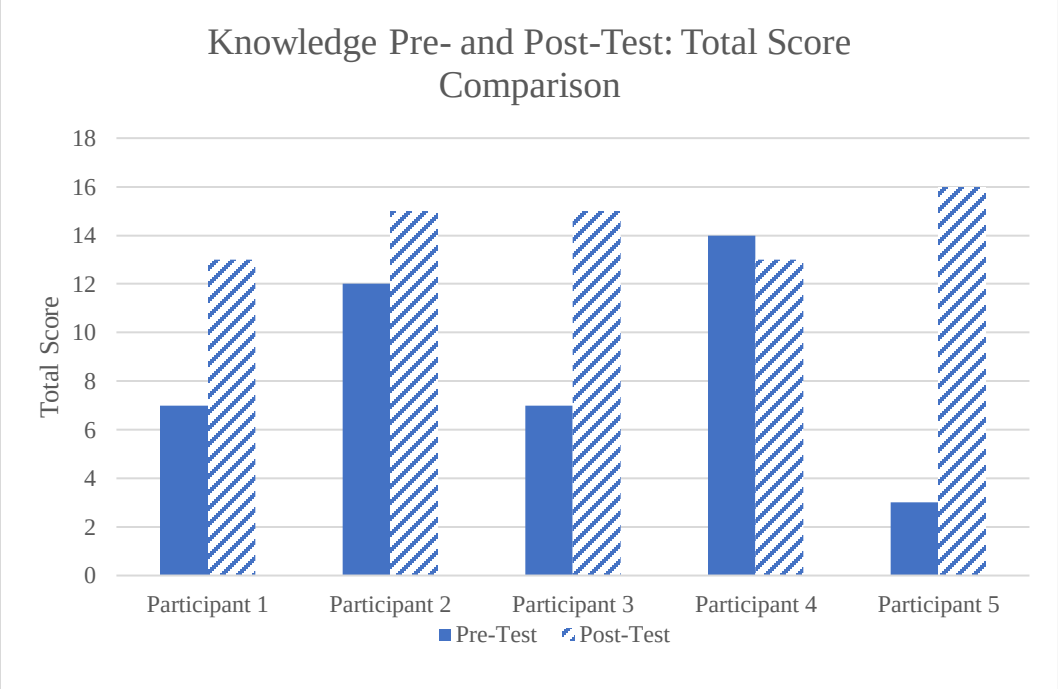

Figure 8

Participant 1 Knowledge Scores

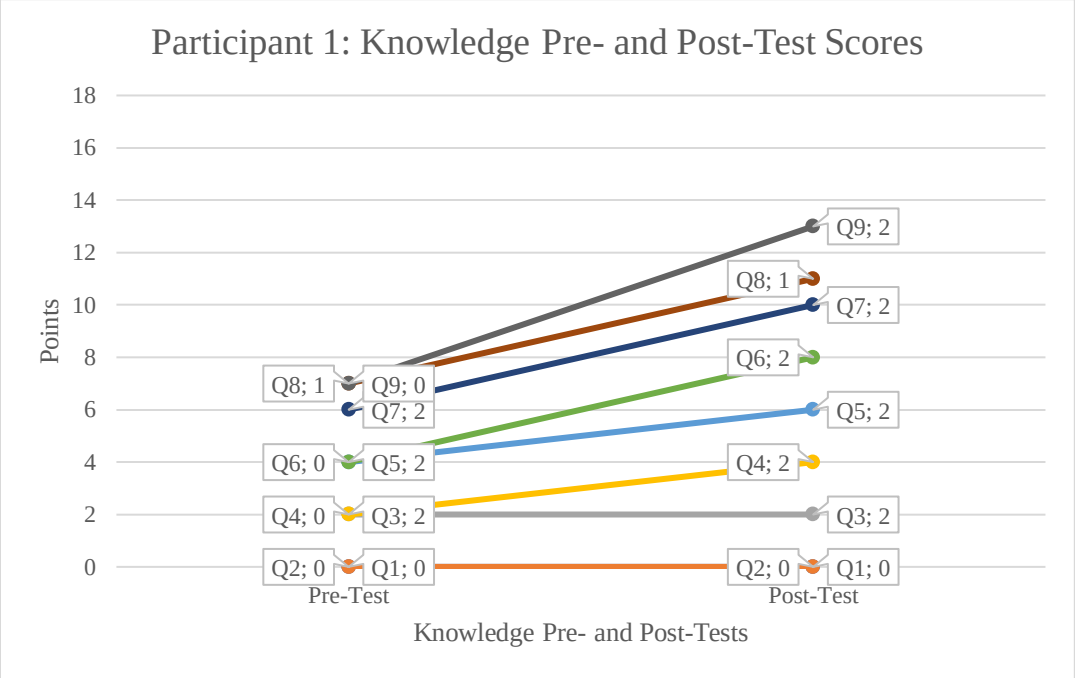

Figure 9

Participant 2 Knowledge Scores

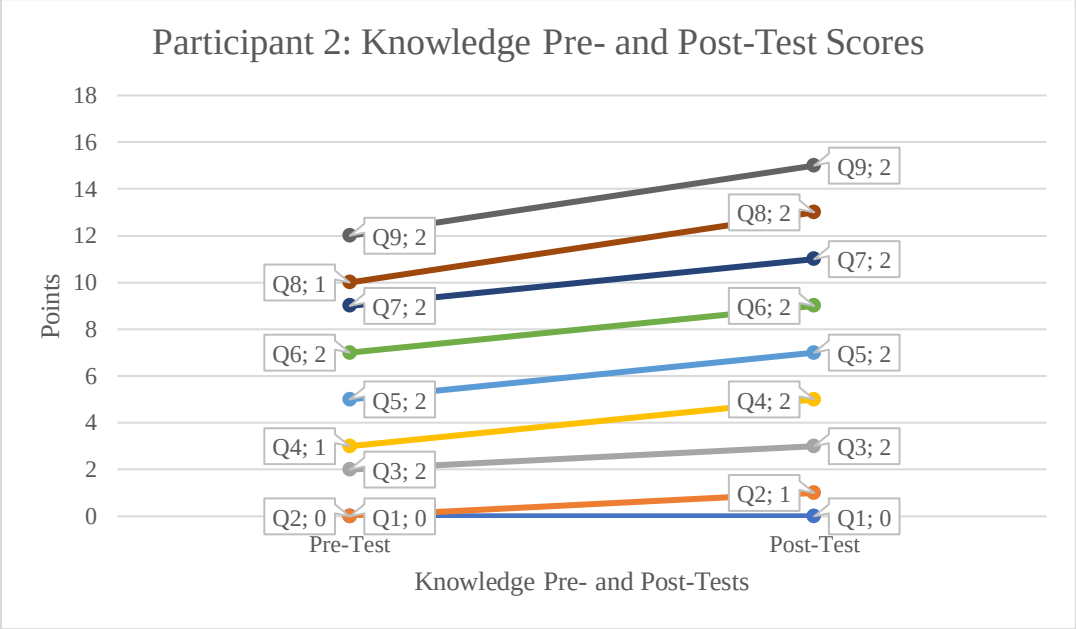

Figure 10

Participant 3 Knowledge Scores

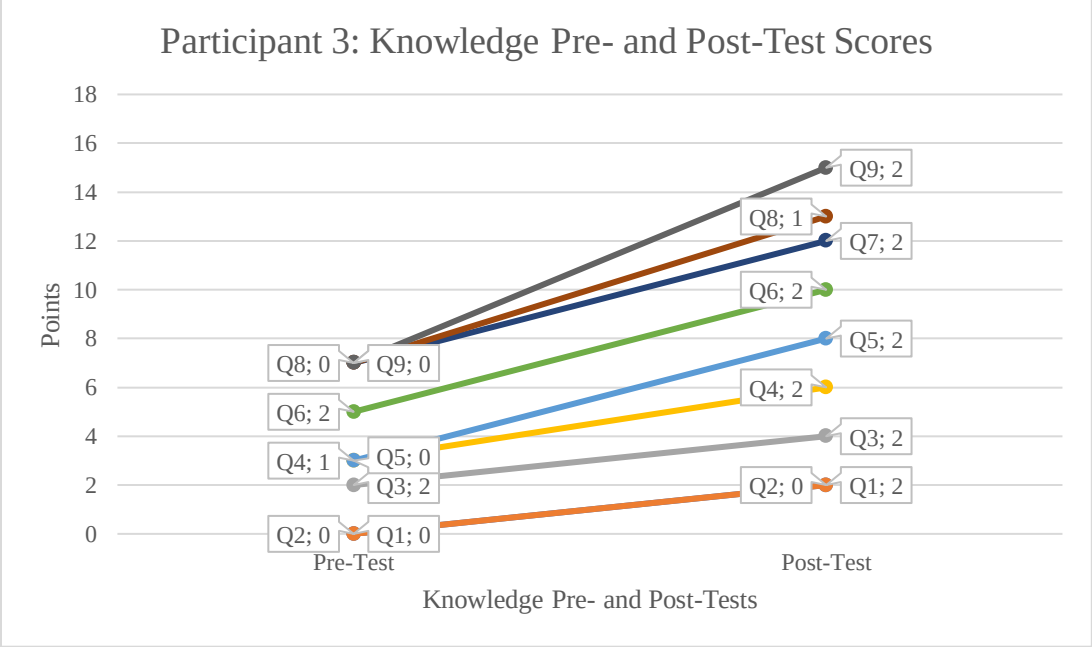

Figure 11

Participant 4 Knowledge Scores

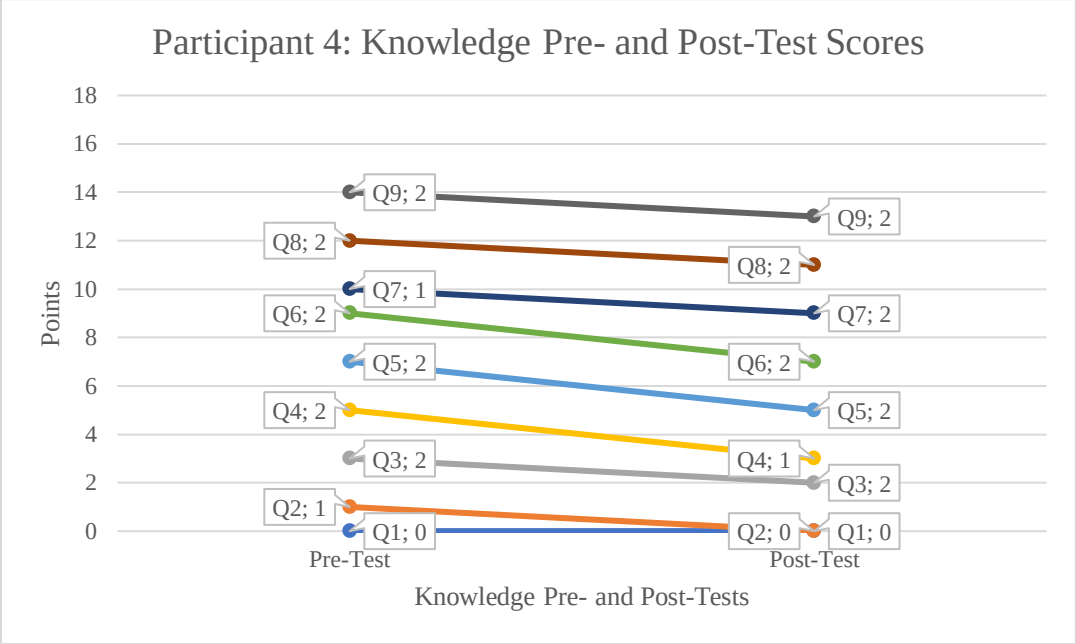

Figure 12

Participant 5 Knowledge Scores

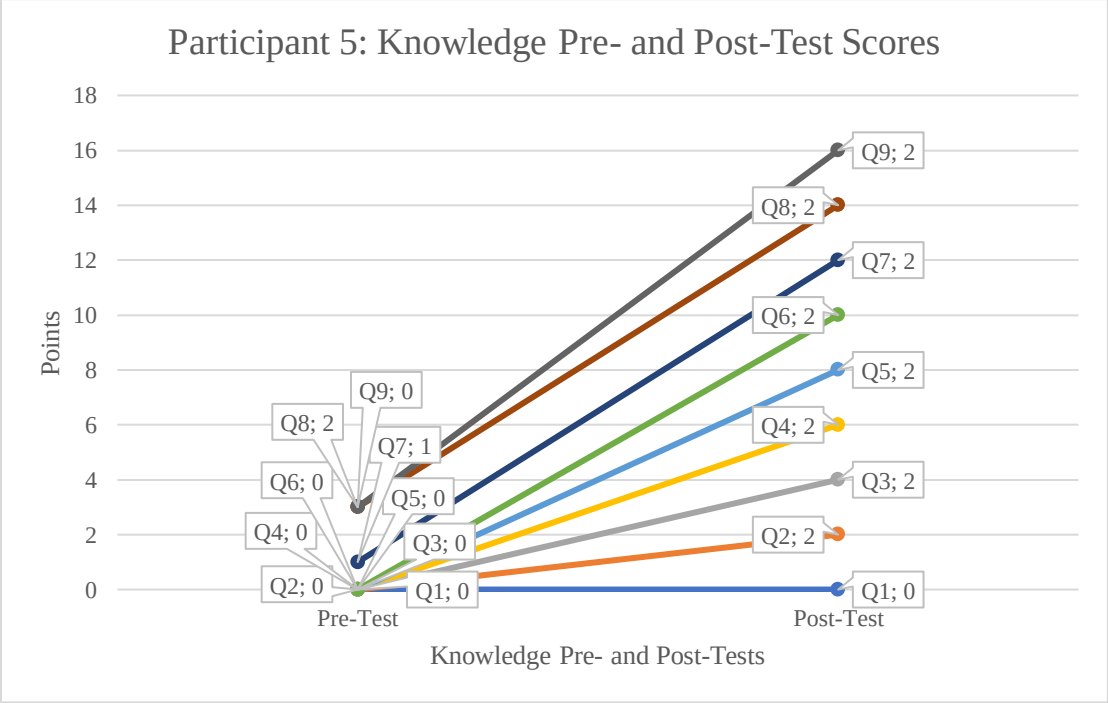

Table 5

Reponses to Knowledge-Based Questions

Question	Pre-test					Post-test				
	Mdn	*M*	*SD*	*Min*	*Max*	*Mdn*	*M*	*SD*	*Min*	*Max*
What do AMTA's professional competencies recommend related to gender identity, gender expression, and sexual orientation?	0.00	0.00	0.00	0.00	0.00	0.00	0.40	0.89	0.00	2.00
Summarize at least two findings from music therapy research on working with LGBTQ clients.	0.00	0.20	0.45	0.00	1.00	0.00	0.60	0.89	0.00	2.00
Describe two considerations for communicating respectfully with LGBTQ clients.	2.00	1.60	0.89	0.00	2.00	2.00	2.00	0.00	2.00	2.00
List at least two ways that LGBTQ patients may experience discrimination in healthcare settings.	1.00	0.80	0.84	0.00	2.00	2.00	1.80	0.45	1.00	2.00

Table 5 (Continued)

Question	Pre-test					Post-test				
	Mdn	*M*	*SD*	*Min*	*Max*	*Mdn*	*M*	*SD*	*Min*	*Max*
Define the term "microaggression".	2.00	1.20	1.10	0.00	2.00	2.00	2.00	0.00	2.00	2.00
Describe one example of a microaggressions that an LGBTQ individual may experience.	2.00	1.20	1.10	0.00	2.00	2.00	2.00	0.00	2.00	2.00
Describe the difference between "sex" and "gender".	2.00	1.60	0.55	1.00	2.00	2.00	2.00	0.00	2.00	2.00
Define the term "transgender" and describe one common misconception about being transgender.	1.00	1.20	0.84	0.00	2.00	2.00	1.60	0.55	1.00	2.00
Describe one consideration for selecting music for LGBTQ clients	0.00	0.80	1.10	0.00	2.00	2.00	2.00	0.00	2.00	2.00

Note. Each question was scored out of a total of two possible points. Results are rounded to nearest one hundredth.

Qualitative Analysis

Secondary Research Questions

I created the secondary research questions to gather and interpret feedback from participants about the training, in hopes that this information may improve future educational trainings or guide researchers in this area. We only included themes that were represented by at least two comments from participants (see Table 6). We identified two themes related to what participants found most helpful: knowledge of LGBTQ topics and musical considerations. Three themes emerged related to what participants would like to know more about this topic: LGBTQ advocacy, healthcare discrimination, and overall wanting to learn more. All participants who responded to the question about what aspect of the training they would change said they would change nothing. The theme *the training was helpful* emerged in relation to the question about additional feedback. In addition to themes related to the research questions, one theme, positive emotions, emerged as well. Several participants provided comments conveying positive emotions about the impact of the training and interest in pursuing more knowledge on this topic.

Table 6

Feedback Questionnaire: Qualitative Analysis

Question	Themes	Participant Quote
What information was most helpful to you in today's training?	Knowledge of LGBTQ Topics (*n* = 3)	"All of it. Every part of this presentation taught me at least 1 new thing that will help me be a better music therapist and even a better person for having the knowledge."
		"Learning about the discrimination that transgender people face in the healthcare system. I knew it was an *[sic]* problem, but I did not know the extensiveness of the issue."
		"So much of this was helpful! The list of resources for LGBTQ+ individuals and the connections to things that are currently happening in our world were probably the most helpful aspects to me."
	Musical Considerations (*n* = 2)	"Learning about what sorts of musical considerations to apply to a music therapy session with an LGBTQ client"
		"Musical considerations"
What would you like to know more about on this topic?	LGBTQ Advocacy (*n* = 2)	"How to be an advocate for less discrimination in the healthcare system"
		"I would like to learn more about the inequalities in the healthcare system for LGBTQ clients and how I can better educate myself on how to be an advocate in the healthcare field"

	Healthcare Discrimination (*n* = 2)	"How to be an advocate for less discrimination in the healthcare system."
		"I would like to learn more about the inequalities in the healthcare system for LGBTQ clients and how I can better educate myself on how to be an advocate in the healthcare field."
	Overall More on the Topic (*n* = 2)	"I would be happy to learn more about this topic altogether. I think it is so important to learn as much as we can about everyone."
		"Future research since this is a topic for ongoing learning"
What aspects of the training would you change	Nothing (*n* = 3)	"Nothing. I loved this training."
		"None, I think that this training went very well!"
		"N/A. I found it very helpful!"
Please provide any additional feedback on today's presentation.	Training was Helpful (*n* = 3)	"This training helped me in understanding what I can do to be a better music therapist, but it also helped me on a personal level. My cousin recently came out to our family as transgender, and while I have wanted to help our family understand her and what this means for her, I didn't know how. I now feel like I have a better grasp of how I can be supportive of her in answering all of our families *[sic]* questions even though I can't answer them for her or speak for how she is feeling."
		"I learned a lot and my brain is still absorbing it all."
		"I thought that this presentation was very informative and helpful."

CHAPTER 5. DISCUSSION

Music therapy students in this pilot study demonstrated statistically significant positive changes in their perceptions of preparedness to demonstrate skills related to supporting LGBTQ clients following a one-hour presentation. No conclusions could be drawn about changes in knowledge based on quantitative data. Written feedback from participants revealed a variety of themes related to perceiving value in the knowledge gained from the training and wanting to learn more. In this chapter, I will provide additional information and discussion about the result from this pilot study.

Primary Research Question 1

To what extent will music therapy students' perceptions of preparedness for working with LGBTQ clients change after participating in a one-hour training?

Participants completed identical pre-tests and post-tests that measured their perceptions of their own preparedness to demonstrate specific skills and knowledge related to working effectively and respectfully with LGBTQ clients. Overall positive changes in scores between the preparedness pre-tests and post-tests reached statistical significance, and all five participants demonstrated improved overall scores on the post-test as shown in Figure 1. These results suggest that an educational training that specifically addresses considerations for working with LGBTQ clients may improve students' perceptions of their preparedness for working with LGBTQ clients. Furthermore, improvement between pre- and post-tests was distributed across a variety of individual questions (see Figures 2–6), suggesting that a one-hour educational training may improve perceptions of preparedness to demonstrate a wide variety of skills related to serving LGBTQ clients.

To my knowledge, no research exists that specifically surveys music therapy students on perceptions of their own preparedness for working effectively with LGBTQ clients. In a 2013 survey by Whitehead-Pleaux et al., 59% of music therapists reported feeling ill-prepared to work with LGBTQ communities. Consistent with Whitehead-Pleaux and colleagues' (2013) survey of professionals, results from this pilot study suggest that there is room for improvement in helping music therapy students feel prepared to provide high quality services to LGBTQ clients. Considering that overall, there appears to be a need for increased education in healthcare related to serving LGBTQ communities, it is useful to know that even brief, targeted education in this area has a positive impact on students' feelings of preparedness to serve LGBTQ clients.

Two individual questions ("I feel prepared to use appropriate terminology when discussing LGBTQ topics" and "I feel prepared to demonstrate an understanding of healthcare disparities experienced by LGBTQ people") reached statistical significance in terms of improvement between the pre- and post-tests. This suggests that information on LGBTQ terminology and disparities in healthcare may be particularly useful for increasing music therapy students' perceptions of their preparedness to work effectively with LGBTQ communities. Using affirmative and respectful language is crucial in demonstrating respect toward the LGBTQ community (Gold, 2019; Quinn et al. 2015), which also has impacts on health. For example, transgender and non-binary people have reported being half as likely to attempt suicide when their pronouns are respected (The Trevor Project, 2020), highlighting the impact of language on the health of LGBTQ communities.

Researchers have also discussed ways that healthcare professionals may be unaware of the discrimination and challenges experienced by LGBTQ people within healthcare settings. For example, McGlynn et al. (2019) found that even healthcare professionals who view themselves as "LGBTI friendly" are likely to make incorrect assumptions that LGBTI people do not experience significant problems in healthcare. Students in my pilot study reported feeling significantly more prepared to demonstrate an understanding of healthcare disparities following the presentation, suggesting a need for more education on discrimination that occurs in healthcare settings. Importantly, terminology and healthcare discrimination are connected. For example, Quinn et al. (2015) found that LGBTQ patients reported feeling safer in healthcare settings where staff used gender neutral language or displayed the Human Rights Campaign logo to indicate being inclusive of LGBTQ patients. In other words, this pilot study further supports that the use of terminology surrounding the LGBTQ community within healthcare settings is deserving of attention and education.

Although this pilot study represents a small sample size, it does provide some evidence that even a one-hour educational presentation may improve music therapy students' perceptions of their preparedness for working with LGBTQ clients. While I suspect that the content of the training was primarily responsible for improving these perceptions, it is also possible that the process of taking the pre- and post-tests and engagement in discussion could have additionally contributed to this positive change in perceptions. Additionally, it is important to consider that student participants self-reported their perceptions of their own preparedness, which made this test more subjective to grade compared to the knowledge-based test.

Primary Research Question 2

To what extent will music therapy students' knowledge of considerations for working with LGBTQ clients change after participating in a one-hour training?

Participants took identical pre- and post-tests that measured knowledge of specific information related to providing quality music therapy services to LGBTQ clients. Because changes between the pre- to post-test did not reach statistical significance, no conclusions could be drawn from the results of the knowledge tests. The small number of participants in the pilot study limited the power. Despite this limitation, there was a trend of positive changes between the pre- and post-tests. Four out of five participants scored higher total scores on the knowledge post-test following the educational presentation, as shown in Figure 7. Given the limited number of participants, one participant scoring lower on the post-test compared to the pre-test may have skewed the data.

Considering that this presentation was given to current music therapy students, presenting data in terms of grades may be useful in demonstrating increased competency. The average total score of the knowledge pre-test was 48%, which would typically be considered a failing grade. On the knowledge post-test, the average total score improved to 80%, which would typically be considered a “B” grade in most college classes and considered to be meeting educational competencies. No changes between individual questions reached statistical significance. The participant with the lowest knowledge pre-test score, however, demonstrated perfect post-test scores on all individual questions except for question 1 (see Figure 12). This suggests that a student with limited knowledge

of LGBTQ topics in music therapy may be able to demonstrate improvement after one hour of education on a variety of individual questions.

Only one participant correctly answered the following question in the post-test: "What do AMTA's professional competencies recommend related to gender identity, gender expression, and sexual orientation?" The wording of this question may have been unclear to students and would benefit from revisions in future trainings. Additionally, only two out of five participants received all or partial credit for the second question, which asked participants to summarize at least two findings from music therapy research on working with LGBTQ clients. It is possible that this information was not effectively conveyed to students in the training, and may need to be further developed in future trainings.

Participant 4 scored slightly lower overall on the knowledge post-test compared to the pre-test. Because Participant 4 did not answer one question on the knowledge post-test in which they had scored correctly on the pre-test, this may have lowered their overall score. Additionally, the researchers debated the accuracy of Participant 4's answer to Question 4 on the post-test. Furthermore, Participant 4 demonstrated the highest score on the knowledge pre-test compared of all participants, which may have resulted in a ceiling effect. Considering these factors, along with the subjectivity of scoring, a decrease in the overall score of Participant 4 may not convey an actual decrease in knowledge.

Written feedback responses from participants additionally reflected positive perceptions that the content of the presentation increased knowledge on specific topics, including LGBTQ advocacy in healthcare and musical considerations. Previous research

has suggested that music therapy education should better prepare students for working with LGBTQ or queer populations (Baines et al., 2019; Steward, 2019; Whitehead-Pleaux et al., 2013). Consistent with this previous research that highlights a need for expanded LGBTQ education in music therapy, the overall low scores on the knowledge pre-test demonstrate room for growth for music therapy students on knowledge of LGBTQ topics.

Secondary Research Questions

I provided a four-question feedback section with the intention to gather qualitative, written data about participants' perceptions of the training presentation. All participants' written comments are listed in Appendix H. Overall, comments reflected positive perceptions about the impact of the training. For example, one participant stated that information about transgender discrimination was helpful. Considering the tremendous harm that transgender communities can face (Johns et al., 2019; Robert Wood Johnson Foundation, 2017b), a positive statement about the usefulness of learning more about transgender discrimination suggests that music therapy students may welcome more education about the impact of discrimination on transgender communities.

Another participant stated feeling that the list of LGBTQ resources that was provided at the end of the presentation was helpful. This feedback suggests that music therapy students may benefit from a handout of LGBTQ resources, which in this pilot study included national advocacy organizations, links to additional guidelines for supporting LGBTQ clients, suggested articles in music therapy, suggested playlists, and local community resources. Considering that a variety of forms of support can provide protection to LGBTQ communities from minority stress, especially youth (Marx &

Kettrey, 2016; Snapp et al., 2015), it is helpful to know that music therapy students may perceive value in learning about a variety of resources aimed to support LGBTQ clients. Two comments reflected a desire to learn more about LGBTQ advocacy, and two comments reflected a desire to learn more about discrimination toward LGBTQ people in healthcare. These two topics are connected in the sense that developing an awareness of discrimination and its negative consequences on the health of LGBTQ people points to a need for increased LGBTQ advocacy. In other words, when students learn about the prevalence of discrimination in healthcare, they may be inclined to make efforts to advocate for policies and practices that better serve LGBTQ communities.

Because overall changes in knowledge did not reach statistical significance, it is helpful to know that following the presentation, several participants expressed a desire to learn more about various aspects of working with LGBTQ clients in the feedback portion of the post-test. Given that multiple participants expressed a desire to learn more after the presentation, a brief educational presentation may serve as a starting place for students to identify areas of LGBTQ education and advocacy they would like to learn more about. Considering the individual differences and various intersections of identity, even music therapy students who identify as being part of the LGBTQ community may benefit from increased education in this area. Multiple participants in this pilot study identified as a sexual orientation other than "straight" yet reported benefiting from the information that was presented. This suggests that education on LGBTQ topics may benefit music therapy students regardless of their own sexual orientation.

During the process of open coding, a theme of positive emotions emerged. Although this theme was not directly related to the research question, it may be helpful

for music therapy educators to know that students may experience positive emotions when provided with opportunities to learn about LGBTQ topics in music therapy. Considering the relative diversity of the participants' self-identified sexual orientations, along with the training being voluntary, it is possible that the participants already had positive feelings about LGBTQ advocacy. Additionally, the participants in this pilot study voluntarily decided to participate in the educational presentation. Therefore, it is likely that participants were already interested in LGBTQ advocacy and may have more positive feelings about LGBTQ advocacy compared to a more general population of music therapy students.

Limitations

This pilot study had several important limitations. A small number of participants ($N = 5$) limits the strength of conclusions drawn. Because the training presentation and data collection took place during the early part of the COVID-19 pandemic, some students may have been unavailable for a wide variety of reasons, including personal health reasons, the illness or death of family members, and economic hardship. Additionally, the training took place during the height of ongoing protests surrounding police brutality toward the Black community. This may have restricted the availability of Black music therapy students, or other students impacted by these events. All five participants in this pilot study identified as being white and as women. A more racially diverse sample of students would strengthen a future study. Furthermore, because no participants identified as transgender, no conclusions can be drawn about the impact of the presentation on transgender music therapy students. A larger and more diverse sample

size of music therapy students may more effectively identify the impacts of a training presentation on considerations for working with LGBTQ clients.

The limited number of questions (9) in the knowledge-based test may have limited the validity of the knowledge results. I chose to test participants on knowledge using questions that required written responses in hopes that it would encourage deeper reflection of the subject. To provide adequate time for participants to write responses, I decided to limit the number of knowledge questions. Because of this, results from these tests may not fully capture participants' knowledge on the pre-tests and post-tests. Additionally, because answers to the questions were interpreted by myself and the research assistant, there was a degree of subjectivity to the scoring of these questions. Considering that only one participant correctly answered a question about AMTA's professional competency related to gender identity, gender expression, and sexual orientation, the wording of this question may not have been clear to students. Furthermore, only two out of five participants correctly summarized two research findings in music therapy on the post-test, suggesting that this information may not have been delivered effectively in the training.

Finally, the short length of the presentation (one-hour) somewhat limited the amount of content that I could deliver in the training. In planning the presentation, I assumed that one-hour may be a reasonable amount of time that music therapy students would be willing to commit to an educational training outside of school. Because the length of the presentation was limited to one-hour, I used my best judgement to determine what information was most important to include in the presentation. Although I used a variety of resources to guide the content of the presentation, it is likely that my

personal biases impacted what I decided to include in the presentation. Although this is not necessarily considered a limitation, it is important to consider these influences.

Suggestions for Future Research

Future researchers should consider implementing and evaluating a similar training for a larger sample size of students, which could strengthen findings from the present pilot study. Additionally, they should consider methods of evaluating knowledge on LGBTQ topics that increases reliability, such as using a larger number of multiple-choice questions to test knowledge. For any research evaluating knowledge and perceptions of preparedness for working with LGBTQ clients, researchers should be mindful of the ongoing development of LGBTQ culture, legislation, terminology, and research. Furthermore, researchers should engage in ongoing reflection of their own attitudes, identities, and biases surrounding sexuality and gender that may impact research.

The content of similar educational trainings and research should be informed by the most currently available information. Additionally, although this presentation did include quotes and video footage from individuals who identify as being part of the LBGTQ community, it may have been strengthened by including a diverse sample of presenters who identify as a variety of subgroups and racial/ethnic identities within the LGBTQ community. Future researchers may also consider implementing a similar educational training for board-certified music therapists rather than students alone. Considering that young adults are more likely to identify as LGBTQ/queer (Jones, 2021), and therefore may be more knowledgeable on LGBTQ topics, it is possible that older adults may benefit from additional training about working with LGBTQ communities.

Additionally, future researchers may consider evaluating other approaches to delivering LGBTQ educational content to music therapy students. In this pilot study, several participants indicated being interested in furthering their knowledge and exploring more resources after the presentation, suggesting that a training like this may simply serve as a starting place for learning more. Longitudinal research and more qualitative research in this area may help music therapy educators to better understand how to best prepare students to support diverse LGBTQ communities. Finally, although this presentation included information about intersections of LGBTQ identities and racial/ethnic identities, I did not specifically include information about disabled LGBTQ people. Future researchers should consider including the disabled community in research on LGBTQ education in music therapy. Additionally, there are other aspects of identity that were not specifically addressed in the presentation, such as socioeconomic status, nationality, language, and geographic location. All of these factors may impact an LGBTQ person's lived experiences.

Implications for Education and Clinical Practice

This pilot study provides preliminary evidence supporting the impact of an educational training for music therapy students on considerations for working with LGBTQ clients. Although the training for this study took place in a single hour-long session, music therapy educators may need to consider what is most feasible for their programs. For example, music therapy educators could consider finding opportunities to integrate considerations for LGBTQ clients into existing curriculum and discussions. For example, a discussion about building rapport could include discussion about using appropriate pronouns. As another example, a discussion about the potential for music to

cause harm could include acknowledgement of ways that music can reinforce heterosexist and cissexist attitudes.

Because legislation, culture, and research surrounding LGBTQ communities has changed rapidly in recent years, music therapy educators should consider the most currently available research and recommendations when educating students on LBTQ topics in music therapy. Music therapy clinicians should similarly consider the most current literature to inform best clinical practices for supporting diverse LGBTQ clients. In addition to considering available research in music therapy, educators and clinicians should also consider research within the fields of medicine, psychology, gender and women's studies, and sociology, along with recommendations from organizations that advocate for LBGTQ communities. Additionally, music therapy clinicians and educators should consider the voices of diverse individuals representing the LBGTQ community. Music therapists should recognize the work of Black queer feminists who have laid a foundation of intersectionality in social justice movements. Finally, the important role of music in LGBTQ culture and the significance of safe community music spaces should be honored and recognized.

Educators and clinicians who do not feel prepared to educate students on LGBTQ topics may benefit from seeking more education and supervision themselves. Music therapy educators and supervisors should approach LGBTQ topics with awareness of personal bias, and with an understanding that culture, terminology, research, and legislation surrounding LGBTQ communities is constantly changing. For students who are less experienced with LGBTQ topics, or whose biases may limit their ability to advocate for LGBTQ people, research based on the minority stress theory may offer a

starting place to understand specific examples of ways that discrimination can harm the health of LGBTQ people. Understanding ways that discrimination leads to health disparities may help students understand why specific consideration should be given to supporting LGBTQ clients.

Queer theory may guide music therapy students toward ideas about actionable steps toward building more inclusive and affirmative music therapy practices (Baines et al, 2016; Baines et al., 2019). Some resources that I recommend for educators and clinicians include the chapter "LGBTQ+ Music Therapy" in *Music Therapy in Multicultural Context* (Robinson & Oswanski, 2021), the chapter "The Cultures of the Lesbian, Gay, Bisexual, Transgender, and Questioning Communities (Hardy & Whitehead-Pleaux, 2017), and the SafeZone Training Facilitator Guide (2019). Finally, music therapy clinicians and educators should acknowledge the important contributions of BIPOC activists who have been leaders in intersectional social justice movements both within and outside of academia.

The current shutdowns during the COVID-19 pandemic have restricted or eliminated access to many music spaces that typically provide support and community support to LGBTQ people. Music therapists may want to consider the consequences of these shutdowns on LGBTQ communities, and consider the urgency of providing support to LGBTQ clients who may be unable to access safe community music spaces. Music therapy educators should consider including educational content that specifically prepares music therapy students to consider the unique needs and experiences of LGBTQ communities in the face and aftermath of a global pandemic.

Conclusion

This pilot study provides preliminary evidence that music therapy students benefit from opportunities to learn about specific ways to support LGBTQ clients. Based on an exploratory analysis, music therapy students in this pilot study demonstrated significant improvement in their perceptions of their own overall preparedness to support LGBTQ clients following the educational training. Students demonstrated statistically significant improvement in two individual perceptions questions: one regarding LGBTQ terminology, and the other regarding healthcare disparities.

Changes in knowledge after the training were not statistically significant, so I could not draw conclusions about changes in knowledge. Four out of five participants, however, demonstrated an overall improvement in knowledge following the training. Furthermore, it is important to consider that a small sample size limited the power. Future researchers may want to consider including a larger number of participants, and expanding the number of knowledge-based questions to increase the validity of this measure. A larger sample size of student may also increase diversity of participants. Additionally, the training took place during the COVID-19 pandemic, which could have limited availability of students for a variety of reasons.

Results from participants' written feedback responses reflect positive perceptions about the knowledge gained in the presentation, along with positive emotions about the training. Furthermore, written comments by participants reflected positive perceptions about the knowledge gained during the training, particularly in the areas of LGBTQ advocacy and discrimination within healthcare. Considering the theme of wanting to learn more that emerged from the written feedback survey, music therapy students may

be interested in learning more about specific ways to support LGBTQ clients. Furthermore, an unexpected theme of positive emotions emerged from the qualitative results. This suggests that music therapy students may experience positive emotions surrounding opportunities to learn more about supporting LGBTQ clients.

Two main theories were represented in the training—the minority stress theory and queer theory. In music therapy education, research based on the minority stress theory may help students understand specific ways that various forms of discrimination can negatively impact the health of LGBTQ people. Queer theory may be useful in guiding music therapists toward implementing more inclusive practices, and challenging heterosexist and cissexist attitudes. In summary, the minority stress theory reveals harm that LGBTQ communities experience, while queer theory envisions a path toward building a more inclusive existence for all people regardless of sexual orientation, gender identity, or gender expression.

The COVID-19 pandemic has exacerbated existing inequities for LGBTQ communities. As allied healthcare professionals, music therapists should be aware of how discrimination can impact LGBTQ people and work to mitigate this harm by providing affirmative services and advocating for inclusive policies in the various places that music therapists work. Educational opportunities for music therapy students to learn about diverse LGBTQ clients may help students feel more prepared to demonstrate respect toward LGBTQ clients and advocate for the rights and dignity of LGBTQ clients across settings. Music therapy educators should implement educational content that includes information on the impacts of discrimination on LGBTQ communities, best understood practices for working with LGBTQ clients based on existing research, consideration for

intersectionality, acknowledgement of the role of music in LGBTQ culture, and tools and resources that may be useful for students and their clients. A one-hour educational training on working with LGBTQ clients may serve as a starting place for music therapy students to feel more prepared to provide quality services to LGBTQ clients.

APPENDICES

Appendix A: IRB Certificate of Approval

University of Kentucky | Office of Research Integrity
IRB, RDRC

Modification Review

Approval Ends:	IRB Number:
3/6/2021	54682

TO:	Cecilia Wright, BA Music Office OfMedical Education PI phone #: [redacted] PIemai[redacted]
FROM:	Chairperson/ViceChairperson Nonmedical Institutional Review Board (IRB)
SUBJECT:	Approval of ModificationRequest
DATE:	4/23/2020

On 4/23/2020, the Nonmedical Institutional Review Board approved your request for modifications in your protocol entitled:

Evaluating a Training for Music Therapy Students on Working with LGBTQ Clients

If your modification request necessitated a change in your approved informed consent/assent form(s), the new IRB approved consent/assent form(s) to be used when enrolling subjects can be found in the "All Attachments" menu item of your E-IRB application. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.]

Note that at Continuation Review, you will be asked to submit a brief summary of any modifications approved by the IRB since initial review or the last continuation review, which may impact subject safety or welfare. Please take this approved modification into consideration when preparing your summary.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research" available in the online Office of Research Integrity's IRB Survival Handbook. Additional information regarding IRB review, federal regulations, and institutional policies may be found through ORI's web site. If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at 859-257-9428.

APPENDIX B: EDUCATION TRAINING ADVERTISEMENT

Invitation to Participate in Training and Study

Dear music therapy program director or professor:

I would like to invite your music therapy students to attend a one-hour web-based educational training entitled *Music Therapy Considerations for LGBTQ Clients* that I plan to host via Zoom. Currently enrolled music therapy students will be invited to participate in a research study about the training, which includes an online pre- and post-test that evaluate students' overall knowledge and perceptions of preparedness for working with LGBTQ clients.

Please forward this invitation to students and colleagues who may be interested in attending the training session. Although only current music therapy students will be eligible to participate the study, anybody who is interested, including professional music therapists and allied healthcare providers, may attend the training.

Interested students: The total time of the training and data collection will be approximately 90 minutes and will take place on Wednesday, June 3rd at 7pm. To attend the web-based training, use this link [Zoom Link]. The link will direct you to a "waiting room", and the research assistant will invite you into the meeting. Before the training presentation, the research assistant will review the informed consent information and invite attendees to ask questions. Next, the research assistant will share a link to the pre-tests. Following an approximately one-hour training presentation, participants will be asked to complete a post-test. You may choose to leave the study at any time or to skip questions you do not want to answer. You are welcome to attend the training session without participating in the study.

If you have any questions, please email the primary researcher, Cecilia Wright, at [redacted] or faculty advisor, Dr. Olivia Yinger, at [redacted]. If you would like more information about the study before the training presentation, please email the research assistant, Emma Martin, at [redacted]. Thank you for your consideration

Appendix C: Demographics Questionnaire/Educational Background

What is your gender identity?

- ○ Male
- ○ Female
- ○ Non-binary or genderqueer
- ○ Prefer to self-identify (please specify)

_____

Do you identify as transgender?

- ○ Yes
- ○ No
- ○ I'm not sure.

What race/ethnicity best describes you? (You may select more than one)

- ☐ Black or African American
- ☐ Hispanic or Latinx
- ☐ Asian or Asian American
- ☐ American Indian
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Multiple ethnicities or multiracial
- ☐ Prefer to self-identify (please specify)

What is your age?

_____

What is your sexual orientation?

- ○ Lesbian
- ○ Gay
- ○ Bisexual
- ○ Mostly Gay
- ○ Mostly Straight
- ○ Pansexual
- ○ Asexual
- ○ Queer
- ○ Straight
- ○ Questioning
- ○ Prefer not to say
- ○ Prefer to self-identify (please specify)

_____

Are you currently enrolled as a music therapy student in an AMTA-approved program?

- ○ Yes
- ○ No

Have you earned the MT-BC credential through the Certification Board for Music Therapists (CBMT)?

- ○ Yes
- ○ No

Appendix D: Perceptions-Based Questionnaire

I feel prepared to use appropriate terminology when discussing LGBTQ topics.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to demonstrate an understanding of healthcare disparities experienced by LGBTQ people.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to discuss the impact of microaggressions with LGBTQ clients.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to choose music that validates LGBTQ identities and does not perpetuate stigma.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to demonstrate an understanding of topics related to transgender identities.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to normalize and validate a wide range of sexual orientations, gender identities, and gender expressions.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to support a client who is in the coming out process.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to consider the role of my own sexual orientation in the therapeutic process.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to consider the role of my own gender identity in the therapeutic process.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

I feel prepared to guide clients to resources and organizations that support LGBTQ people.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

When appropriate, I feel prepared to refer clients to healthcare professionals who provide affirmative services to LGBTQ patients.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree

APPENDIX E: KNOWLEDGE-BASED QUESTIONNAIRE

What do AMTA's professional competencies recommend related to gender identity, gender expression, and sexual orientation?

_____

Summarize at least two findings from music therapy research on working with LGBTQ clients.

_____

_____

_____

_____

_____

Describe two considerations for communicating respectfully with LGBTQ clients.

_____

_____

_____

_____

_____

List at least two ways that LGBTQ patients may experience discrimination in healthcare settings.

_____

_____

_____

_____

_____

Define the term "microaggression".

_____

Describe one example of a microaggressions that an LGBTQ individual may experience.

_____

Describe the difference between “sex” and “gender”.

_____

_____

_____

_____

_____

Define the term “transgender” and describe one common misconception about being transgender.

_____

_____

_____

_____

_____

Describe one consideration for selecting music for LGBTQ clients.

_____

_____

_____

_____

_____

Appendix F: Feedback Questionnaire

What information was most helpful to you in today's training?

_____

_____

_____

_____

_____

What would you like to know more about on this topic?

_____

_____

_____

_____

_____

What aspects of the training would you change?

_____

_____

_____

_____

_____

Please provide any additional feedback on today's presentation.

_____

_____

_____

_____

_____

Consent to Participate in a Research Study

KEY INFORMATION FOR EVALUATING A TRAINING FOR MUSIC THERAPY STUDENTS ON WORKING WITH LGBTQ CLIENTS

We are asking if you choose to volunteer for a research study about a one-hour web-based training on working with LGBTQ clients in music therapy. We are asking you because you are a music therapy student who is attending a web-based training about considerations for working with LGBTQ clients. This page gives you key information to help you decide if you want to participate. Detailed information follows this page.

WHAT IS THE STUDY AND HOW LONG WILL IT LAST?

By doing this study, we hope to understand if a one-hour web-based training session about music therapy with LGBTQ clients may impact students' knowledge and perceptions of preparedness for working with this population. The content of the training itself will last approximately one hour. Your participation in the research component related to the training is expected to take an additional 30 minutes, making the total time involved approximately 90 minutes.

WHAT ARE REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?

There are no rewards for participating in the study. The information obtained in the study, however, may benefit others by improving the quality of music therapy services delivered to LGBTQ clients.

WHAT ARE REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?

The study poses no more than minimal risk for participants, but some questions could make you feel uncomfortable. If that happens, you may skip a question and you are free to leave this study at any time. Completion of the pre- and post- tests delivered before and after the training is completely voluntary.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part, it should be because you really want to volunteer**. You will not lose any services, benefits or rights you would normally have if you choose not to**

volunteer. As a student, if you decide not to take part in this study, your choice will have no effect on your academic status or class grades.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?

If you have questions, suggestions, or concerns about the study, contact Cecilia Wright, MT-BC, a graduate student at the University of Kentucky, at [redacted].You may also contact the faculty advisor for this study, Dr. Olivia Yinger of the University of Kentucky, Department of Music Therapy. Her contact information is [redacted] or [redacted]. If you have any concerns or questions about your rights as a research volunteer, contact staff in the University of Kentucky, (UK) Office of Research Integrity (ORI) between 8am and 5pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428.

DETAILED CONSENT

ARE THERE REASONS WHY YOU WOULD NOT QUALIFY FOR THIS STUDY?

Participants must be age 18 or older. If you are not currently enrolled as music therapy student, you would not quality for this study. If you are currently a board-certified music therapist (MT-BC), you would not qualify for this study. Additionally, you would not qualify for this study if you do not plan to attend the researcher's training session.

WHERE WILL THE STUDY TAKE PLACE AND WHAT IS THE TOTAL TIME INVOLVED?

The research procedures will be conducted online via webinar software. The researcher will provide interested participants, along with anyone else who wants to access the training presentation, with an announcement stating the time of the training session and a link to the training session. The total amount of time the training session is approximately one hour, and the pre- and post- test will take an additional 30 minutes. The total time involved will be approximately 90 minutes for those participating in the study.

WHAT WILL YOU BE ASKED TO DO?

Anyone attending the training will access the training presentation through a link sent via email. The researcher will adjust settings so that attendees of the presentation will not be visible or heard by others in the meeting, although first names (or the name attached to your Zoom account) will be visible. Prior to the one-hour presentation, the research assistant will share a link to an online form that will include the informed consent information, a demographic questionnaire, perceptions of preparedness questionnaire, and a pre-test knowledge questionnaire. Approximately 15 minutes will be given to complete these items. Next, the researcher will enter the meeting and deliver a one-hour training presentation. Following the presentation, the research assistant will provide

participants with a link to complete a knowledge post-test and perceptions post-test questionnaire. The knowledge pre-test/post-test will gather information about the training's potential to inform students about considerations for working with LGBTQ clients. The pre-test/post-test perceptions questionnaire will gather information about students' perceptions of their preparedness for working with LGBTQ clients.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

This study poses no more than minimal risks to participants, but some questions may make you uncomfortable because they ask you to reflect on own attitudes and experiences related to sexual orientation and gender identity and expression. You are free to skip over questions that you do not feel comfortable answering, and may leave the study at any time. There is minimal risk for identifying information to be revealed from the pre- and post-tests, and participants will not be required to sign any documents.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

Participation in the training and study may improve participants' knowledge of considerations for working with LGBTQ individuals. This increased knowledge may improve the quality of music therapy services you provide to current or future LGBTQ clients. Additionally, the feedback provided by participants may help the research improve future training sessions on this topic. Finally, results from this pilot study may guide future research in this area.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the research study, you may still attend and benefit from attending the web-based educational training.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in the study.

WHO WILL SEE THE INFORMATION YOU GIVE?

When we write about or share the results from the study, we will write about the combined information. We will keep your name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing what information that you gave to us. All data collected in the study will be electronic, and will be stored in a secure OneDrive folder. We will make every effort to safeguard your data, but as with anything online, we cannot guarantee the security of data stored online. You should know that there are some circumstances in which we may show your information to other people. For example, the law may require us to share

your information with officials of the University of Kentucky, who may look at or copy pertinent portions of records that identify you.

CAN YOU CHOOSE TO WITHDRAW FROM THE STUDY EARLY?

You can choose to leave the study at any time. You will not be treated differently if you decide to stop taking part in the study. If you choose to leave the study early, data collected until that point will remain in the study database and may not be removed. There are several reasons that the investigators conducting the study may need to remove you from the study, including not following directions.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THE STUDY?

There are no rewards or payment for taking part in this study.

WILL YOU BE GIVEN INDIVIDUAL RESULTS FROM THE RESEARCH TESTS/SURVEYS?

Generally, tests used for research purposes are not meant to provide results that apply to you alone.

WHAT ELSE DO YOU NEED TO KNOW?

If you volunteer to take part in this study, you will be one of about 10 people to do so. The primary researcher is Cecilia Wright, a graduate student who is being guided in this research by faculty advisor, Dr. Olivia Yinger. There may be other people on the research team assisting at different times during the study.

WILL YOUR INFORMATION BE USED FOR FUTURE RESEARCH?

Your information collected for this study will NOT be used or shared for future research studies, even if we remove the identifiable information like your name.

Consent to Participate in Research Study

By submitting the online pre-tests, you are consenting to participate in this research study

Do you consent to participate in the research study?

- ○ Yes
- ○ No
- ○ I am not eligible to participate

Appendix H: Feedback Responses

Question	Participant Quote
What information was most helpful to you in today's training?	"All of it. Every part of this presentation taught me at least 1 new thing that will help me be a better music therapist and even a better person for having the knowledge."
	"Learning about the discrimination that transgender people face in the healthcare system. I knew it was an [*sic*] problem, but I did not know the extensiveness of the issue."
	"So much of this was helpful! The list of resources for LGBTQ+ individuals and the connections to things that are currently happening in our world were probably the most helpful aspects to me."
	"Learning about what sorts of musical considerations to apply to a music therapy session with an LGBTQ client"
	"Musical considerations"
What would you like to know more about on this topic?	"How to be an advocate for less discrimination in the healthcare system"
	"I would like to learn more about the inequalities in the healthcare system for LGBTQ clients and how I can better educate myself on how to be an advocate in the healthcare field"
	"How to be an advocate for less discrimination in the healthcare system."
	"I would like to learn more about the inequalities in the healthcare system for LGBTQ clients and how I can better educate myself on how to be an advocate in the healthcare field."

	"I would be happy to learn more about this topic altogether. I think it is so important to learn as much as we can about everyone."
	"Future research since this is a topic for ongoing learning"
What aspects of the training would you change?	"Nothing. I loved this training."
	"None, I think that this training went very well!"
	"N/A. I found it very helpful!"
Please provide any additional feedback on today's presentation.	"This training helped me in understanding what I can do to be a better music therapist, but it also helped me on a personal level. My cousin recently came out to our family as transgender, and while I have wanted to help our family understand her and what this means for her, I didn't know how. I now feel like I have a better grasp of how I can be supportive of her in answering all of our families [*sic*] questions even though I can't answer them for her or speak for how she is feeling."
	"I learned a lot and my brain is still absorbing it all."
	"I thought that this presentation was very informative and helpful."

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VITA

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EDUCATION

December 2017	University of Kentucky *Music Therapy Equivalency Program*
May 2012	University of Tennessee *Bachelor of Arts in Music*

PROFESSIONAL EXPERIENCE

February 2021-present	Wildwood Music Therapy, LLC *Co-Founder, Co-Owner, and Music Therapist*
March 2020 – present	Wellness Music Therapy Center *Music Therapist: Independent Contractor*
March 2019 – present	Lex Therapy *Music Therapist: Independent Contractor*
January 2019 – present	Central Music Academy *Cello Instructor*
February 2018 – July 2019	UK College of Medicine *Standardized Patient*
2008 – present	Self-employed *Cello Instructor and Cellist*

SCHOLASTIC ACHEIVEMENT

May 2020	Recipient of Dr. Ralph McCracken Award
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April 2019	American Music Therapy Southeastern Regional Conference Presenter
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