Music Therapy for the LGBTQ+ Community: Guidelines and Methods

by

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In Partial Fulfillment of the Requirements for the Degree of

MASTER OF SCIENCE

in

The Department of Music Therapy

State University of New York

New Paltz, New York 12561

August 2025

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Submitted in partial fulfillment of the requirements for the Master of Science degree in Music Therapy at the State University of New York at New Paltz

Abstract

Members of the LGBTQ+ community often struggle with a host of individual, societal, and psychosocial factors, such as poor mental health, substance abuse, eating disorders, and discrimination. While a neglected population in the music therapy literature, music therapy remains a promising therapeutic modality to treat the mental health conditions LGBTQ+ individuals often present with. Music also has influences on identity formation, is connected to the LGBTQ+ community, and is an open and nonjudgmental platform for free expression. The following guidelines are based on research and clinical experience of music therapy with members of the LGBTQ+ community. Specific music therapy methods such as song communication, projective movement, songwriting, composition, gender-affirming voicework, and melodic intonation therapy may meet the needs of the LGBTQ+ community. Receptive methods such as song communication and projective movement increase empathy and intimacy between members of the LGBTQ+ community and allow for the reclamation of gender-affirmative movements and vocalizations that have previously been repressed. Improvisational methods may offer clients the ability to explore their inner thoughts and feelings as related to identity, reach catharsis, and connect musically with others. Re-creative music therapy can aid clients in sharing and coming to terms with their thoughts, feelings, and aspects of their identities in ways that can be expressed and further experienced and validated by others. Compositional methods such as songwriting provide creative opportunities to build individualized views of identity and to challenge norms of gender and sexuality. In addition, gender-affirming voicework encourages one to take up affirming and authentic space with their body and to experience authentic imagery, and melodic intonation therapy may show promise in combatting gender dysphoria caused by the voice in transgender clients. More research is needed to solidify the

efficacy of music therapy with the LGBTQ+ community, but it remains a promising therapeutic modality to address the community's current needs.

Keywords: music therapy, LGBTQ, lesbian, gay, bisexual, transgender, queer, gender identity, sexual orientation, guidelines, music therapy methods, receptive methods, improvisational methods, compositional methods, recreative methods

Introduction

Individuals who are LGBTQ+ identify as lesbian, gay, bisexual, transgender, queer, questioning, and any diverse form of sexual orientation and gender identity that are not socially and culturally aligned with one's assigned sex (American Psychological Association, n.d.-a). Historically a marginalized population, the rights of LGBTQ+ individuals have been expanded along with the community's wide recognition and acceptance in the past several years. Examples of expanded rights to this population include the extension of marriage rights to same-sex couples, the inclusion of a non-binary X gender marker on official documents in some states, and protections against discrimination in the workplace, renting, and homeownership (Kite & Bryant-Lees, 2016).

Cultural Considerations & Issues

LGBTQ+ individuals often experience mental health disorders, self-injury and suicidal ideation, and substance abuse and addiction. Adults in this community are more likely to show symptoms of mental health disorders, especially depression and anxiety, than non-LGBTQ+ adults (Cochran et al., 2014; King et al., 2008). Similarly, lesbian, gay, and bisexual youth are more likely to show symptoms of mental health disorders than heterosexual youth (Lucassen et al., 2017; Marshal et al., 2011). Depression symptoms are greater in LGBTQ+ youth experiencing discrimination and a lack of LGBTQ+ identity acceptance (Barnett et al., 2019; Gnan, et al., 2019; Russell et al., 2011).

LGBTQ+ individuals are also at higher risk of endorsing self-injury, suicidal ideation, and suicide attempts than non-LGBTQ+ individuals (di Giacomo et al., 2018; King et al., 2008). Suicidal ideation is particularly prevalent among transgender individuals (Herman et al., 2019; McDermott et al., 2018). Suicidal ideation is higher among LGBTQ+ youth who regularly

experience bullying, both online and in person (Bochicchio et al., 2021; de Lange et al., 2022; Jadva et al., 2021). Suicidal ideation and attempts are also higher among LGBTQ+ youth whose families are not accepting of their LGBTQ+ identity (de Lange et al., 2022).

Substance misuse and substance use disorders are also prominent among individuals who identify as LGBTQ+ (e.g. Connolly & Gilchrist, 2020; Plöderl & Tremblay, 2015). Substance use is particularly high among bisexual individuals (e.g. Demant et al., 2017; Newcomb et al., 2014) and alcoholism is high among lesbian and bisexual women (Gonzales & Henning-Smith, 2017; Kerr et al., 2014; Wilsnack et al., 2008). Discrimination has been shown to play a role in the prevalence of substance use disorders within the community (e.g. Lee et al., 2016; Slater et al., 2017), as well as the community's bar culture, loneliness, and the targeted marketing of substances to the community (Demant et al., 2017). Stress around identity formation and disclosure and the use of substances as a form of self-medication during a lack of social and familial acceptance are also possible influencers (Felner et al., 2020). Alcohol, tobacco, and cannabis appear to be the most prominent drugs used among LGBTQ+ adults (Demant et al., 2017).

LGBTQ+ individuals are also more likely to endorse eating disorders and eating disorder behaviors than their heterosexual and cisgender counterparts (Parker & Harriger, 2020). This is likely influenced by social media, LGBTQ+ media, and family that present appearance ideals to be interrelated with one's sexual orientation or gender identity, LGBTQ+ stereotypes, and the affirmation or constraints put onto bodies within LGBTQ+ spaces (Gordon et al., 2019). Lesbians are more likely to report having higher BMIs (Boehmer et al., 2007; Jones et al., 2019), which may increase their likelihood of developing eating disorder behaviors (Mason, 2016). Older research also indicates that adult and adolescent gay males are more likely to endorse

eating disorder behaviors than heterosexual males, such as dietary restraint, more purging, and more exercise (French et al., 1996; Lakkis et al., 1999). Bisexual females are more likely to endorse eating pathology than gay and lesbian individuals (Shearer et al., 2015). Transgender youth are more likely to report eating disorders and eating disorder behaviors than cisgender youth (Guss et al., 2017), and the prevalence of these behaviors are linked to exposure to stigma and violence (Watson et al., 2016). Dissatisfaction with the body is common for transgender people, which is a risk factor for the development of eating disorder behaviors (Bandini et al., 2013). Additionally, changes in body fat and bodily appearance may accentuate masculine or feminine features, making the individual appear more as their identified gender (McGuire et al., 2016).

LGBTQ+ individuals are also more likely to be disabled than the average population. Using data from the 2020 Behavioral Risk Factor Surveillance System, the Human Rights Campaign found that one in three surveyed LGBTQ+ adults reported having a disability, while one in seven LGBTQ+ youth reported having a disability (HRC Foundation, n.d.). One in two transgender people endorsed having any kind of disability, in comparison to one in three cisgender LGBTQ+ individuals and one in four non-LGBTQ+ individuals (HRC Foundation, n.d.). Cognitive, independent living, and mobility issues and disabilities were the most likely to be endorsed.

Needs & Resources

Individual, interpersonal, and social issues can influence the likelihood of the development of adverse health outcomes (Meyer, 2003). Examples of such are having a lack of institutional protections, the risk of family rejection, and the presence of bias-based victimization (de Lange et al., 2022; Russell & Fish, 2016). Non-normative modes of gender and sexual

expression are also often the targets of societal stigma, discrimination, and in some cases the law (Russell & Fish, 2016; Virupaksha et al., 2016).

The minority stress model can also explain the prevalence of adverse health outcomes within the LGBTQ+ community (King et al., 2008). The model theorizes that minority groups may be at a greater risk for adverse health outcomes due to their identities being largely stigmatized in society (Meyer, 2003). Emerging from research conducted by social scientists documenting the increased level of health disparities within minority individuals, the model asserts that systemic and social issues, such as lack of legal protections, social stigma, and family rejection, may directly contribute to poor physical and mental health outcomes in LGBTQ+ people (Meyer, 2003). Emerging research in this area includes hypotheses that propose the prevalence of health disparities within individuals of multiple intersecting marginalized identities (Robertson et al., 2021; Shangani et al., 2020).

Members of the LGBTQ+ community also regularly face conversion therapy. Sometimes referred to as reparative therapy and sexual orientation change efforts (SOCE), conversion therapy refers to any form of intervention aimed at changing one's sexual orientation or gender identity (American Academy of Child & Adolescent Psychiatry Sexual Orientation and Gender Identity Issues Committee, 2018) and is generally regarded to be a dangerous, damaging practice (American Medical Association & Health Professionals Advancing LGBTQ Equality, 2022; American Psychiatric Association Council on Minority Mental Health and Health Disparities, 2018; American Psychological Association Division 44, n.d.). Several ethical violations are found within its practice (Alempijevic et al., 2020), including informing clients that homosexuality is a disorder without evidence that that is true, breaches of confidentiality, improper pressure put on clients, rejecting and abandoning clients who come out as gay or

lesbian, the indiscriminate use of treatment, and the shaming of clients (Drescher et al., 2016). Despite its unfavored status among many major American medical and scientific institutions, protections and promotions of conversion therapy efforts continue to be sought after in legal, health, spiritual, and religious settings all around the globe (Drescher, 2002; International Rehabilitation Council for Torture Victims, 2020; Outright International, 2019). According to a report conducted by the UCLA Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy, almost 700,000 LGBTQ+ adults and 350,000 adolescents in the U.S. have received conversion therapy as of 2019 (Mallory et al., 2019). Additionally, in the Trevor Project's 2021 national LGBTQ youth mental health survey, a report surveying nearly 35,000 LGBTQ+ youth and adolescents aged 13-24, 27% were subjected to conversion therapy in the last year and 83% reported being subjected to conversion therapy before adulthood (The Trevor Project, 2021).

Along with the mental health consideration that bears out in the literature, Baron (1996) also suggests that transference and countertransference between client and therapist, loss and mourning, and the use of compulsive heterosexuality as a defense against depression and anxiety are issues that arise in therapy with LGBTQ+ clients. When coming to terms with their authentic identity, it is not uncommon for LGBTQ+ people to feel a loss of their sense of former heterosexual or cisgender identity that is often expressed as a form of grief. Additionally, LGBTQ+ individuals may be struggling with the loss of their friends, family members, and communities over their identities. It is not uncommon for LGBTQ+ individuals to struggle with adjustment issues, such as to a homophobic, transphobic, and heterosexist society, as well as issues with coming out (Baron, 1996).

Along with the high rates of mental health disorders, suicide, and substance use reported within the LGBTQ+ community, several intervenable factors are also identified, such as adverse childhood experiences (ACEs), internalized self-stigma, not talking about emotions, loneliness, low body- and self-esteem, a lack of connectedness with adults and caregivers, and self-medication as a coping mechanism (Austin et al., 2022; Demant et al., 2017; Felner et al., 2020). Protective factors that may mitigate mental health disorders include social support, strong connections with school and family, positive school experiences, and higher perceived safety at school and home (Bochicchio et al., 2022; de Lange et al., 2022; McDermott et al., 2018), which can also be utilized in therapeutic settings for strengths-based approaches and support-building. In addition, there is evidence supporting a relationship between activism and resilience within LGBTQ+ individuals involved in grassroots organizing (Scheadler et al., 2023). However, it has exposed LGBTQ+ participants to oppression within and outside activism spaces (Hagen et al., 2018).

As of 2025, several organizations exist to address the social, interpersonal, and individual needs of the LGBTQ+ community. Examples of U.S.-based organizations include the Human Rights Campaign, a political group advocating for LGBTQ+ rights (Human Rights Campaign, n.d.); The Trevor Project, a suicide prevention and crisis intervention nonprofit (The Trevor Project, n.d.); and the American Civil Liberties Union (ACLU), a legal organization that advocates for several social issues, including LGBTQ+ and disability rights, criminal law reform, reproductive freedom, and racial justice (American Civil Liberties Union, n.d.). There are also international projects, such as Rainbow Railroad, that assist LGBTQ+ individuals who are fleeing persecution from countries that are hostile towards the LGBTQ+ community (Rainbow Railroad, n.d.).

Referral and Assessment Guidelines

Therapeutic interventions are common among LGBTQ+ individuals due to the severity of the issues members of the community can face (Israel et al., 2008). Along with other therapeutic modalities, music therapy is a promising therapeutic modality that can address and treat these issues and other needs of LGBTQ+ individuals given music's influence on identity formation (Scrine, 2019b; Tarrant et al., 2002), the interwoven history between music and LGBTQ+ identity celebrations (Morris, 2017), and music's open, inviting, and nonjudgmental platform for identity exploration and expression (Taylor, 2012).

In addition, music therapy has demonstrated promising outlooks in individuals with mood and anxiety disorders. Aalbers et al. (2017) found that music therapy and music-based interventions along with treatment as usual decreased patient- and clinician-reported depressive symptoms. Erkkilä et al. (2011) found that interventions utilizing improvisational music therapy greatly decreased both depression and anxiety symptoms in participants. Clinical improvisation, song discussion, musical audiobiography, music-assisted relaxation, songwriting, and the Bonny Method of Guided Imagery in Music have been shown to be promising interventions for individuals with eating disorders, allowing space to process the cause of one's eating disorder and their symptoms, establish a sense of self, express feelings to decrease anxiety, build self-esteem, and find validation (Pasiali et al., 2020). In individuals with substance use disorders, music therapy and music-based interventions have shown to have a positive effect on motivation, decreases negative emotions and increases positive emotions, aids in the development of social problem-solving skills, and introduces healthy coping strategies (Hohmann et al., 2017).

When moving forward with referral and assessment procedures, it is important to remember the history of pathologization of LGBTQ+ identities (Kort, 2018), and how some

clients may be wary of receiving therapeutic interventions because of this history. Aspects of one's identity should be primarily viewed as aspects of a client's lived experiences instead of pathologies that need to be pharmaceutically or medically managed (Mizock, 2016). For trans and gender-nonconforming clients, expressions of curiosity and naivete about one's experiences have been argued to be beneficial within the therapeutic space (Dyche & Zayas, 1995). However, it can place the client into a potentially burdensome educator role; Mizock (2016) suggests all therapists be trained under the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (American Psychological Association, 2015) in order to avoid unintentionally projecting a binary construct of gender into therapy and assuming gender is the most important aspect of one's life. The same author suggests supporting clients' individual narratives of gender without imposing limited assumptions of it (Mizock, 2016).

Clinician Qualifications

The most common reasons for seeking therapy among lesbian clients are that they experience trauma, have difficulty with breakups, and value personal growth (Chase, 2004). Clients have reported struggling with vague feelings they have difficulty understanding, needing support to find their courage, or in finding a new perspective. Based on responses from a survey, LGBTQ+ individuals appear to select a therapist that are also LGBTQ+ 41% of the time (Liddle, 1997). A report by the same author found that LGBTQ+ clients are likely to have difficulty connecting with care providers, particularly psychiatrists, who challenge the notion of their sexual identity (Liddle, 1999).

With the right cultural competence training, heterosexual therapists have been able to deliver successful and effective therapy to LGBTQ+ clients. Heterosexual therapists working with LGBTQ+ clients must be willing to develop familiarity with the LGBTQ+ culture, examine

their own privileges, work through their own transference and countertransference issues, and explore their attitudes about the LGBTQ+ community (Bernstein, 2000). It is important for music therapists to refer a client to an alternative therapist if they do not feel adequately comfortable or prepared to work with clients who identify as LGBTQ+. This is important because if a client does not receive adequate culturally competent care, their well-being is likely to be damaged (Chase, 2004). Even if music therapists do not work with LGBTQ+ individuals, they will most certainly encounter friends and relatives of their clients who are LGBTQ+. Therapist attitudes and friend and family dynamics can influence the client's experience, and the therapist's attitude can affect the treatment of the client through negative countertransference (Chase, 2004). Supervision, individualized therapy, and self-reflection may be helpful culturally competent methods for heterosexual and LGBTQ+ therapists alike to explore their attitudes and services to LGBTQ+ populations (Chase, 2004). Faria (1997) suggests that therapists should adapt their language to match that of the client (e.g. describing someone as "gay" rather than "homosexual", and including one's found family within their definition of "family"). It is also important to adapt the clinical practice space to LGBTQ+ clients by expanding their musical vocabulary and recognizing that LGBTQ+ clients may bring issues to the therapeutic space that may not be adequately addressed through treatment styles for other populations (Chase, 2004).

During the assessment process, it is imperative that the music therapist be aware of the impact that the client's LGBTQ+ identity is having on the client, and any other relevant information about the client's LGBTQ+ identity. For instance, what identity labels does the client identify with? How long has the client known they are LGBTQ+? Who in their life knows that they are LGBTQ+? Are they supportive or not? How is the client affected by having an LGBTQ+ identity in the settings they occupy daily? These are some baseline questions and areas

of inquiry that may be important for the music therapist to be aware of during the initial baseline assessment. Lack of adequate support systems present in the client's life may raise concern that they are not receiving the resources and support they may need to function, increasing their risk of adverse physical and mental health outcomes.

Methods & Procedures

The following music therapy methods may meet the therapeutic needs of LGBTQ+ individuals. Each method's overview, materials, procedures, and relevant information to observe will be reported in-depth in this section. Additionally, each section will explore how each music therapy method variation has been used, as reported in the literature, to address therapeutic issues commonly experienced by the LGBTQ+ community or to illustrate their potential applications.

Receptive Music Therapy

- *Song Communication:* The client shares a song with the music therapist that communicates messages aligned with a decided theme, such as a relationship or coming out story, or that is important to the client or the goal of the session. Songs may also be discussed therapeutically during song communication.
- *Gender-Affirming Movement:* The client and music therapist move along to a favorite song of the client's, holding space meant for the client to explore sexual orientation or gender-affirming movements, words, and vocalizations.
- *Self-Expression and Exploration with Expressive Arts:* The client listens to music (either pre-recorded or played live) in combination with other expressive arts, such as drawing, writing, or movement, to evoke sexual orientation and gender-affirming images, promote identity exploration, and to reflect and construct personal meanings.

- *Music Relaxation and Stress Reduction:* The client will listen to music to evoke a relaxed response.

Improvisational Music Therapy

- *Referential Conversation:* Clients communicate with each other or with the music therapist to express emotions, experiences, or themes, such as aspects of one's identity, coming out story, relationship issues, or personal feelings.
- *Instrumental Exploration:* Clients explore a range of instruments to discover their evocative and associative potential respective of an experience, relationship, or identity.
- *Musical Exploration of Feelings:* Clients use spontaneously created music to explore an array of feelings and emotions as related to identity.

Re-creative Music Therapy

- *Vocal Re-Creation:* The client and music therapist sing LGBTQ+ pre-composed songs with or without accompaniment.
- *Therapeutic Lessons:* The client and music therapist engage in vocal or instrumental lessons to address therapeutic issues through performance.

Compositional Music Therapy

- *Gender-Bending Song Parodies:* The client and music therapist select a song and modify the lyrics to make them more affirming of the client's sexual orientation or gender identity experience.
- *Musical Audiobiography:* The client will compile pre-recorded music and sounds into a collection that reflects important emotions, experiences, and relationships as related to therapeutic issues.

Guidelines for Receptive Music Therapy

Receptive methods engage clients in music listening. The client then responds through silence, with words, or through creative expression, such as art and movement. Receptive method variations include music-assisted relaxation, imaginal listening, projective listening, movement to music, and song discussion (Bruscia, 2014a).

Song Communication

Overview. Song communication provides clients with an opportunity to share something about themselves with the therapist or the group. Clients can also share songs that demonstrate a feeling they have or an experience they want to express (Bruscia, 2014a; Jackson & Heiderscheit, 2021). Song communication allows clients to share their thoughts, feelings, and experiences in a more subtle and comfortable way before moving into a more vulnerable open discussion about therapeutic issues. It often provides a blank slate to move into other music experiences, such as song discussion or songwriting. Goals for song communication may include enhanced self-expression, identifying experiences and emotions, and increasing self-awareness around a particular emotion or topic (e.g. Bruscia, 2014a; Jackson & Heiderscheit, 2021).

Preparation. Clients may or may not choose to 'prepare' a song for a song communication session; sometimes, while participating in music therapy, inspiration can hit in the moment, and the client can communicate through a song that immediately comes to mind. Paper and pencil can be provided for the client and therapist to write down and organize their thoughts about the song or can be provided if the client and therapist move into another music experience. Sheets with questions about the song and what the client heard in them may also be distributed if the therapist decides that the song should be discussed in a certain way (Jackson, 2013). These sheets can also help to stimulate discussion among clients who may be more

withdrawn and less insightful. Music should be shared through high quality materials so that both the client and music therapist can listen to it, such as through a speaker. Music can also be performed live if preferred by the client. Music therapists that perform live should have extensive time dedicated to practicing the song(s) so the client can clearly hear and in turn identify their thoughts, feelings, and emotions that arise during the experience.

What to observe. Affect, body language, and mood can be affected even when listening to familiar music. The music therapist should take note of any changes since they can often communicate the internal experience of the client and can be key points of discussion (Jackson, 2013). Take note of any insights that the clients make about the song itself, such as its lyrics, mood, quality, or tempo. The language that the client uses can be used to connect important therapeutic issues and themes that arise during the session (Jackson, 2013). During groups, it is important to take note of how clients respond to each other. While client interactions can express a relation between them, songs can also bring about points of contention, withdrawal, or hostility.

Procedures. Before introducing song communication, it may be ideal to ask the clients what song they want to bring to the session and take note of their responses. This will be ideal for preparing lyric sheets, which will be distributed during the session when each song is introduced. Taking a few quiet moments for clients to center themselves and get in touch with their current thoughts, feelings, and experiences may be beneficial for them to bring into discussion when related to therapeutic issues that arise within the shared songs. After playing the song recording or playing it live, allow the clients to sit for a few moments to reflect on the experience. If question sheets are present, allow the clients to take time to fill in their own responses. Then, begin the discussion. Allow the clients more space to talk and only verbally direct the discussion as much as necessary to keep the clients engaged (Jackson, 2013). During

these discussions, there may not be any right or wrong answers to certain questions, for allowing clients to come to terms with their own experiences and thoughts may be more beneficial and healing than any insight coming from what another has to say (Jackson, 2013). Be sure to highlight the important insights that come up during the discussion such as LGBTQ+ specific themes, giving space for the clients to reflect and come up with their own suggestions on how to move forward following the experience. In some instances, the music therapist and client may move into a different music experience, such as improvisation or movement, before formally bringing the session to a close.

Gender-Affirming Movement

Overview. Gender-affirming movement offers the client the space to present their authentic selves through bodily movements, words, song, and vocalizations (Harris, 2022). It can be moved into from other music experiences, such as song communication, improvisation, and vocal psychotherapy (Harris, 2022). Some goals of gender-affirming movement may include evoking a higher sense of self-esteem within the client, to allow the client to have an experience where they take up affirmative and authentic space, and to enhance their sense of freedom within self-expression.

Preparation. During gender-affirming movement, there should always be enough space for both the client and the therapist to move freely and authentically. Make sure the space around the doorway and the area where the experience will be had is clear of obstacles. The therapist should be aware of any physical conditions and chronic pain that may influence the ability to participate in movement sessions. Movement sessions may be ideal for those who are athletic and enjoy movement, as well as for those who may be experiencing agitation, rumination, or holding stress within their bodies (Jackson, 2013). This experience may also be ideal after a level

of trust is established between the client and the music therapist, and if the client has difficulty with self-expression or appears to be isolated (Harris, 2022).

What to observe. Client affect may greatly be affected by gender-affirming movement sessions. It may also be useful to monitor a client who has a medical condition or chronic pain limiting their physical movements. Allow the client space to pause the experience if needed, and to join in with their movements if they are hesitant or appear to be needing support within the space.

Procedures. Before beginning gender-affirming movement, it may be useful to start with improvisation or song communication to learn the current emotional state of the client. The music therapist should define song communication and gender-affirming movement with the client to establish a shared definition. The music therapist and client will then listen to the song together. After listening, the music therapist and client should discuss the therapeutic needs expressed by the song. If the client response suggests repression and isolation, it may be useful to transition into the affirmative movement experience (Harris, 2022). The music therapist will then invite the client to stand if they can or shift their body into a position more comfortable for movement. While listening to the song again, the client and music therapist will freely move their bodies to the music, allowing space for repressed experiences to be expressed in the therapeutic space. To close the experience, the music therapist and client will discuss what the movement brought to the space and how it met (or did not meet) the client's therapeutic needs. The session will end with a summary of both discussions and with the identification of important topics that arose during the discussions.

Self-Expression and Exploration with Expressive Arts

Overview. During these experiences, the client will listen to pre-recorded or live music and respond by engaging with other expressive arts, such as drawing, writing, or movement to evoke insight into therapeutic issues (Jackson, 2013). While the primary mode of expression during these experiences is not music-based, the music is used as a tool to assist the client in expressing thoughts, feelings, experiences, and images in an additional creative arts format (Jackson, 2013). Increased self-awareness, the ability to name certain difficult emotions and effectively respond to them (e.g. Jackson, 2013), and to reflect and construct personal meanings (e.g. Bain et al., 2016) are relevant goals for this experience.

Preparation. This experience may often take place after the client has some established self-awareness and identification of their emotions and experiences (Jackson, 2013). The client (or clients if in a group) may decide if they want multiple artistic mediums available or just one. If they decide multiple, the music therapist should make sure the client has access to a variety of art-related materials, such as pencils, pens, markers, colored pencils, oil pastels, paint and paintbrushes, notebook paper, printer or paint paper, scissors, tape, glue, and modeling clay. Access to tables and a sink are important for accessibility and cleanliness, especially if using paint or oil-based supplies. Additionally, space should be made in the room if the client decides to incorporate movement into their experience (Jackson, 2013). It is very important to safeguard materials that may be used for self-injury or suicide. Music choices should reflect the issues that arise for the client or group and support any desired movement or interaction (Jackson, 2013).

What to observe. While the client engages in the experience, the music therapist should draw connections between the music and what the client is producing artistically (Jackson, 2013). Descriptive words may be used by the client that can be used to bridge their art with their internal experience and with the music experience. These same terms can be used to highlight

potential changes the client can make in their day-to-day life that meet therapeutic goals (Jackson, 2013).

Procedures. The music therapist should begin the experience by describing the intent of combining music listening with creative arts expression. Clients may need to learn how certain mediums and art materials can be used. Further, they should be encouraged to use the music as a source of creativity for alternate creative arts expression (Jackson, 2013). The music should be repeated as many times as the client needs to feel comfortable and satisfied with the results of their art. Ask the client how their art reflects their experience listening to the music and how it may relate to their thoughts, feelings, moods, images, and experiences it may have evoked (Jackson, 2013). Use the client's description to highlight any opportunities for increased growth as it relates to the client's therapeutic goals.

Music Relaxation and Stress Reduction

Overview. Music relaxation can help clients become more in-tune with their bodies and how they respond to stimuli. It can also reduce anxiety and tension and introduce knowledge and the application of stress-reduction techniques for clients (Jackson, 2013). In other words, it can be a useful coping mechanism for anxiety. Music relaxation can be done in combination with movement, breathing exercises, or imagery (Jackson, 2013). Music choices should be made after an assessment of the client's physical and emotional state (Jackson, 2013) and can be pre-recorded or live. Examples of goals for the experience are for the client to experience a decrease in tension in their bodies, increase mindfulness, and to learn a new coping strategy for stress and anxiety (e.g. Jackson, 2013).

Preparation. To prepare for a music relaxation experience, the music therapist should make sure that the room and environment are as safe and comfortable for the client as possible.

Clients should be given the choice to sit on a chair or on the floor, and floor supports such as pillows, blankets, and yoga mats can be used. For clients who cannot use the floor, make sure they have a comfortable chair to sit in for the experience. The music choices should be variable to accommodate changes of affect and emotional state that may occur during the session, such as music with changes in tempo and melodic movements (Jackson, 2013). Music without words is preferred since words may evoke a stress response within the client, interfering with relaxation (Jackson, 2013).

What to observe. When observing a client during a relaxation response, the rate of their breathing is the best indicator of a relaxation response (Jackson, 2013). A release of tension in the client's muscles is also a sign of relaxation, such as the shoulders lowering and the release of a clenched jaw or lips (Jackson, 2013).

Procedures. While LGBTQ+ individuals are more likely to struggle with anxiety disorders, following the standard procedure for this experience would work for any client. Before beginning the experience, the music therapist should take note of how the client is experiencing their tension, whether that be physical or psychological (Jackson, 2013). The music therapist should decide, based on the client's music preferences and tension appearance, whether to have the client engage in a passive relaxation experience (such as with imagery) or an active relaxation experience (such as with movement) (Jackson, 2013). Passive relaxation experiences are ideal for clients with lower energy levels, while active relaxation experiences may be better for clients who are agitated, ruminating, or holding a lot of stress in their bodies (Jackson, 2013). The beginning music in the experience should match the initial state of the client. If a client is more agitated at the start of the session, the music should begin with more energy that will gradually lessen throughout the experience. Likewise, if the client demonstrates psychomotor

retardation at the start of the session, the music should match that energy but gradually move into more upbeat and energized movement (Jackson, 2013).

To begin, the music therapist should direct the client to make themselves comfortable on the chair or floor. If the experience is passive, the client may be directed to close their eyes or comfortably fix their gaze. Direct the client to inhale while tensing a particular group of muscles, holding their breath with the muscle tension for at least four seconds, and then slowly exhale with the release of tension within the muscles. Make sure the client does this with each muscle at least twice to make sure they are aware of the physical sensation that the muscle relaxation evoked (Jackson, 2013). After each release, ask the client to become aware of the physical sensation in each muscle group. If the client has lower energy, it is ideal to focus on larger muscle groups up and down the body to quickly evoke relaxation before they run out of energy (Jackson, 2013). To close the session, inform the client that these progressive muscle relaxation exercises along with favored music with varying tempi can be useful, accessible tools to cope with anxiety and stress.

Guidelines for Improvisational Music Therapy

In improvisational music therapy, the client spontaneously creates music to express themselves, acknowledge their emotions, and to explore aspects of themselves and their relationships with others (Bruscia, 2014a; Gardstrom & Hiller, 2022). This can be done vocally, instrumentally, or with body percussion. Improvisational experiences are often identified as either referential or non-referential. A non-referential experience is done without reference to a theme or subject and is more focused on the musical elements of the experience. A referential experience incorporates elements of non-musical experiences into the music, such as thoughts, emotions, images, or themes (Bruscia, 2014a; Gardstrom & Hiller, 2022).

Improvised Conversation

Overview. During an improvised conversation experience, the client will use instruments to express engage in a conversation with the therapist, other clients or parts of themselves. They will be encouraged to express experiences, emotions, and themes related to the current therapeutic issue (Eyre, 2013). It can be used to develop nonverbal communication skills, the ability to relate to and listen to others, appropriate engagement, and reality orientation (e.g. Eyre, 2013). These types of skills may be beneficial for members of the LGBTQ+ community to relate to each other and to express aspects of their identity that may be commonly misunderstood or misinterpreted by others. Improvised conversations can be referential or non-referential.

Preparation. The therapist should provide a variety of high-quality instruments that are easily adaptable. Examples of instruments that can be used in this experience are xylophones and related pitched percussion instruments, upright drums, tambourines, ocean drums, rain sticks, crotales, sleigh bells, and egg shakers. They should be placed at the center of the room and easy to reach.

What to observe. The primary goal of this experience is to engage the clients in nonverbal communication exchanges with others through instruments (Eyre, 2013). The music therapist should be aware of the elements of the client's communication skills through their instruments and body language, such as rhythm, dynamics, phrasing, expression, and mood (Eyre, 2013). Some clients may also be keener to lead musically, while others may take on more of a follower role within the experience. This may suggest that some clients may be more willing to share aspects of their identity with others, while others may be more withdrawn in doing the same.

Procedures. This experience may be best done in a group split into pairs with two clients or with the client and the music therapist, while other members of the experience observe (Eyre,

2013). The music therapist may ask some foundational questions relating to how the clients carry on a conversation with others, such as “What aspects of communication make up an ideal conversation?”. The music therapist may then explain how such experiences can be translated into instrumental conversation, since musical elements such as tone, phrasing, rhythm, and volume can match that of a spoken conversation (Eyre, 2013).

Two clients or a client and music therapist should demonstrate a musical conversation for the rest of the group. Afterwards, the other clients and the music therapist should discuss what emotions or moods they heard in the conversation and how well they matched (Eyre, 2013). Through this experience, clients can learn to more effectively and appropriately meet each other during interpersonal exchanges.

Instrumental Exploration

Overview. In this experience, the client or clients explore a range of percussion and atmospheric instruments to discover their evocative and associative potential (Eyre, 2013). These improvisations may be referential or nonreferential. Nonreferential experiences should be given before referential ones (Eyre, 2013), since they are important introductory experiences that may lead to the creation of a referent for a follow-up improvisation. Nonreferential and referential instrumental explorations are best suited for clients who work well in groups and do not become overstimulated easily (Eyre, 2013). They are also useful for clients to identify and express their experiences and emotions, increase self-esteem, and establish a bridge for verbal communication (e.g. Eyre, 2013). It also gives clients an opportunity to try something new. These experiences have the same preparation as the improvised conversation experience.

What to observe. The music therapist should observe how the clients are orienting themselves to the instruments, how they hold them, what associations they make with them, and

the emotions that are evoked by them (Eyre, 2013). It is also important to observe the interpersonal connections clients may make through playing their instruments (Eyre, 2013).

Procedures. The music therapist will begin the experience by demonstrating the sounds of the various instruments and asking the clients what feelings, memories, experiences, or images it may have evoked (Eyre, 2013). The clients should then be invited to explore the array of instruments, how they sound, and how they feel. The music therapist should also make a special point that there is no right or wrong way to play (Eyre, 2013). After they choose an instrument, ask a client to play it for a bit, asking them what they liked and disliked about the instrument, and what feelings, memories, experiences, and images playing it evoked (Eyre, 2013). Encourage clients to share aspects of any gender or sexuality-related images or experiences that came to them during the experience. While the process of selecting an instrument and playing it is nonreferential, the experience will become referential once a feeling, memory, experience, or image is assigned to playing the instrument (Eyre, 2013).

Musical Exploration of Feelings

Overview. Musical exploration of feelings involves spontaneously created music being used for the client to identify and explore feelings and emotions (Jackson, 2013). Through spontaneously created sound, the client's emotions may manifest and take on new meaning, opening opportunities for growth and exploration (Jackson, 2013). When in depressed states, clients may have difficulty identifying and naming the emotions they may be experiencing, which hinders their ability to process them (Jackson, 2013). Relevant goals for this experience include naming and identifying emotions heard during music-making, identifying emotions heard within the music, and the expression of certain emotions or mood states (e.g. Jackson, 2013).

Preparation. The preparation for this experience is very similar to that of improvised conversation. There should be enough space for clients and the therapist to move, play, and make music (Jackson, 2013). Place the instruments in a space that is accessible to all group members. Remind clients that they can change instruments if they wish to do so (Jackson, 2013).

What to observe. Remember that clients must be able to identify and name emotions that happen externally before they are able to do the same internally (Jackson, 2013). Make note of the emotions the clients name within both the music they hear and the music they create, for the goal is to ultimately name the emotions that arise internally. Be sure to connect what the clients say about the improvisation experience itself with any feelings they were able to identify within their (and others') music.

Procedures. The experience should begin with the music therapist naming and demonstrating each of the instruments, and potentially followed by a discussion of how emotions can be expressed through music (Jackson, 2013). Examples of relevant LGBTQ+ specific emotions or themes to express include aspects of one's identity that may be misinterpreted or misunderstood by others, as well as potential frustrations about others and society not understanding and not accommodating one's gender and sexuality experiences. The music therapist (or client) may want to demonstrate playing an emotion on an instrument of their choice as an example. Direct the client(s) to focus on something specific in the music while they play it (Jackson, 2013). The music therapist should begin the experience with a supportive beat on a drum or a series of notes of an ostinato, encouraging others to gradually join in the improvisation experience (Jackson, 2013). After the experience, bring the session to a close with a discussion on what emotions were played and heard within the music experience (Jackson, 2013).

It may be helpful to consider the usefulness of referential vs. nonreferential improvisation for this experience. Having a referential improvisation with an emotion as a referent may be ideal for clients who have difficulty identifying emotions heard within music (Jackson, 2013). For example, the group could play the sound of sadness, anger, or joy on their instruments. Nonreferential improvisations may be employed more frequently once clients are more skilled in identifying emotions within the music (Jackson, 2013). These experiences may look like a client being invited to identify emotions within the music while playing without deciding on an emotion as a referent. It may also be useful to have a discussion on what certain emotions sound like before the experience begins.

Guidelines for Re-creative Music Therapy

Re-creative music therapy is a therapeutic process in which a client interacts with pre-existing musical material (Bruscia, 2014a; Gardstrom et al., 2025). These interactions often involve the client recreating a song's lyrics to best suit their therapeutic needs. During re-creative experiences, the music therapist may encounter terms, pronouns, and descriptive words that they may not recognize, so it is important for the music therapist to educate themselves during and outside of the experience on these unfamiliar terms. It is also important to allow the client to use the terms that most authentically represent themselves in the re-created song (Bruscia, 2014a; Gardstrom et al., 2025).

Vocal Re-Creation

Overview. During vocal re-creation, the client sings pre-composed songs with or without accompaniment to engage the client physically, emotionally, and neurologically (Eyre, 2013; Sullivan, 2003). Singing songs has multiple therapeutic benefits, such as increasing group cohesion; connecting to our past, present, future, and relationships; evoking emotions; and the

expression of personal meaning (Bruscia, 1998, 2014a; Gardstrom et al., 2025). Examples of goals that can be met through singing include improving group cohesion or reality orientation, and increasing self-expression, self-esteem, emotional awareness, or attention (e.g. Eyre, 2013).

Preparation. The room can be set up with chairs in a circle, around a table or not. The therapist will need a piano, guitar, or percussion instrument to accompany the songs. The therapist might also want to distribute song lyrics among the clients or use a pre-made songbook with popular songs that the clients may know (Eyre, 2013).

What to observe. Range of affect, emotional expression, and mood are important to observe during vocal re-creation and can provide insight into the client's level of engagement if they are not actively singing. Note what song choices are made and what that may reflect about the deciding client's thoughts, feelings, or emotional state. Clients may also choose to relate to one another during the experience (Eyre, 2013).

Procedures. The therapist may ask clients to choose songs, or the clients can choose from a collection of pre-selected songs presented by the therapist. The therapist may also ask if the clients want to choose songs along a particular theme, such as songs that make one happy, songs about connection, or songs that remind about a certain point in the past (Eyre, 2013). It may also be important to have a collection of songs that appeal to the LGBTQ+ community (examples of these songs can be found in Appendix A). When a selection has been made, the music therapist or another client will lead the group on voice and guitar, piano, or percussion. The way the song is presented in terms of volume and energy level should be determined based on how the clients present themselves (Eyre, 2013).

Therapeutic Lessons

Overview. Therapeutic lessons involve the client and music therapist engaging in vocal or instrumental lessons to address therapeutic issues through performance (Bruscia, 2014a). What is most important during therapeutic lessons is that the underlying thoughts, feelings, experiences, and images that arise during the lessons are addressed, while musical accuracy takes secondary importance (Jackson, 2013). Goals for this experience may include the client working through a difficult emotion, increasing emotional expression, and increasing self-awareness or feelings of self-efficacy (e.g. Jackson, 2013).

Clients who are not in acute distress, are interested in creative expression, and have the stability and willingness to work through issues that may arise during the lessons may best benefit from therapeutic lessons (Jackson, 2013). Emotional stability and an interest in working on oneself may ensure smooth application of interventions and may ensure that clients are having their therapeutic needs met. Clients who do not have appropriate emotional awareness of their internal experiences, face more acute symptoms, or are seriously withdrawn may benefit more from less confrontational interventions (Jackson, 2013). The therapist should also be reasonably proficient on voice or the instrument the client chooses to effectively teach it. Care should be taken when selecting therapeutically appropriate repertoire for the client.

Preparation. The environment for a therapeutic lesson is very similar to that of a traditional music lesson. The space should be quiet and private (Jackson, 2013), and the client and therapist should have access to music stands, a chair without arms, a mirror, and a piano. Smaller handheld percussion instruments, as well as paper, pencil, and other art materials may be useful if improvisation and imagery are of important focus during the session. Recording and playback materials, such as a recording application or speaker, may be useful, if the recordings can be easily erased at the end of the session to protect client confidentiality. For music

selections, what is most important is that repertoire that focuses on the important therapeutic issues that arise in the session are selected (Jackson, 2013). The repertoire should match or be slightly above the skill level of the client.

What to observe. Affect, mood, and behavioral patterns are of importance for the therapist to monitor during therapeutic lessons. Behavioral and emotional signs such as becoming tearful or frustrated about a certain passage, wanting to immediately correct mistakes, not correcting any mistakes, wanting to quit, or having a slouched, unfocused posture may be signs of deeper issues that may be beneficial to explore through the music (Jackson, 2013).

Procedures. Therapeutic lessons may be done with clients who are and are not LGBTQ+, but when working with LGBTQ+ clients, the music therapist should be prepared to address LGBTQ+-related issues that may arise during the lessons. Therapeutic lessons should always be defined for the client, discussing the differences between therapeutic lessons and traditional music lessons (Jackson, 2013) and how the client may benefit from them. The client may already have a piece or a collection of pieces to explore during therapeutic lessons. If they do not, it is important to have and go through a list of selected repertoire that may address certain therapeutic issues with the client and allow them to select the repertoire they feel is best for them. Notice any body language or words that may suggest discomfort or hesitation and allow the client to discuss any thoughts or feelings they have about engaging in therapeutic lessons. During the lesson, note any behavioral, mood, or affect changes regarding playing the music, and be sure to engage the client and ask them about their behaviors (Jackson, 2013). Allow them to talk about any thoughts, feelings, experiences, or images that come to mind as they play the music. If the client is hesitant about moving forward through a certain passage of music, give them musical and or therapeutic suggestions on how to progress through the difficult passage, proactively practicing

the passage with them (Jackson, 2013). If the client becomes overwhelmed with emotion during the lesson, it may be useful to transition to another expressive medium, such as brief instrumental improvisation or drawing to allow the client to more concretely express or describe what they are experiencing (Jackson, 2013). Using the examples that arise during the new experience, the client and music therapist can transition back into the therapeutic lesson, using the repertoire's musical context to address difficulties that arose during the new experience (Jackson, 2013). Recordings may be a helpful form of record-keeping to show the client patterns in their changes in behaviors during sessions and how the therapeutic lessons are benefiting them therapeutically and musically (Jackson, 2013).

Guidelines for Compositional Music Therapy

Compositional methods involve the creation of original musical works, songwriting, song transformation, and the creation of song parodies (Baker, 2015; Bruscia, 2014a). It can often provide a blank slate for identity exploration and declaration that is often so important for young LGBTQ+ individuals (Tarrant et al., 2002). Like re-creative experiences, it is important to allow for changes in nouns, pronouns, verbs, and adjectives as the client sees fit to more accurately describe aspects of their identity and experience.

Gender-Bending Song Parodies

Overview. In a gender-bending song parody (Bain et al., 2016), the client and music therapist modify the lyrics of a preexisting song to create an expressive, authentic, musical representation of aspects of the client's sexual orientation or gender identity. The client can choose whether to privately recreate the song within the span of one session or perform the recreated song, in which it would become compositional music therapy. Goals for the experience can be for the client to improve self-esteem, gain a sense of control (e.g. Bain et al., 2016),

increase a sense of self-awareness of identity, and to creatively and authentically express aspects of their identity.

Preparation. For a gender-bending song parody, clients may choose songs that have simple melodic and harmonic structures and have words that are easily modifiable to fit a therapeutic topic or aspects of the client's identity (Jackson, 2013). Song sheets are useful to present the structure of the song and the lyrics that the client may choose to modify (Jackson, 2013). A whiteboard or large pad should be available for the therapist or client to write down suggestions for lyrics.

What to observe. Clients may bring up meaningful aspects of their identities and experiences as they consider lyrics for the song parody. Some of the phrases and terms used by the clients may inspire melodies and harmonies to most accurately express the intentions of the words the clients use as lyrics (Jackson, 2013). If working in a group, it may be ideal to check in with members who are more withdrawn and less keen on sharing their ideas (Jackson, 2013). The music therapist should also be prepared to encounter words that they may not recognize but may most accurately express an aspect of the client's identity. Remember to stay more informed and curious on these terms that the clients use instead of approaching the topic with judgment.

Procedures. Begin the experience by presenting the original song either by playing a recording of it or performing it for or with the client or group. Remind the client(s) of the intent of the song parody and encourage them to modify or create lyrics based on that intent (Jackson, 2013). Clients may want to break up into smaller groups to brainstorm ideas and create lyrics together rather than work with the whole group. These small groups may be given the responsibility of writing one stanza or one part of the song, such as one or a few lines from a verse (Jackson, 2013). It may be ideal to allow everyone to compose the chorus together. Then,

using a background music recording or instrumental performance, perform the song using the new words and phrases. To bring the session to a close, encourage the clients to share the importance of changing these words and phrases, highlighting important points of identity disclosure and exploration, problem-solving, and how they may relate to others (Jackson, 2013).

Musical Audiobiography

Overview. The creation of a musical audiobiography (Bruscia, 2014b) involves the client and music therapist compiling pre-recorded music and sounds into a collection that reflects important emotions, experiences, and relationships as related to the client's therapeutic issues (Jackson, 2013). Prerecorded songs, originally recorded songs and improvisations from the client's music therapy sessions, and other sounds can all be included in the final product (Jackson, 2013). Relevant goals for this experience may include providing opportunities for emotional processing, identity affirmation, and empowerment (e.g. Bain et al., 2016); increasing self-awareness about a particular topic or issue; increased self-expression; to explore feelings of self-worth and competency; and practice problem-solving with a long-term project (e.g. Jackson, 2013).

Preparation. This experience begins by initially collecting a wide variety of recordings that are accessible to the client, including digital song formats, CDs, MP3s, records, and digital music library recordings. Ideally, computer software will be available for audio editing and recording (ex. Audacity, Logic Pro X, GarageBand, etc.). A digital microphone or voice recorder that can be USB-connected to a computer can assist with vocal or instrumental recording (Jackson, 2013). An electronic device with plenty of available system space is ideal for completing the project, since it can be long-term and take up several megabytes of data. Online music platforms, such as Spotify and Apple Music, may be useful for compiling prerecorded

songs and audio files that the music therapist and client can easily share with one another. Paper and pencil for brief planning and for taking notes on ideas that spontaneously arise may also be beneficial.

What to observe. It is important to make note of how the client's perspectives may be modified through their engagement with this music experience (Jackson, 2013). Note how the client expresses coping skills, as well as dysfunctional behaviors, throughout the process of compiling and creating audio files for the project, helping them become aware of these skills and behaviors as they progress through the project (Jackson, 2013). Observe how the client may project or relate to the music product as it is being completed, relating them back to the therapeutic issues being addressed by this experience (Jackson, 2013). The client may also want to be very specific in finding music and sound selections that are adequate in defining what this music project means to them, which can be a demonstration of autonomy and the wish to dictate aspects of their own life and experiences (Jackson, 2013).

Procedures. Before beginning this experience, it is important to let the client know that the musical audiobiography will be completed over a length of time, and it is good to get a sense of what their commitment level to such a project will be (Jackson, 2013). The theme of the audiobiography should be decided by the client with assistance from the music therapist if needed. Examples of LGBTQ+-specific themes for a musical audiobiography may include the client's coming out or gender identity exploration journey, coming to terms with their identity, exploring their feelings about their gender transition, or coping about a relationship that may have been lost because of their LGBTQ+ identity disclosure. The client and music therapist should also plan the experience from beginning to end, exploring potential music choices and identifying recording equipment and or computer software that will be needed to complete the

project (Jackson, 2013). Encourage the client to bring in personal music sources while also allowing them to borrow relevant resources from the music therapy space, such as CDs, records, and songbooks. Assist the client in working with the relevant musical resources until the client is satisfied with the product in what they wish the finished product to express (Jackson, 2013).

It may also be useful to explore what other music experiences the client may want to include if what the materials they have are not satisfactory enough (Jackson, 2013). For example, if a client is looking to express an emotion, experience, or theme that no pre-recorded song or sound can accurately describe for them, the therapist may suggest they create an improvisation, such as a feelings exploration or a referential conversation. Recordings of these experiences can be used in the final musical audiobiography product and can enhance its personalization and meaningfulness (Jackson, 2013).

When the product is finished to a satisfactory extent as determined by the client, a final recording can be made of all the included recordings, sounds, and songs in the project. Listen to the full final recording or the collection of recordings that are included in the audiobiography product and allow the client to explain what the finished product means to them. Allow them to sit with the emotions of how it felt to complete this project. If therapeutically beneficial, the client may also choose to perform the audiobiography (Jackson, 2013). Assistance from the therapist may be required. This may look like a presentation of the whole final recording, a selection of the most meaningful music and sound recordings in the collection, or a live performance of these meaningful songs and sounds that the client and music therapist can collaborate on during the performance (Jackson, 2013).

Other Methods & Theoretical Orientations

Gender-affirming voicework. Gender-affirming voicework is a method whose development draws from the workings of speech-language pathology, queer autoethnography (Adams & Jones, 2016), the Alexander Technique (Alexander Technique, n.d.), and Guided Imagery and Music (GIM) (Gumble, 2019). Developed by Maevon Gumble, gender-affirming voicework aims to conceptualize breath, body, voice, and emotions as a collection of experiences that can be queered and views the voice as a blank slate for development, self-advocacy, and expression (Gumble, 2019). While speech-language pathology focuses on communication disorders, sessions focusing on gender-affirming voicework often place a lot of emphasis on breathing, which allows a client to become more deeply connected to their body and the physical sensations they experience. From there, the client and therapist may move to projective experiences such as movement or drawing, improvisations, and other chanting or toning exercises. These experiences aim to allow the client to take up authentic and affirming space with their bodies, experience gender imagery to support emotion- and identity-based work, and experience music and noisemaking in the moment (Gumble, 2019), which may differentiate gender-affirming voicework from the work of speech-language pathologists. Experiences can be formulated to support clients who wish to increase their vocal range and improve their technique, as well as clients who wish to be more spontaneous in their music-making. In this sense, this method can be beneficial for LGBTQ+ clients who wish to work on their voices to improve self- and listener-based gendered perceptions of their voices as well as clients who wish to connect more their sense of self through being in touch with their bodies and voices. Additionally, having a space for one to intimately and authentically explore their identities and the space they take up can be important to LGBTQ+ individuals, particularly for those who work in spaces where discrimination may occur (Freitag, 2013). This practice is

still early in development and can be conceptualized along a myriad of music therapy methods and practices and appears to be accommodating of therapeutic techniques conceptualized for LGBTQ+ clients of many needs (Gumble, 2019).

Melodic intonation therapy. Melodic intonation therapy (MIT) is a method that uses exaggerations of the rhythm and melody of speech to make speech patterns more resemblant of singing (Norton et al., 2009). Closely aligned with re-creative music therapy, it is often used with individuals with non-fluent aphasia and is usually carried out by a speech language pathologist. The application of musical elements to speech can be beneficial to clients with aphasia since many of them are capable of singing words they cannot speak. MIT can be a useful technique to modify the average fundamental frequency of transgender women's voices (Loutrari & Georgiadou, 2024). Such an intervention can be important since voice can play a significant role in gender dysphoria[1] in transgender people (Pu et al., 2025). Additionally, distress may be experienced if the gendered signifiers of one's voice do not match those of their physical appearance (Knight et al., 2023). Musical adaptations of speech exercises in vocal improvisation or re-creative experiences that allow for the exploration of speech and tone can be beneficial for transgender clients who wish to adapt the average fundamental frequency of their speech.

Radically inclusive queer music therapy. Radically inclusive queer music therapy is a theoretical orientation that draws from queer theory, an interdisciplinary study encouraging the destabilizing of sexuality and gender labels and a deeper engagement with identity subjectivity through an understanding of its relation to other identity categories (Bain et al., 2016; Stein & Plummer, 1994; Watson, 2005). In its conception and growth in therapeutic settings, this orientation is characterized by the striving for radical empowerment, resistance, and

[1] Gender dysphoria is discomfort or distress related to an incongruence between one's gender identity, sex assigned at birth, and/or primary or secondary sex characteristics (American Psychological Association, n.d.-b).

liberation instead of assimilation into the expectations of the dominant culture (Bain et al., 2016). It encourages a queering of all aspects of music therapy practice, including environment, assessment, therapeutic musical activities, and radical self-exploration through musical experiences (Bain et al., 2016), since music is a useful aid in identity formation and expression (Tarrant et al., 2002). To queer a practice involves a radical disruption of dominant understandings and narratives of heteronormativity, and it strives to legitimize non-normative identities by demonstrating that queerness is, always has been, and always will be present among history and cultures (Cregan, 2012). Queering a practice is to create space for marginalized peoples and identities that have historically been denied or excluded from healing spaces and explicitly create that space for them to explore and declare their identities in their full authenticity and legitimacy. This is important because spaces have long since been the site for binary, heterosexual masculinity privileging, creating a sense of hostility or exclusion for those who do not fit into the traditional binary or definitions of masculinity (Butler, 1993, 2000, 2011).

The authors who conceptualized this practice encourage practitioners who work with LGBTQ+ clients to aid the client in using music as a tool for confronting, utilizing, and empowering their queer identity through music experiences. Clinicians should invite their clients to consider the effects of their LGBTQ+ identity on their music preferences during assessment, musically express their queerness through improvisation and songwriting, and critically discuss song lyrics (Bain et al., 2016). The practice of radically inclusive queer music therapy has been conceptualized to allow marginalized clients to reclaim and express their voices that have been stolen and silenced by the dominant society, establish ownership of the self and identity, and encourage resilience and empowerment building (Bain et al., 2016). The authors also consider the helpfulness of projective drawing, a music therapy method that involves a client drawing out

images and responses they have to music that is playing since it gives the clients the freedom to create, construct, and process personal meanings to their past, present, and future (Bain et al., 2016). Such experiences reinforce a critical understanding of the self (Bain et al., 2016). Although this paper is primarily focused on music therapy methods that have shown to meet the therapeutic needs of the LGBTQ+ community in the literature, this theoretical orientation informs much of the interventions discussed throughout this paper and how they can be adapted.

Session Focuses

When working with LGBTQ+ clients, it is sometimes ideal to have a particular focus during a session. The following focus areas may be where therapeutic issues may arise for some LGBTQ+ clients.

Coming out. Music therapy groups and individual sessions have shown to benefit gay men when emphasis is placed on exploration of the coming out process. Aronoff & Gilboa (2015) explored the roles music played for seven gay men in the coming out process. They found that music offered four roles for the individuals: 1) music as a companion to fill the loneliness of isolation, as a friend, and as a protective mechanism against social rejection; 2) music as a "concealing and exposing" force regarding aspects of the research participants' lives, such as sexuality; 3) music as a force of strength for their inner selves, to share their intimate secrets with and to come to terms with who they were; and 4) music as an aid for change and a motivational force to come out (Aronoff & Gilboa, 2015). Many LGBTQ+ individuals struggle to find the words to describe or come to terms with their identity, and this study found that music could aid in the exploration of the inner self that sometimes can shelter those identities. Additionally, music played the role of a friend and to fill in the gaps of isolation that so many LGBTQ+ individuals feel when first coming out. This study's findings support those of Antebi & Gilboa

(2016), demonstrating that music often fills in the gap of personal and societal acceptance through the offering of a safe, inclusive medium allowing for self-discovery, a role of music that Bain et al. (2016) strive to bring into music therapy practice.

Parental involvement. Parental involvement in music sessions has also demonstrated a promising outlook for their well-being and that of their children. Pandya (2023) led joint music sessions made up of lesbian and gay young adults and their parents. The author found that participants with higher formal education and participation in the session work reported higher scores of perceived parental support for sexual orientation; positive dimensions of parent adult relationships, such as thoughtfulness and affection; and well-being. Additionally, they scored lower on negative dimensions of parent adult relationships, such as hostility and insensitivity. These findings suggest that parental involvement in music sessions is an effective family-based therapeutic intervention with persons of diverse sexual orientations and can increase rapport between parents and their young adult children. Parental support can be a protective factor for LGBTQ+ youth well-being (Bouris et al., 2010), and can have ramifications for mental health, school belonging, self-esteem, and suicidality among this population (Hatchel et al., 2019; Ryan et al., 2010).

Closing Remarks on Methodology

Many of the music therapy methods discussed have implications and may be useful for clients in both the individual and group format. Where the client is in terms of treatment and their clinical goals are relevant factors in deciding whether individual or group interventions will be the most beneficial to them. For example, if the client's treatment goals involve building social cohesion and improving interactions with others, a group format may be the most suitable for them (Jackson, 2013). A group format may also work best when working with a cohort of

individuals whose treatment timelines are similar and have been working together to build a cohesive group structure (Jackson, 2013). On the other hand, if a client is working through deeply troubling personal thoughts and emotions that may not be suitable to be dealt with in groups, or if the client is dealing with personal issues that may need to be kept confidential (such as HIV or coming out status), an individual format may best suit their needs (Jackson, 2013). While the clients' treatment teams may be the deciding body for which experiences the client will be exposed to, it is necessary for the music therapist in these circumstances to be adaptable and design experiences that most appropriately address the client's needs within the circumstances, while protecting client confidentiality and fostering a sense of safety (Jackson, 2013).

Determining the size of the group, the frequency of the group, and its duration will depend on the needs of the clients. Groups that are around six to eight members but do not exceed ten members may be useful in fostering a sense of familiarity and safety within the members while allowing for a diversity of shared thoughts and ideas (Jackson, 2013). Smaller groups may also be ideal for individuals who are more focused on a certain topic, who have similar needs, and who are able to build a small cohesive unit to have intimate and emotional discussions together (Jackson, 2013). Larger groups, or groups that exceed ten or twelve members, may be ideal for more specific interventions such as group improvisation or drum circles (Jackson, 2013). This allows for the inclusion of more musical voices that may not be used to the structure of improvisation or drum circles, but whose treatment goals are very similar and whose voices may be critical in the overall topic or issue of the group.

Session time depends on the capacity of each client, but the general music therapy session is anywhere between forty to sixty minutes (Jackson, 2013). One session a week is

typical for clients, but when working in facilities like hospitals or psychiatric units, music therapists may see individual clients several times a week anywhere between fifteen minutes to an hour, depending on the client's needs and treatment goals. When working in a facility, it is paramount for music therapists to adequately meet and design experiences that do not leave the client with any unresolved feelings about the music experiences before the end of the session or before their discharge.

Guidelines on Sequencing Experiences Within a Session

Opening/warm-up experiences. Warm-ups can include discussions about a topic that is a session focus, engagement in a brief music experience to communicate a thought or simply giving mood ratings. The warm-up experience may be determined by the goal of the session or by the client's goals as determined by their care team, if applicable. For example, if the music therapist is leading an improvisational referential conversation session, a warm-up experience of discussing how we communicate and what we do when communicating with others may precede the music experience. Warm-up experiences may also serve as assessments for the music therapist (Eyre, 2013).

Transitions between experiences. During music therapy, any number of music experiences can be used. Some clients feel that one experience may adequately address one of their therapeutic needs, while others may need to engage in multiple experiences to feel that they are making progress (Jackson, 2013). For clients who need more than one music experience, a logical sequence of experiences may begin with a music experience to help the client become more aware of their thoughts and emotions, followed by an experience that allows for a deeper recognition of those thoughts and emotions, and finally a closing experience to help the client integrate any insights that may have come to them during the previous experiences (Jackson,

2013). For example, the client and music therapist may begin with song singing, which may help the client become aware of their current thoughts and emotions, followed by song communication to help the client gain some insights, and perhaps end with gender-affirming movement to further materialize and affirm these insights brought about during the song singing and song communication.

Some of the experiences described, such as gender-affirming movement or gender-bending song parodies, may seem more appropriate for trans and gender-diverse clients. However, it may be appropriate to involve some cisgender gay, lesbian, or bisexual clients in these experiences. This may provide clients with the opportunity to recreate historical modes of gender-bent expression recorded within these communities. It is important to remember that there is a history of gender non-conformity within gay, lesbian, and bisexual communities (Gordon & Meyer, 2008) that may be worth exploring through music, depending on the client and their experiences.

Closing experiences. Closing experiences offer the client an opportunity to reflect on and integrate what occurred during the music therapy session and to identify new insights about themselves and their lives. Like warm-up experiences, closing experiences can encompass a wide variety of musical and non-musical formats, such as discussions, mood ratings, or improvisations. Closing experiences are generally meant to bring a close to the session, helping the clients realize what went on during the session and help them logically integrate that new knowledge into their everyday lives, or to bring a sense of resolution to any difficult emotions, thoughts, or experiences brought up during the session (Jackson, 2013). Closing experiences may match the format of the opening experiences. For example, using the referential improvisation experience from before, the clients may come to conclusions about self-expression and

autonomy through referencing an emotion or experience musically with others. For the closing experience, the music therapist may invite the clients to reflect on what they learned during the experience in an open discussion format, allowing them to bring any new insights about themselves or about communication into their daily lives outside of the experience.

Contraindications

While music therapy may have its benefits with this population, some interventions are not without their contraindications. During receptive experiences, some clients may not be able to sit comfortably for the duration of a relaxation or imagery session (Brooks, 2013). Clients who also have physical disabilities or limitations may be hindered in their movements during movement experiences. Adapting the space so it is free of obstacles and allows for one's freedom of movement with mobility aids may help to mitigate these issues during receptive experiences. In addition, Jackson (2013) mentions that clients who are cognitively challenged and lack abstracting abilities may not benefit from song communication or experiences involving lyrics. Eyre (2013) also suggests that song discussion experiences may be less suitable for clients who are attention-seeking or who are in acute psychosis or mania so much so that the music is overstimulating.

Clients may also be sensitive to loud noises and get overstimulated easily, which may make some improvisational experiences uncomfortable (Brooks, 2013; Jackson, 2013). In addition, being asked to create spontaneous sounds in the moment may be a source of stress for some clients (Brooks, 2013). Group experiences with themes around coming out or LGBTQ+ identity work may be a source of fear or shame for some clients due to family or peer influence, and internalized homophobia (Brown & Trevethan, 2010; Chow & Cheng, 2010).

Some songs used in sessions may include pronouns that may incorrectly reference the client or another person in their life, which may be potentially upsetting. During compositional methods, make sure to allow the space for the client to declare their own pronouns and terms to be used in both original and pre-existing songs. For example, if a non-binary client is working with the song *Scars to Your Beautiful* by Alessia Cara, they may want to change the song's predominant pronoun of 'she' to 'they' to more accurately reflect their gender identity. Likewise, if another client is using the same song to reflect about another individual in their life, the pronouns may be changed from 'she' to 'he'.

Some LGBTQ+ clients may also not want to have discussions about or have sessions focusing specifically on their LGBTQ+ identity. While having an LGBTQ+ identity has several ramifications for one's experiences and survival, each LGBTQ+ client is different and may have different perspectives on the importance of their identity in their lives. Some may find their identity greatly influential and important, while others may not.

Examples of Music Therapy With LGBTQ+ Clients: Descriptive Papers and Research Findings

There is a paucity of research demonstrating the usage and outcomes of music therapy methods among LGBTQ+ individuals. Some research in related medical and therapeutic fields, such as speech language pathology, have implications for music therapy practice.

Descriptive Papers and Case Studies

Song communication may be a promising therapeutic experience for gay men. In a small session based on the musical presentation model (MPM), Aronoff (2016) led a music therapy group where each member introduced themselves to the group using songs of their choice. By the end of the session, a marked increase in intimacy and the ability to empathize with the other

members of the group was seen among the members (Aronoff, 2016, as cited in Gold, 2016). Additionally, the song communication experience resulted in participants feeling more intricately connected to the gay community and having a deeper appreciation and acceptance of their own sexual identities. These results are like those of Antebi & Gilboa (2016) and Aronoff & Gilboa (2015), in that the music shared in this group provided opportunities to address similar therapeutic needs. A deeper appreciation and understanding of the self and the feeling of connectedness with others were concurrently elicited during the song communication group. In this case, the music allowed for less isolation and a greater sense of self-acceptance to be felt among the members of the group, two therapeutic needs that are often expressed not just by gay men but by other members of the LGBTQ+ community.

Introducing and including movement in music experiences may also be therapeutically beneficial to LGBTQ+ clients. Harris (2022) conducted a movement to music session with a queer client who had been struggling with grief following his mother's sudden death, as well as intimacy and self-esteem issues. The client had mentioned the song *I'm Coming Out* by Diana Ross, a song that he had linked to positive childhood memories of his mother and of him dancing around to it in his room. This "dance party" was re-created in the session, and although a bit shy and awkward at first, it provided the space for the music therapist and the client to explore gender-nonconforming and flamboyant expressions, leading to a palpable release and increased sense of trust to explore expressions of queerness in the room (Harris, 2022). This experience allowed for not only the exploration and eventual proclamation of queerness, but also for the reclamation of childhood experiences that had been repressed (Harris, 2022). Although ill-researched, this kind of music experience offered a musical space for the client to take up and to

proclaim as his own, prompting an authentic expression of his queerness and to revisit a joyful moment from childhood.

Research Findings

Research on the use of songwriting in music therapy suggests several therapeutic potentials that would address the needs of those in the LGBTQ+ community. It is an accessible therapeutic medium that allows for interpersonal connections between people of varied cognitive and emotional abilities and has the potential to explore experiences and construct narratives of our past, present, and future (Baker et al., 2017). It has also shown to be a deeply emotional process due to music's influence on memory and imaging (Baumgartner et al., 2006) and has demonstrated meaning to clients, activating hope and willingness to change (Silverman et al., 2016). Scrine (2019a) describes an arts-based qualitative research study in which students aged 14-18 participated in a songwriting experience. Participants were asked to picture their "perfect world" in relation to gender and sexuality. Their ideas were used as launching points to write a song as a group. The process allowed for the participants to build their own views of their identities, deconstruct definitions of sex and gender, and advocate for liberatory relationships between themselves, other people, and society (Scrine, 2019a). Results of this study suggest that songwriting can serve as an affirmative medium for young people in validating and celebrating the diversity within their gender and sexuality experiences.

Antebi & Gilboa (2016) interviewed active gay and lesbian composers. Analysis of interview transcripts suggested that compositional developments among the participants often paralleled the coming out process. The researchers identified four key roles of composed pieces: song as therapist, song as a sensor, song as a presenter, and song as a rebel (Antebi & Gilboa, 2016). For these composers, composition offered a safe and private space to explore a multitude

of aspects of the coming out process and what they may expect to experience in their process. This study offers implications for music therapists suggesting that songwriting and composition may be important methods to use with gay and lesbian clients, particularly with those who may be struggling with or "trapped" in a phase of the process of coming out. Coming out can be an extremely important and impactful process for some LGBTQ+ individuals to experience. While identity disclosure can be a cost to well-being in some contexts (D'Augelli, 2006), it is also associated with higher life and job satisfaction (Huffman et al., 2008). Additionally, non-disclosure can affect one's sense of identity and authenticity (Stenger & Routlet, 2018).

Since speech is adaptable to musical elements, melodic intonation therapy (MIT) may be a useful tool for adapting or modifying the pitch of spoken words. Loutrari & Georgiadou (2024) applied an adaptation of MIT to assess its ability to raise the average fundamental frequency of the voices of transgender women. The authors noted a statistically significant rise in the average fundamental frequency of the participants after the adapted MIT sessions, meeting the potential need for physical and vocal gendered signifiers to match.

Summary & Conclusions

LGBTQ+ individuals often face interpersonal, individual, and social factors that uniquely influence the state of their health. Compared to the general population, LGBTQ+ individuals can face increased rates of depression, anxiety, self-harm, suicidal ideation, substance use disorders and eating disorders due to social stressors such as discrimination and lack of institutional protections. Music therapy is a promising therapeutic modality to utilize for members of the LGBTQ+ community given music's influence on the community and identity formation, as well as its inviting and nonjudgmental platform for self-exploration and expression.

While there is a paucity of research on music therapy methods used for members of the LGBTQ+ community, music therapy methods such as song communication, projective movement, songwriting, composition, gender-affirming voicework, and melodic intonation therapy seem to benefit and meet the therapeutic needs of LGBTQ+ individuals. These methods may increase cohesion and connection among members of the community, help clients explore and come to terms with personal relationships, improve self-efficacy and mindfulness, and increase the sense of comfort in one's gender identity or sexual orientation. Additionally, music sessions focusing on coming out and involving parents and loved ones in music experiences have also shown to solidify and expand connections between the LGBTQ+ client and others in their lives. The efficacy of music therapy methods to address therapeutic issues experienced by members of the LGBTQ+ community have not been explicitly researched. However, it may be reasonable to suggest that engaging LGBTQ+ clients in receptive methods can provide opportunities for stress reduction, self-exploration through other artistic mediums and imagery, reflect and construct personal meanings, and experience gender-affirming movements and vocalizations. Improvisational methods may offer clients the ability to explore their inner thoughts and feelings and connect musically with others. Re-creative music therapy may aid clients in sharing and coming to terms with their thoughts, feelings, and identities in ways that can be expressed and further experienced and validated by others. Compositional music therapy offers creative music-making opportunities to aid clients in understanding and expressing themselves, their identities, and the people in their lives. Overall, more research is needed to truly explore the efficacy of these music therapy methods with the LGBTQ+ community.

While the world is often chaotic and hostile towards LGBTQ+ people, influencing feelings of hopelessness, helplessness, and hypervigilance and constantly pushing them into

survival mode, assisting these individuals in recognizing their strengths, maintaining control, and fostering a sense of empowerment will make all the difference in fostering and forging powerful, radical ideas of strength and persistence in their identity. Music is a powerful tool upon which to explore systems of oppression, mental health and discrimination experiences, and to build and construct new identities, new understandings of the self, and meanings within the world.

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Appendix A

LGBTQ+ songs to use with LGBTQ+ clients

1. American Teenager – Ethel Cain
2. Bloom – Troye Sivan
3. Born This Way – Lady Gaga
4. Dancing on my Own – Robyn
5. Follow Your Arrow – Kacey Musgraves
6. Gimme! Gimme! Gimme! (A Man After Midnight) – ABBA
7. Girls Like Girls – Hayley Kiyoko
8. Good Luck, Babe! – Chappell Roan
9. I Will Survive – Gloria Gaynor
10. I'm Coming Out – Diana Ross
11. I'm Every Woman – Chaka Khan
12. Pink Pony Club – Chappell Roan
13. Somebody Loves You – Betty Who
14. True Trans Soul Rebel – Against Me!
15. The Village – Wrabel
16. We R Who We R – Kesha
17. You Need to Calm Down – Taylor Swift