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Exploring Social Perceptions of Queer and Trans Music Therapists and Clients:

A Qualitative Story Completion Study

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Abstract

Existing research presents a mixed picture on music therapists' preparedness to work effectively with LGBTQIA+ clients, highlighting deficits in training and a lack of insight on the part of some music therapists into what LGBTQIA+ inclusive practice actually entails. Alongside this, there is a growing literature on clinical practice with and interventions for LGBTQIA+ clients; however, there is an absence of research exploring *directly* with members of LGBTQIA+ communities their experiences and perceptions of music therapy. The current study aims both to expand the limited literature exploring music therapists' preparedness to work with LGBTQIA+ clients, and to begin to explore LGBTQIA+ people's perceptions of music therapy. It does so through use of the novel, creative method of story completion (SC)—participants were given two (of four) "story stems" based on a hypothetical implied first therapy session scenario involving a trans or queer client or therapist and asked to complete them. Forty-six participants (20 trainee/qualified music therapists [nine of whom identified as LGBTQIA+]; 23 LGBTQIA+ people; three no demographic data) wrote a total of 87 stories. Reflexive thematic analysis was used to develop three themes: 1) disclosure in therapy is important for the therapeutic relationship and the client; 2) effective therapists are non-judgmental and inclusive; and 3) shared identity matters. The analysis suggests a lack of knowledge of LGBTQIA+ communities and inclusive practice on the part of straight and cisgender music therapists, alongside an aspirational commitment to an open and non-judgmental approach. The stories written by LGBTQIA+ participants recognised the potential for prejudicial treatment—these participants framed openness as an ethical imperative.

Keywords: homophobia; inclusion; LGBTQIA+; music therapy; reflexive thematic analysis; transphobia

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Introduction

Over the past decade, literature on LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual; the plus sign is used to cover all of the other non-conforming gender and sexual identities not encompassed by the acronym) inclusive music therapy has expanded, focusing on theoretical frameworks (e.g., Bain et al., 2016; Baines et al., 2019; Fansler et al., 2019), clinical practice with LGBTQIA+ clients[1] (e.g., Hardy & Monypenny, 2019; Lee, 2022a), and the self-reflections of LGBTQIA+ identified music therapists including on their intersecting identities (e.g., Lee, 2022b; Myerscough & Wang, 2022; Scrine, 2019).

Whitehead-Pleaux et al. (2012) developed best practice guidelines for working affirmatively with LGBTQ[2] clients—their recommendations included the music therapist creating a "safe(r) space"[3] for clients, avoiding assumptions about sexual orientation and gender identity and expression, responding respectfully to disclosures of sexual and gender identity, using inclusive language, becoming familiar with LGBTQ literature, culture and issues, exploring their own beliefs and "biases" around gender and sexuality, and engaging in ongoing training. The existence of such guidelines for inclusive practice raises the question of how prepared music therapists are to work with LGBTQIA+ clients.

Music Therapists' Preparedness to Work with LGBTQIA+ Clients

Existing research raises questions about how well-placed music therapists are to support LGBTQIA+ clients effectively. Ahessy's (2011) global survey of music therapy training programmes and associations to assess the inclusion of LGB[4] issues in music therapy and continuing professional development showed that although LGB issues are considered important, they are largely overlooked in the literature as well as in training and professional development. Boggan et al. (2017) explored the perspectives of 12 LGBTQ+ music therapists and music therapists who have experience of working with LGBTQ+ clients on Bain et al.'s (2016) queer music therapy framework[5]. Participants identified various strengths with Bain et al. and that it needed to more substantially integrate intersectionality theory to better serve a diverse range of LGBTQ+ clients.

Whitehead-Pleaux et al. (2013) surveyed 409 mostly North American qualified and trainee music therapists' attitudes toward the LGBTQ community and showed that over half of the participants did not "feel prepared to work with these communities" (p. 413) and had not received training on LGBTQ issues and culture, and very few sought out

[1] Since conducting this research, the first author has changed their perspective on the term "client" and in line with their commitment to anti-oppressive music therapy prefers and uses the terms "people in therapy" or "people engaging in therapy." However, to maintain research integrity we use the term "client" as this was the term we used in the research materials and in the first author's dissertation that this paper has been developed from.

[2] When discussing particular studies, we use the acronym used by the authors.

[3] Safe(r) is a term used by Choudrey (2022) to emphasise the subjective nature of safety. We cannot guarantee that a space is inherently safe for someone else. If we were to call a space safe, we would imply that we know what safety means for another person. Therefore, the term "safe(r) spaces" or "principled spaces" suggests the idea of committing to principles that shape and support a space to "increase the possibility of safety for all involved" (Choudrey, 2022, p. 76). It's important to note that Whitehead-Pleaux et al. (2012) used the term safe space.

[4] The authors noted that their focus was specifically on sexual and not gender identity—hence not including transgender and intersex issues.

[5] This framework draws on queer theory—"an interdisciplinary field that destabilizes sexuality categories and challenges the concept of normal and fixed identities" (Bain et al., 2016, p. 23)—to provide a "radically inclusive approach to therapy with LGBTQ clients" (p. 22).

supervision to work with this community. Despite this, a majority felt they understood the needs of this population, that their clinical approach was open and affirming and they were comfortable working with LGBTQ clients. Whitehead-Pleaux et al. (2013) described this dichotomy as "concerning" (p. 414) and argued that many music therapists needed "to be more informed and educated" (p. 414) about LGBTQ communities and the experiences of LGBTQ individuals.

More recently, Wilson and Geist (2017) explored straight, cisgender, and LGBT music therapy students' perceptions of their preparedness to work with LGBT clients in the US. A total of 38.9% had received no formal training relating to the LGBT community and were overall somewhat unfamiliar with the academic literature on the LGBT community. Most defined their clinical approach as open and affirming but did not provide space on clinical documentation for clients to self-define their gender and sexuality. The students' perception was that they were neither prepared or unprepared to talk with LGBT clients about gender and sexual identity related topics. Music therapists lack of preparedness to work with LGBTQIA+ youth was noted by Vencatasamy (2022), stating that therapists "haven't done the thinking, and they bring with them those prejudices […] There's this fear that we don't get challenged by these voices because we don't hear them."

LGBTQIA+ Therapists and Clients

Our literature search identified no research exploring the perspectives of LGBTQIA+ music therapy clients and the perspectives of members of LGBTQIA+ communities on music therapy more broadly. Within the wider psychotherapy literature, most LGBTQIA+ psychotherapy research has prioritised the perspectives of therapists (Berke et al., 2016), and it is only relatively recently that attention has been paid to the experiences and perspectives of LGBTQIA+ clients, and particularly trans clients (e.g., Compton & Morgan, 2022). For example, Shelton and Delgado-Romero (2011) explored sexual orientation microaggressions experienced by 16 LGBTQ psychotherapy clients. These included the "assumption that sexual orientation is the cause of all presenting issues," "avoidance and minimising of sexual orientation" and "expressions of heteronormative[6] bias" (Shelton & Delgado-Romero, 2011, p. 215). McCullough et al. (2017) explored the experiences of transgender and gender nonconforming (TGNC) counselling clients, reporting that some participants sought out therapists with a similar identity because they thought they would be better able to understand and empathise with their experiences and create a sense of safety. Participants also reported negative experiences of cisgender counsellors' lack of knowledge and invalidation of their identities, which was contrasted with experiences of trans affirmative counselling where the counsellor used affirming language endorsed by TGNC communities, conveyed respect by using their correct name and pronouns, and advocated for their rights and acted on their behalf to reduce systemic barriers and harms. These studies provide a sense of how LGBTQIA+ individuals might experience music therapy.

McCullough et al. (2017) highlight the issue of a therapist and client sharing similar identities—a reoccurring theme in the literature on LGBTQIA+ psychotherapy clients—with some studies reporting a preference for similarity and others finding that it doesn't increase clients' rating of therapists, and competence outranks a shared sexual orientation (Borden et al., 2010). A related issue is that of therapist self-disclosure, and specifically therapist disclosure of sexual and gender identity. Again, the literature provides varied perspectives on this. Speaking to both shared identities and therapist self-disclosure, Borden et al.'s (2010) LGB college student participants rated therapists who disclosed

[6] A concept from queer theory that highlights the social privileging and normalisation of heterosexuality.

personal background information including a "homosexual" orientation as more expert and trustworthy than those who disclosed a "heterosexual" orientation or only professional background information. In the wider psychotherapy literature, there are numerous position pieces—written by LGBTQIA+ therapists—arguing for the benefits of therapist self-disclosure of sexual and gender identity for LGBTQIA+ clients include creating a safe(r) [7] and accepting therapeutic space, role modelling, countering internalised homophobia and increasing therapeutic credibility (Henretty et al., 2014). Risks have also been noted such as overidentification and blurring boundaries (Henretty et al., 2014).

Concerning LGBTQIA+ music therapists, the British Association of Music Therapy's (BAMT) Diversity Report (Langford et al., 2021), which surveyed 509 qualified and trainee music therapists (around half of BAMT's membership), found that 11.59% of participants identified as queer and around 1% as trans or non-binary. Trans and non-binary people were described as "severely underrepresented" both in the profession and in the client population. It is unclear if the report's authors meant numerically, which arguable is not the case with regard to therapists. Some of the quotations from participants included in the report referenced the existence of homophobia in the profession (also refer to Ben-Aharon et al., 2022) and the dismissal of the relevance of sexuality and gender to therapeutic practice.

There is very little research exploring the experiences and perspectives of LGBTQIA+ music therapists. McSorley (2020) included three non-binary and one trans (alongside four cis women) music therapists in her study of gender microaggressions (everyday invalidations or insults enacted by other music therapists and clients such as misgendering) in music therapy environments (also refer to Ben-Aharon et al., 2022). The trans and non-binary participants reported the gender dysphoric impacts of microaggressions, and avoiding/delaying coming out [8] as a form of self-protection. The participants more generally noted the potential for client-enacted microaggressions to negatively impact the therapeutic relationship, with some describing these incidents as resulting in "irreparable harm" and "loss of connection" (p. 6). White, non-disabled and younger trans and non-binary participants reported positive experiences of feeling affirmed when coming out in some music therapy spaces, alongside negative experiences of microaggressions. Biedka (2022) interviewed five LGBTQIA2[9]+ and cisgender and straight music therapists about their experiences of working with LGBTQIA2+ clients. The LGBTQIA2+ music therapists viewed their lived experiences as LGBTQIA2+ as a resource for therapy and thought they were better placed to work effectively with LGBTQIA2+ clients. The participants described implicitly communicating their identity to LGBTQIA2+ clients through their appearance/self-presentation and song selection (also refer to Monypenny & Hardy, 2022). Informed by their own experiences of therapists not disclosing, one participant explicitly disclosed their identity to clients and shared their own experiences of identity exploration while holding some ambivalence around this related to the risk of centring themselves in the therapy and violating boundaries. Self-disclosure was perceived as a form of role modelling for LGBTQIA2+ clients and a way of (quickly) developing trust. The participants thought that music therapists have a responsibility to create a safe(r)[10] space for LGBTQIA2+ clients, and examples of affirmative practice included asking for pronouns and using queer music to define the space and develop rapport. The participants

[7] It's important to note that Henretty et al. (2014) use the term safe.

[8] As is widely acknowledged, coming out is not a one-off event, but a potentially lifelong process of disclosure of gender and sexual identities because of cisheteronormative assumptions in the wider society.

[9] 2 here refers to two-spirit—a term used by some Indigenous LGBTQIA+ folk in the US and Canada.

[10] It's important to note that Biedka (2022) uses the term safe space.

questioned whether straight and cisgender music therapists (who do not identify and act as allies) were adequately prepared to work effectively with LGBTQIA2+ clients—noting their struggles with language and concepts, a lack subcultural knowledge, and the problematic combination of a perception of this client group as "less than" (p. 159) and a straight/cis "savior complex" (p. 159).

The literature on LGBTQIA+ music therapists to date mostly consists of commentaries (e.g., Liboro & Lee, 2022), self-reflections (e.g., Harris, 2019) and autoethnographies (e.g., Ben-Aharon et al., 2022; Monypenny & Hardy, 2022) from LGBTQIA+ music therapists—many of which address themes touched on by Biedka (2022) around disclosure of sexual/gender identity to, and shared identities with, LGBTQIA+ clients (e.g., Ben-Aharon et al., 2022; Harris, 2019; Liboro & Lee, 2022; Monypenny & Hardy, 2022). For example, Monypenny and Hardy (2022) make the case for "radical self-disclosure" as both a therapeutic and political act when working with the LGBTQIA+ community. They argue that therapist self-disclosure can reduce power imbalances, create safety and trust, and foster solidarity through acknowledging collective trauma and marginalisation, and an "out" therapist can role model authenticity and coping skills. They concluded that "therapist self-disclosure is essential to queer visibility, representation, and liberation" (p. 682)—benefitting both queer clients and queer music therapists who "deserve freedom of authenticity" (p. 682).

The Current Study

This research seeks to build upon existing research on music therapists' preparedness to work with LGBTQIA+ clients by exploring their perceptions of queer and trans clients and music therapists. It also provides a new perspective by exploring the perceptions of LGBTQIA+ people regarding queer and trans music therapists and music therapy clients. We hoped the data would shed light on music therapists and LGBTQIA+ people's perceptions of effective (affirmative and inclusive) and ineffective therapeutic practice with LGBTQIA+ clients, including therapist and client self-disclosure.

Methodology

This study used the novel, creative qualitative method of story completion (SC) to explore trainee and qualified music therapists and LGBTQIA+ individuals' social perceptions of queer and trans music therapists and music therapy clients. SC is similar to the vignette technique that is used frequently in psychotherapy research—where participants respond to a hypothetical scenario (e.g., Borden et al., 2010). In SC research, rather than respond to a fully realised hypothetical scenario, participants are given the start of a story based on a hypothetical scenario (the "story stem") and asked to complete it (Clarke & Moller, 2023). In the current study, participants were asked to spend 10 minutes completing a story with a recommended length of 200 words. The story stems focused on an implied first session of music therapy and either the client or music therapist thinking the other might be trans or queer. The use of SC, and in particular third person SC, arguably creates the possibility of accessing a wider range of perceptions, including socially undesirable ones, because participants express themselves indirectly in the form of a story and therefore do not have to "take ownership" of their response—as "it's just a story" (Moller et al., 2021). There is some evidence from the wider psychotherapy research literature that in interviews, self-presentation and professional credibility concerns can delimit and direct therapists' responses (e.g., Rance et al., 2010). SC has been used in psychotherapy research on a range of topics, including young adults' perceptions of fat therapists (Moller & Tischner, 2019), therapists' meaning-making around straight sex (e.g., Shah-Beckley et al., 2020), and parent constructions of children with gender variance (Butler et al., 2022).

As Moller et al. (2021) outline, SC data, and what they give access to, can be theorised in different ways. Our approach to SC aligns with their socially situated perceptions framework, which they locate within a contextualist epistemology. Here, SC is understood as giving access to the social understandings around a topic accessible to participants. In this framework, it is possible that the story content reflects aspects of participants' opinions or experiences, but their reaction to a real-world scenario cannot be read off or predicted from their story because of the demands and expectations of story writing (in a western context) and because any actual reaction will be context dependent. Although contextualist approaches reject the notion of a single knowable truth, they are still interested in understanding provisional, local, and context-specific truths (Madill et al., 2000). A contextualist framework assumes that similar (e.g., demographically or contextually) groups of participants might draw on similar social understandings, and those with different backgrounds and contexts may have access to different understandings.

Researcher Personal Statement

At the time of the research, the first author (FA) was a music therapy trainee, with an interest in psychodynamic, anti-oppressive, resource oriented, neurocosmopolitan[11] and queer approaches to music therapy. The research was also shaped by their personal positioning as white, middle-class, gender non-conforming, pansexual and neurodivergent. The second author (SA) is a qualitative, critical and LGBTQ+ psychologist, with an interest in developing SC as a qualitative method. They identify as a white, middle-class, queer, disabled, non-trans[12] woman. The third author is a musician, music therapist and music therapy educator and researcher. They identify as white, middle class, cis male and heterosexual.

Participants and Recruitment

There were 46 participants, aged 18–72 years (mean 34 years; six no age data); refer to Table 1 for a simplified summary of the self-identified characteristics of the 43 participants who provided (partial or complete) demographic data. There were similar numbers of trainee/qualified music therapists and non-therapists (20 trainee/qualified music therapists [11 trainees; nine qualified]; 23 non-music therapists; three no data). Although white cisgender heterosexual women were the largest single gender and sexual identity group (n = 9), reflecting the preponderance of cisgender female music therapists (Langford et al., 2021), most participants identified as LGBTQIA+ (n = 32). Many participants self-identified with multiple genders and sexualities, such as pansexual/demisexual and trans/genderqueer.

The study was advertised in various ways: through our personal social media accounts, music therapy and LGBTQIA+ organisations, charities, and groups, and the psychology participant pool (i.e., a credit-bearing research participation scheme for first and second-year psychology undergraduates) at our university. The preponderance of LGBTQIA+ people in the participant group (i.e., that nine of the qualified/trainee music therapist

[11] Walker describes a neurocosmopolitan individual as one who "accepts and welcomes neurocognitive differences in experience, communication, and embodiment in the same sort of enlightened way that a cosmopolitan individual accepts and welcomes cultural differences in dining habits. In a future society that's truly embraced the neurodiversity paradigm, neurocosmopolitanism would be the prevailing attitude toward neurocognitive differences among humans" (Walker & Raymaker, 2021, p. 9).

[12] We use this term to open up a space between trans and cisgender, and between feelings and (publicly claimed) identities.

participants also identified as LGBTQIA+) could reflect our social networks, and/or it could indicate a particular enthusiasm among LGBTQIA+ identified music therapists to participate in LGBTQIA+ focused music therapy research.

Table 1. Participant Self-Identified Demographics (*n* = 42).

Demographic	Categories	Number of participants
Question: How would you describe your gender?	(Cis) Female / Woman	17
	Male	9
	Non-binary / Gender Non-conforming / Gender Fluid*	8
	Female / Woman*	3
	Trans*	2
	Unclear	2
	Intersex	1
Question: How would you describe your sexuality?	Heterosexual / Straight*	9
	Bisexual*	9
	Gay*	8
	Pansexual*	5
	Queer	4
	Asexual / Demisexual/ Aromantic	3
	Lesbian	1
	Not labelled	1
	Trans-lesbian when “en femme” and straight when not	1
	Unclear	1
Question: How would you describe your spirituality / faith / religion / belief (or lack of)?	None / No Spirituality/ Not Religious/ Unbelieving	14
	Agnostic	8
	Atheist	6
	Christian	5
	Spiritual	5
	Reform Jewish*	2
	Muslim	1
	Unknown	1
Question: How would	Middle*	23

Demographic	Categories	Number of participants
you describe your social class?	Working*	15
	None	3
	Unclear	1
Question: Do you consider yourself to be disabled?	Non-disabled	27
	Disabled	15

Note: * Variants of this category.

Data Generation

The study was delivered online via the *Qualtrics* survey platform. Participants were asked to read a participation information sheet, answer a consent question, and create a participant code (to allow for retrospective withdrawal). They were then randomly presented with one of two sets of two stems (therapist trans and client queer or therapist queer and client trans), with the two stems within the set also presented in a random order. The completion instructions were based on those in Braun and Clarke (2013). The wording of the stems was inspired by the Moller and Tischner (2019, p. 37) "fat counsellor" first therapy session story stem that reads:

> Kate has been finding it really difficult to cope with life so she has decided to go for counselling. As she walks into the counselling room for the first time, her first thought is: "Oh, my counsellor is fat!"

This stem provided a useful starting point as Moller and Tischner reported that it prompted rich data with participants seemingly unconstrained by social desirability norms. Our story stems were:

> *Therapist queer/trans* – Alex/Jamie has been finding it really difficult to cope with life, so they have decided to go for some music therapy. They walk into the music therapy room and think "oh, I think my therapist is queer/trans."

> *Client queer/trans* – Charlie/Chris has been finding it really difficult to cope with life, so they have decided to go for some music therapy. They walk into the music therapy room and the music therapist thinks "oh, I think my client is queer/trans."

The protagonist in each stem scenario had a different gender-neutral name to more clearly distinguish the stem variations (Alex therapist queer; Jamie therapist trans; Charlie client queer; Chris client trans). We didn't think the "oh, I think my therapist/client is *LGBTQIA+*" would seem authentic so we used more specific identity labels of queer and trans. We chose queer because many LGBTQIA+ people use it as an inclusive term that encompasses a range of LGBTQIA+ identities, giving participants some freedom in how they interpreted this term[13]. We used the phrase "I think…" rather than use the Moller and Tischner phrasing, "Oh, my counsellor *is* fat!," because sexuality and gender identity are not necessarily readable from appearance and environments. It seemed more authentic to

[13] Although as Serano (2024) argues, the term queer in practices often privileges white, cisgender gay men. We also acknowledge that this term has a complex history due to its use as a slur against LGBTQIA+ communities and some people may experience this term differently.

suggest they might be queer/trans rather than definitively presuming their identity, although this prompted some participants to provide explanations for this thought in their stories (refer below).

The stems left some details ambiguous so that participants had to "fill in the blanks" (Moller et al., 2021, p. 291). Participants were not given details about the client's difficulty in coping, the client's (in the therapist queer/trans stems) and therapist's (in the client queer/trans stems) gender or sexual identity, or the emotions surrounding the thought. This reflects the actuality of some initial therapy sessions where the therapist or client may not know the other's gender/sexual identity, unless specifically referred for something related to their gender/sexual identity or requesting a therapist with a particular gender/sexual identity. The lack of emotional description allowed the initial thought to be read as worry, surprise, confusion, delight or something else.

The dataset consisted of 87 stories from 46 individuals in which five participants wrote one story and 41 wrote two stories (20 therapist trans stories, 25 therapist queer, 23 client trans, 19 client queer). Stories ranged in length from two to 308 words, with a mean word length of 190, at the lower end of that reported in the literature (Clarke & Moller, 2023). In the wider SC literature there is no consensus around dataset size, with the number of completions in empirical research varying from 44 to over 1,000 (Moller et al., 2021). We reviewed the dataset when around 80 stories had been submitted and determined the dataset had sufficient "information power" (Malterud et al., 2016) to meaningfully address our research question.

Ethical approval for this study was granted by the Psychology Ethics Committee at our university and the British Psychological Society's Code of Human Research Ethics (2021) was followed throughout the research.

Analytic Process

The data were analysed using the six-phase process of reflexive thematic analysis (TA), an organic and recursive analytic approach that focuses on patterned meaning and, in this instance, sociocultural discourses (Braun & Clarke, 2022). Despite having six distinct phases, the recursive and flexible nature of reflexive TA allows back and forth movement between phases for deeper interpretation. The FA led the analytic process with the SA acting as a "critical friend" (Smith & McGannon, 2017)—offering critical feedback on the FA's developing interpretations and encouraging reflexivity. The process began with dataset familiarisation, with both the FA and SA reading and making notes on the data and meeting to share observations. The FA then systematically coded the data, and clustered together codes to create initial themes. Through reviewing the initial themes and discussions with the SA, the following three themes were finalised to make sense of the data's complexities: 1) Disclosure in therapy is important for the therapeutic relationship and the client; 2) Effective therapists are non-judgemental and inclusive; and 3) Shared identity matters. Spelling and minor punctuation and grammatical errors in the illustrative data extracts have been corrected to aid readability. Data extracts are tagged with the following information: the participant number, whether the client or therapist in the stem is thought to be queer or trans; if the participant identified as LGBTQIA+ and/or was a qualified or trainee music therapist; NDD indicates the participant provided no demographic data. For example, LGBTQIA+CT refers to the *Chris* stem where the music therapist thinks "oh my (C)lient is (T)rans" and the participant identified as LGBTQIA+. Refer to Table 2.

Table 2. Data Extract Code Key.

02…	Participant number
TQ	Therapist Queer story stem
TT	Therapist Trans story stem
CQ	Client Queer story stem
CT	Client Trans story stem
MT	Participant is a music therapist (qualified or training)
LGBTQIA+	Participant identified as LGBTQIA+

Analysis

Before reporting the themes, we contextualise them in relation to some of the key characteristics of the stories. In 16 of the 45 trans/queer therapist stems, the client was also depicted as definitively or potentially trans or queer. In three of the 42 trans/queer client stems, the therapist was also potentially LGBTQIA+ or had a trans or queer child. In stories when the client was either described as potentially trans in the story stem or introduced as trans in the stories, the reason for seeking therapy, if mentioned, typically related to social marginalisation of the trans experience. This included general references to "trans issues" (05CTMT) and more specific references to questioning gender, experiencing transphobia or internalised transphobia (Bockting, 2015), gender reassignment, and gender dysphoria. In stories where the client was either described as potentially queer in the story stem or introduced as queer in the stories, the overwhelming reason for seeking therapy, when mentioned, was questioning their sexuality or gender identity. One story mentioned difficulty navigating acceptance of homosexuality due to the client's family's religious and cultural beliefs. Most of these responses were written by music therapists, which suggests a basic level of familiarity with LGBTQIA+ concerns among the music therapist participants. At the same time, this also reflects an assumption that a queer/trans client's sexual/gender identity is the cause of their presenting issues (Shelton & Delgado-Romero, 2011); not an assumption typically made by the LGBTQIA+ participants, nor reflective of the literature on the therapy experiences of LGBT clients (e.g., "sexual orientation/gender identity" was the fourth most common presenting concern in Israel et al., 2008).

As noted, using the wording "oh I think…" prompted participants to offer reasons for this thought in around a third of the stories. The most common reason was related to the notion that trans and queer people are potentially identifiable through visual signifiers. Queer identities were portrayed as visible mainly through adornment (e.g., clothes and hairstyles), and trans identities as visible through adornment and the physical (unadorned) body, and particularly through the perceived misalignment of a person's gender expression and physical secondary sex characteristics:

> *The therapist is making an assumption based on seeing a feminine appearance with what they perceive as masculine traits (i.e., Adams Apple, facial stubble). (02CTMTLGBTQIA+)*

> *The music therapist was trying to analyse the pitch of Charlie's voice, whether it matched her initial theory of thinking they are trans. Charlie sits down and the music therapist looks closely, almost analysing Charlie's clothes and hairstyle. (07CTMT)*

> *They also noted the therapist's brightly coloured short hair, tattooed arms and edgy but professional*

> *fashion style. Francis noted that her style reminded them of some of their queer friends and thought maybe my therapist is queer too. (04TQLGBTQIA+)*

Trans therapists/clients were mostly depicted as trans women or transfeminine individuals, reflecting the visibility of trans women in the wider culture[14] (Alabanza, 2022; Faye, 2021). Some stories described the trans individual as non-binary, but none depicted them as trans men or transmasculine individuals. Most music therapists explained the thought that the client/therapist is trans/queer in terms of adornment and the physical body; as did some LGBTQIA+ participants, but the latter also mentioned other reasons for the thought including—in therapist stems—room decoration:

> In the room, the trans flag was hanging on the wall. The therapist enters the room and sees Jamie looking. "I hang the flag so clients of all backgrounds feel welcome" they said, beaming. (18TTLGBTQIA+)

Other reasons included, in therapist stems, the therapist's use of queer music ("songs by known queer icons," 02TQLGBTQIA+MT), their behaviour/attitude, and knowledge, and in client stems, seeing the client being dropped off by their same-gender partner, a different name listed on the referral and the therapist having a largely trans/queer client base. This suggests that LGBTQIA+ participants have access to a wider range of cues associated with gender and sexual identity markers.

Room decoration and other visual signifiers of LGBTQIA+ identities/allyship were not typically mentioned in the trans/queer client stories. Clients in these stories did not question the identity of their therapist and were sometimes depicted as feeling uncertain about whether they could safely discuss gender and sexuality (refer below).

In the stories that included visual signifiers such as "pride lanyards," "pride flag mugs," LGBTQIA+ themed posters, pride and LGBTQIA+ flags, and photos of same-gender partners, these were portrayed mostly by LGBTQIA+ participants as one of the ways LGBTQIA+ concerns were brought into the therapy room and as communicating that queerness/transness belonged in the therapy space (echoing existing research with LGBTQIA+ psychotherapy clients, Berke et al., 2016; Israel, 2008). The use and display of such visual signifiers can be regarded as non-verbal, but deliberate, disclosures (Harris, 2019) (the type of disclosures that cisgender and straight therapists often engage in without deliberation). This brings us to the first theme of the importance of disclosure to the therapeutic relationship and the client.

Theme 1: Disclosure in Therapy is Important for the Therapeutic Relationship and the Client

Around half of the stories explored the disclosure of gender and sexual identity and how this impacted the therapeutic relationship and the client. Both the act of disclosure and the absence of disclosure were depicted as meaningful, and as a source of strong emotions—anxiety, fear, confusion, curiosity and relief. When the client was trans/queer, they were sometimes depicted by LGBTQIA+ participants as anxious and vulnerable regarding the disclosure of their gender or sexual identity (to a presumed cisgender, straight therapist):

> *Chris… is afraid of the music therapists' perceptions… thinking the music therapist will make judgements before anything is said… Chris is thinking of stopping therapy. They haven't felt comfortable to discuss the ins and outs of their gender and sexuality with the music therapist, for fear of how it is received. (25CQMTLGBTQIA+)*

[14] This visibility isn't of course inherently positive (Serano, 2024).

> Chris suspects that this [the therapist thinking they are queer] might happen, as they're aware they can be visibly recognisable as queer. Chris hopes that this doesn't have a negative impact on the music therapy sessions. (33CQLGBTQIA+)

In participant 25's story the "music therapist gives very little away of what they think, or even of themselves as a person" but Chris sees them at a pride parade, when Chris eventually mentions this in therapy "a tension in the room" was broken and "the course of treatment changes direction" suggesting the benefits of disclosure. Client disclosure was generally portrayed as benefitting the client and the therapeutic relationship, and the response from the therapist was often LGBTQIA+ affirming:

> *The therapist looks back at Alex and smiles. "It's great that you've been able to share that with me. Thank you." (20TQMT)*

There was also a clear sense from both music therapy and LGBTQIA+ participants that client disclosure and any discussion of gender/sexual identity should be client-led, reflecting both the principles of person-centred counselling and the valuing of self-determination of disclosure in the LGBTQIA+ community:

> *The therapist notices this assumption, and tries to not take this for granted. They let Chris lead the session and do not mention anything around this, as it is for Chris to decide what to bring to the session. (03CQMT)*

Therapist disclosure—particularly in stories written by music therapists—was portrayed in various ways, reflecting different stances on therapist disclosure in the psychotherapy literature. For example, in some stories, the therapist disclosed readily when asked directly by the client:

> *Alex asks the therapist, "Are you queer by any chance?" The therapist says "Yes, I am actually." (20TQMT)*

This representation of therapist disclosure reflects discussions in queer music therapy and psychotherapy literature where therapist disclosure of gender/sexual identity is understood as increasing connection, trust, and rapport between the therapist and a trans/queer client (e.g., Ben-Aharon et al., 2022; Harris, 2019). This understanding of therapist disclosure moves away from overly rigid boundaries that can contribute to power imbalances in the therapist-client relationship towards feminist and queer positions of shared vulnerability and power (Harris, 2019; Liboro & Lee, 2022; Swanson, 2022). Therapist disclosure was also depicted as role modelling self-acceptance and normalising trans/queer identities for the trans/queer client (Harris, 2015), and in a few stories, therapist disclosure prompted client disclosure:

> *Jamie told Alex [the client] he was gay and had a partner Gerald for 10 years, was happy, Alex blurted out "I've never told anyone but I am a closet gay," he appeared relieved. (41TQLGBTQIA+)*

In another story, the client's feelings about the therapist's sexuality are—eventually—productively addressed, but the therapist avoids self-disclosure:

> *After two sessions, Alex shares that their best friend is queer in the hope that this may enable a conversation to take place between the therapist and Alex. The therapist still does not give anything away about their own personal identity and this frustrates Alex. They do not feel that they can outright ask the therapist and this clouds Alex's experience of music therapy—they are not able to fully immerse themselves in the sessions and Alex finds that the therapy is not helping them to juggle the struggles they are having in their life. Alex retreats into a silent space in sessions each week—they become immersed in the music, and Alex finds solace in this, where they don't have to interact*

> *or look at the therapist. However, there is a lack of honesty in the session, and the therapist is interested in why Alex is so withdrawn and shows no interest in interacting with them. Alex calls the therapist a liar. When the therapist asks Alex to explain this, Alex says that they think they the therapist is queer but they are upset that the therapist will not say anything. The atmosphere in the room is instantly better, as the "issue" has been aired. The therapist discusses with Alex why it is so important to them, although still does not say whether they are queer or not. (10TQMT)*

This story presents self-disclosure as a barrier to objectivity (Ben-Aharon et al., 2022). This story also illustrates the way non-disclosure of a presumed trans/queer identity becomes a barrier to the therapeutic relationship, with issues of trust and safety, until, in some stories, it is addressed, or there is *eventually* disclosure. In stories written by LGBTQIA+ participants, the client was sometimes depicted as wanting to know definitively if the therapist was trans/queer but unsure if it was appropriate to ask, perhaps reflecting this group of participants' uncertainty about the "rules" of therapy:

> *Jamie is unsure about the rules around what the therapist can or should disclose about her personal life. (19TTLGBTQIA+)*

Some stories written by both music therapist and LGBTQIA+ participants minimised the significance of queerness to the therapeutic space, either suggesting queerness isn't relevant to therapy, or that, in the case of trans/queer clients, the therapeutic approach should be the same as it is for all clients:

> *This shouldn't make a difference to the quality of support that the therapist should provide. (15CQLGBTQIA+)*

> *It is important that the therapist remains neutral and asks the right questions to ensure Chris is comfortable. (46CQLGBTQIA+)*

> *They then continue with their session.* (12TTMT)

A few stories didn't mention gender/sexual identity[15] at all—this is what SC researchers describe as story "refusal,"[16] where the participants effectively "refuse" to engage with the topic of interest to the researcher (Clarke & Moller, 2023). In stories written by LGBTQIA+ participants, the underlying assumption seemed to be that trans/queer clients were at risk of experiencing transphobia/homophobia in therapy[17], so the "no difference" framing was about ethical imperatives for fairness and equal treatment. Whereas "refusal" stories and the framing of participant 12's story arguably reflects an oppression-evasive discourse, which serves to deny the experiential and material consequences of social difference and marginalisation (Hadley & Norris, 2016; Leonard, 2020).

[15] This was the entirety of the completion, which frames the thought about the therapist as irrelevant to the therapy.

[16] We use inverted commas around "refusal" to problematise the assumptions underpinning this term—one that belongs more to an essentialist story completion tradition where the focus is on the psychology of the story writers (Moller et al., 2021). The term refusal can be viewed as an assertion of the authority of the researcher—the participant has problematically refused to "comply"—rather than acknowledging the agency and creativity of participants. The term can also imply that participants have failed in their task, whereas from our perspective all data are meaningful and "refusal" stories are included in our analysis for this reason.

[17] This worry and distrust of disclosing identity and of experiencing transphobia and homophobia in the data can be contextualised within the complex historic relationship between psychotherapy and LGBTQIA+ people, including the pathologisation of LGBTQIA+ identities, conversion therapies, and the role that therapists continue to play as gatekeepers for medical transitions (Faye, 2021).

In some stories, after the client discloses, the (typically trans/queer) therapist signposted the client to another therapist or organisation. For instance, in participant 41's story quoted above, after Alex the client comes out, the therapist Jamie responds as follows:

> *Jamie told him he would advise him [the client] to talk to a counsellor and gave him details and told him, "let's get you back into the guitar." (41TQLGBTQIA+)*

The extract from participant 10's story quoted above immediately follows with the client coming out and being referred elsewhere by the therapist:

> *Alex explains that they just want to meet queer people as they are really struggling with not knowing how they identify. The therapist points Alex in the direction of a charity where Alex can ask questions and meet others who are exploring their own identity. (10TQMT)*

Referring the client elsewhere suggests that although music therapy can be a space to share trans/queer identities, it is not a suitable space for these identities to be explored.

Finally, in a few stories, the trans/queer individual in the story was overtly invalidated. For instance, in the following story, Alex, the client and hospital inpatient, is talking to James, the music therapist, about their experience with Emily, the matron. Alex then asks James about their pronouns:

> "You know Emily, the Les?" Alex watched [the therapist's] reaction closely. "The matron?" "Yeah, her. Forced pills down my throat this morning with the rest of the pricks working here… So, when I'm talking about therapy later, how should I refer to you?" "You can refer to me as James." "Yeah but, if your name's James, you're a guy, right?" "Ideally, I'd prefer to be referred to as they, but I appreciate you asking. Getting back to you now, because this is your space…" Alex slid his chair back across the floor hastily, letting out a guffaw, heading towards the door. "I need a smoke." (42TQMT)

Despite Emily's lesbian identity having no relevance to the context or what is consequently discussed, for Alex it is a "master status" (Becker, 1963), an aspect of identity perceived to override others and define the person. Viewing queer identities as a master status can be a hostile act, and in this story, it creates a challenging environment for James to be authentic and disclose their non-binary identity. Alex's laughter and decision to leave the room (which is where the story ends) can be read as a negative response to James's disclosure of their identity, fracturing their current therapeutic relationship.

Theme 2: Effective Therapists are Non-Judgemental and Inclusive

Across the dataset, therapists were predominantly portrayed as effective in supporting a trans or queer client. Both music therapist and LGBTQIA+ participants presented an effective therapist as one who followed general therapeutic techniques such as "listening openly" (05CTMT), being "open minded" (10CTMT), questioning and reflecting on their assumptions and feelings and having a non-judgemental approach. Some stories included therapists who enabled clients to feel safe(r) and explore their identity in the therapeutic space. A few stories depicted ineffective therapists as having a lack of self-reflection or holding anti-LGBTQIA+ views.

An effective therapist was characterised as being aware of their views and feelings towards a trans/queer person, reflecting on their assumptions and not assuming they are correct, or allowing them to "cloud their clarity of thinking" (10CTMT), and using an open, non-judgemental, and person-centred approach:

> *The therapist does not make a statement or say anything about their thought. They try to keep a neutral attitude in the beginning, as they do with every client. By getting to know each other and*

> *according to their musical interactions, then the client might feel comfortable sharing their queer identity. But the therapist cannot make assumptions from the beginning as it is unethical, they need to let the client reveal their identity at their own pace. (36CQMTLGBTQIA+)*

This approach seems consistent with a psychodynamic stance where any assumptions or wondering about the client might be withheld in order to allow space for the client to reveal aspects of themselves in their own time (Alanne, 2023; Bruscia, 2014; De Backer & Sutton, 2014). The wording "cannot make assumptions… it is unethical" in LGBTQIA+ participant 36's story reflects the wording of stories written by LGBTQIA+ participants in the previous theme, which seemed to acknowledge a risk of experiencing transphobia/homophobia in therapy, and communicate ethical imperatives for fairness and an approach that meets the needs of LGBTQIA+ clients. In a few stories by LGBTQIA+ participants, the therapist has lots of experience of working with queer/trans clients, but in others—mostly written by music therapists—they feel unprepared for and anxious about working with a trans/queer client, and saying the wrong thing, but nonetheless endeavour to be an effective therapist:

> *The music therapist recognises in herself a familiar feeling: that she is not quite as prepared for this moment [as] she would like to be… She looks at her client with empathy, and also feels a sense of not wanting to label or pigeon hole them. (20CTMT)*

> *The music therapist is cisgender, so immediately wonders if she will be able to fully understand the ways in which Charlie has been finding it difficult to cope with life (if Charlie is trans and they relate to trans issues). The therapist internally acknowledges her anxiety, and resolves to listen openly and fully to Charlie. (05CTMT)*

A few stories written predominantly by LGBTQIA+ participants, including LGBTQIA+ music therapists, portrayed the music therapist not just as open-minded and nonjudgemental but also as engaging in some of the practices associated with LGBTQIA+ affirmative therapy (Whitehead-Pleaux et al., 2012). In these stories, the therapist actively used gender neutral and inclusive language and created a queer safe(r) space that acknowledged that "normative" or heteronormative spaces may not feel safe for queer people (Rowe, 2022). Inclusive therapists were also presented as engaging in self-education and development:

> *The therapist decides to contact a charity[18] where they are able to ask questions, and explore their own attitude and opinion, so that their own thoughts do not cloud Charlie's experience of music therapy. (10CTNDD)*

> *Something the therapist knows she can proactively do in the sessions, regardless of what Chris says, is keep her language open and inclusive, not exclusively drawing on heteronormative archetypes. Furthermore, she resolves to expand her understanding of queer experiences, by researching and reading reports, theory and novels from queer perspectives, so she has a good understanding of the identity groups which Chris may belong to. (19CQLGBTQIA+)*

The therapist asking the client for their pronouns was a way for therapists to pro-actively communicate that the therapy room was a safe(r) and inclusive space in some stories:

> *The music therapist makes no assumption about the gender or identity of the client, but does immediately ask the client's preferred pronouns[19], as they do with anyone. (13CTMTLGBTQIA+)*

Participant 13 portrayed this as universal effective practice, rather than one reserved for

[18] For North American readers, in the UK the term charity is used instead of non-profit.

[19] We note that "preferred pronouns" is dated and problematic terminology.

potentially trans/queer clients. Many trans and queer clients report having to spend time educating their therapist about their experiences; the need to educate therapists may discourage people from seeking therapeutic support (Rowe, 2022). The idea that therapists should be responsible for educating themselves on stigmatised communities and cultures, has been present in anti-oppressive music therapy for the last decade (Baines, 2013; Rowe, 2022; Scrine, 2022).

LGBTQIA+ affirming therapists were also depicted as thinking about the integration of queerness within a person's identity as well as systemic oppression:

> Being trans is one part of their identity, but not all of it, and may not be the reason for their referral to music therapy… If society had accepted them for who they were, would they have had any need to come to the sessions? (20CTMT)

Here, the therapist does not assume the client's trans identity to be a "master status" (Becker, 1963). The suggestion in this story is that it is important to have awareness of trans/queer identities without presuming that this is the reason for referral to therapy.

Some stories depicted ineffective therapeutic practice, as some therapists made mistakes and were unprepared, but few therapists were portrayed as irredeemably ineffective. Ineffective therapeutic practice was characterised by a lack of reflection after making assumptions about the client's trans or queer identity. In the following extract, the therapist makes assumptions about the client and becomes fixated upon them. After a few sessions, the therapist does not feel they have been making any progress and finally reflects on how they have been thinking within sessions:

> *The therapist finds themselves distracted from what Charlie is bringing and presumes they must have issues with their gender identity. The therapist feels out of their depth and unsure how to work with this… The therapist reflects on their work and realised that they weren't really listening and had made presumptions about Charlie and why they were there. The therapist does some reading around therapy for transgender people and starts to understand that this might not be an issue for everyone and that it's easy to hone in on this. (26CTMT)*

Here, the therapist was initially unaware of their assumptions and how these were negatively affecting the client and therapeutic relationship. Self-reflection is understood as crucial in music therapy for therapists to become aware of their "unconscious biases, fears and motives that can negatively affect their clients" (Harris, 2022, p. 332).

The few portrayals in the dataset of ineffective therapists by both music therapist and LGBTQIA+ participants centred around religious beliefs and being "very conservative in thought" (23CQMT) and an awareness on the part of the therapist that they need to conceal their true feelings and thoughts and *perform* inclusivity and openness—for example, this story is written in the voice of the therapist:

> *I have to show Chris that I am open minded and LGBTQA+ friendly because of the law in the country and in order to get more clients from LGBTQA+ [community]. Though in reality I am a homophobic person who sees them as sinners and if I am not in desperate need for money, I would tell them that I don't have the capacity to work with them. (22CQLGBTQIA+)*

This dramatic portrayal of an ineffective therapist suggests that a therapist can professionally be open-minded and inclusive yet personally hold anti-LGBTQIA+ views. Some stories suggested that a client could potentially be affected by this "hidden" homophobia and transphobia through projection:

> *They wonder if they had not sought out a queer therapist, whether they would have been able to open up in the same way, and what unconscious prejudices they may have carried. (34TTLGBTQIA+)*

Several music therapy texts argue that music therapy is political and self-reflective in design and that therapists are responsible for making their "unconscious prejudices" conscious and unlearning them to avoid harm to their clients (Baines, 2013; Boggan et al., 2017; Dressler & Wilcoxen, 2022).

In summary, effective therapists were, or appeared to be, non-judgemental and inclusive. This was unsurprising, as the word inclusivity is often understood as a marker of effective practice in music therapy (Bain et al., 2016). Inclusivity goes further than being non-judgemental, instead it invites queerness into the room, rejects the idea that LGBTQIA+ individuals are defined by their vulnerability, and engages with the material realities that social oppression perpetuates (Bain et al., 2016; Harris, 2019; Scrine, 2022).

Theme 3: Shared Identity Matters

Many stories explored the therapist and client's shared or different gender and sexual identities and how this impacted the therapeutic relationship. Stories written by both music therapist and LGBTQIA+ participants depicted the therapeutic relationship as enhanced by shared identity through feelings of safety and being understood for trans/queer clients, with trans/queer therapists presented as "knowledgeable and empathetic" (02CTMT) about trans/queer concerns. The lack of a shared identity was mainly portrayed as overwhelming the therapeutic relationship and as a barrier.

Stories where the therapist was trans/queer often portrayed the client as (definitively or potentially) sharing a similar trans or queer identity. This was depicted as overwhelmingly positive from the client's perspective, with the client feeling understood and not having to educate the therapist or explain themselves as a result of similar experiences of "living in a heteronormative world" (45TQMTLGBTQIA+):

> *Awesome, someone who might get me. (17TQNDD)*

> *Jamie is relieved by the possibility that their therapist is trans—a trans woman… Some of the difficult thoughts and feelings that Jamie had been struggling with are connected to their gender identity… Jamie wondered that a therapist, if cisgender and heterosexual, might not sufficiently understand the trans non-binary experience in order to give Jamie the help they need. As such, Jamie is excited by the possibility that their therapist is trans. (19TTLGBTQIA+)*

> *Alex is from a background where identifying as LGBT or queer wasn't accepted, but being able to be around somebody that is proud, open, and comfortable about their sexuality and identity will help Alex deal with, or at least understand, some of their own issues with their sense of self. (32CTMTLGBTQIA+)*

The extract from participant 19's story highlights fears and anxieties depicted in some stories—on the part of both trans/queer clients and cisgender and straight therapists—around difference as a barrier to understanding. The latter extract portrays the LGBTQIA+ therapist as acting as a role model for a queer client, from a conservative background, coming to terms with their identity. The shared identity also created more comfort with the therapy and the feeling of a safe(r) space, where the client could be their authentic self with no fears around disclosure, and feel "more able to open up to the therapist" (45TQMTLGBTQIA+):

> I feel really safe here, like I can be myself. (20TQMT)

"Matching" or shared identities has been widely discussed within the psychotherapy literature (e.g., Cabral & Smith, 2011). In queer music therapy, shared identities are understood as mutually beneficial to the therapy (Trottier, 2019).

There were some stories that presented difference as creating opportunities to work

through negative assumptions and personal prejudices. For instance, in the following extract, the therapist responds to the client Jamie's concerns:

> *Jamie doesn't know how he is going to be able to talk to someone trans. He has never met a trans person before, and gets nervous around other people different from himself… Jamie is coming to the end of his course of therapy… He is afraid that he is not going to be able to understand people different than him still, and his music therapist reassures him. Music therapy is a rehearsal for life. You did it once, in here, without realising it would happen. There's no reason to think you can't do it again. (25TTMTLGBTQIA+)*

However, differing identities were mostly portrayed as creating difficulties with the therapeutic relationship. The trans/queer client felt as though they would not be understood which was mirrored by—as noted in theme 2—some therapists depicted as having good intentions but feeling out of their depth, anxious and ill-prepared to work with a trans or queer client:

> *The therapist feels out of their depth and unsure how to work with this… The client has come to therapy for their anxiety and depression and feels like the therapist doesn't get it. The therapeutic relationship doesn't develop and Charlie stops attending. (26CTMT)*

> *On her two-year masters training, gender identity was never mentioned, let alone discussed. (20CTMT)*

This reflects research showing that many music therapists do not feel as though the training they received sufficiently prepared them for working with the LGBTQIA+ community (Whitehead-Pleaux et al., 2013). One story portrayed a disparity in perception—with difference as a barrier for the queer client but not the straight music therapist:

> *It was important to the therapist that Chris felt comfortable to talk about themselves and although the therapist isn't queer themselves, felt they could make Chris feel safe. But from Chris's perspective they were not so sure and felt the therapist wouldn't necessarily understand them. (34CQLGBTQIA+)*

This story reflects the idea that a therapist may have limited insights, and their world view may be clouded by heteronormativity. This suggests some limitations of the person-centred approach (Moodley et al., 2004). Such an approach can contribute to an inclusivity façade through normative assumptions, overlooking a straight or cisgender therapist's need for self-development and reflection on social privilege, the intersectionality of oppression, and unconscious prejudices (Dressler & Wilcoxen, 2022).

Difference as a barrier was also portrayed through the non-trans/queer character becoming fixated on the other character's trans/queer identity and physical body and disengaging from the therapy:

> *Jamie… could not really listen to the therapist as all he could focus on was thinking if his therapist was trans or not. Jamie grew up in a very religious family and even though in school they learned about IT, Jamie could not stop the feeling… He was so curiously analysing the geometry of those cheekbones. Jamie felt terrible, but at the same time he was so intrigued. (01TTMT)*

The exaggerated tone of this extract emphasises the othering process that dominant culture forces onto queer and trans folk (Ben-Ahron et al., 2022). This story reflected tropes of queer and transness as exotified, otherworldly, and a performance to be watched (Ben-Ahron et al., 2022; Hardy, 2021; Scrine 2019).

Interestingly, a few therapist stories written by LGBTQIA+ participants depicted the client as recognising that trans and queer people's experiences can be difficult, and empathising with the therapist:

> *They also can't help but feel for their therapist with the amount of hate and scapegoating the trans community is facing right now and how it may or may not be impacting their life. It feels strange to say anything to them, as they don't know anything about [the therapist's] life, but [the client] hopes they are okay.* (*34TTLGBTQIA+*)

This creates a role reversal in which the therapist's "difficult life" (28TTLGBTQIA+) becomes the focus of the therapy. This is in line with public attitudes towards trans people: 16% of the public take "pity" on trans individuals (Morgan et al., 2020). Clients were also depicted as assuming that a trans/queer therapists would have "advanced empathy" (37TTLGBTQIA+) because of their lived experience of difference.

In summary, the stories suggest that shared identity matters in the therapeutic relationship by creating a safe(r) space and shared understanding. Although some stories portrayed differing identities as a strength, most portrayed them as a barrier. This difference in identity is more likely to be the norm within music therapy, as UK music therapists predominantly identify as heterosexual/straight (81.93% in Langford et al., 2020) and cisgender (98.63% in Langford et al., 2020).

Conclusions

As previously noted, in attempting to create an authentic stem, the wording "oh, I think my therapist/client is queer/trans," prompted some participants to provide reasons for that thought in their stories. This was revealing as it showed—perhaps unsurprisingly—that LGBTQIA+ participants had access to a wider range of cues for explaining a presumption of queerness/transness than (straight and cisgender) music therapists. However, we acknowledge the unintended parallels with the harmful social media practice of "transvestigating" (Webster, 2024). Transvestigating is characterised by social media users—typically those identifying as gender critical/anti-trans—referring to "apparent physiological cues of one's sex assigned at birth" (Webster, 2024) to support their belief that certain cisgender celebrities are really and secretly transgender.

The access to a wider range of gender/sexual identity cues was one of a number of notable differences between the stories written by music therapists and LGBTQIA+ participants. The stories written by music therapists echoed existing research in suggesting a mixed picture of music therapists' preparedness to work with LGBTQIA+ individuals and communities (e.g., Whitehead-Pleaux et al., 2013; Wilson & Geist, 2017), with some stories explicitly portraying the (straight or cisgender) therapist as feeling anxious and unprepared. The music therapists' stories reflected commitments to person-centered and, in some instances, psychodynamic principles and existing findings that music therapists define their practice with LGBTQIA+ clients as open and affirming (Whitehead-Pleaux et al., 2013; Wilson & Geist, 2017), while also evidencing the lack of knowledge and training about LGBTQIA+ communities identified in existing research (Ahessy, 2011; Whitehead-Pleaux et al., 2013; Wilson & Geist, 2017). For example, music therapists wrote stories in which the queer/trans client's reason for seeking therapy predominantly related to their sexuality/gender, not something reflected in existing research (e.g., Israel et al., 2008), and supporting Wilson and Geist (2017)'s finding that a significant number of music therapists lack familiarity with literature on LGBT communities.

A thread running through stories written by LGBTQIA+ participants was the recognition or fear that therapists can be hetero/cisnormative and at worst overtly homo/transphobic—these participants also wrote stories in which effective therapists were open

and inclusive but this was often framed in terms of an imperative—therapists *should* be open, *should* treat LGBTQIA+ clients the same as other clients. Unsurprisingly, overall, LGBTQIA+ participants also wrote stories suggesting a more in-depth and nuanced understanding of queerness and LGBTQIA+ communities than that of their cisgender and straight counterparts.

Shared identities and therapist disclosure of gender/sexual identity were generally perceived positively in stories written by LGBTQIA+ participants, mapping onto some existing research (Borden et al., 2010). These stories—written by non-music therapists—also indicated a lack of understanding of the "rules" of therapy around therapist self-disclosure. By contrast, stories written by music therapists evidenced both therapist non-disclosure and anti-oppressive critiques of non-disclosure (e.g., Harris, 2019; Liboro & Lee, 2022; Swanson, 2022). Of the music therapist participants, it tended to be the LGBTQIA+ participants whose stories evidenced more nuanced understandings of what LGBTQIA+ inclusive and affirmative practice might entail.

The internal questioning of the other character's identity on the part of the protagonist often overwhelmed the narrative and meant that some stories focused on explaining why this assumption was made rather than exploring what happened between the therapist and the client. In Moller and Tischner's (2019) fat therapist study, their stories similarly often focused on the protagonist's inner monologue, but this provided useful stories of uncensored overt negative perceptions. The negativity in our stories was typically more subtle. For example, the depiction of the trans characters predominantly as trans women, reflects the visibility of trans women in the wider culture and does not reflect the diversity of trans individuals, suggesting participants' imaginings of a trans character were shaped by dominant understandings. Participants mostly interpreted the term "queer" in terms of gay and gender-nonconforming identities—perhaps reflecting the predominance of white gay men and trans women in the wider culture. To specifically explore perceptions of other LGBTQIA+ identities in therapy using SC, stems may need to direct participants to focus on particular identities.

Likewise, we had hoped participants might bring in other aspects of identity—such as race/ethnicity, non/disability and age—to their stories, but the predominant focus was solely on trans and queer identities. Our use of typical Anglo/western—if gender neutral names—likely contributed to this to a lack of focus on race/ethnicity. Again, participants may need to be specifically prompted to focus on other aspects of identity. It is also important to acknowledge that data were sourced from white UK participants, which produced a predominantly westernised perspective on therapy and queer identities.

TA and particularly reflexive TA are commonly used to analyse SC data (Braun et al., 2025)—our use of reflexive TA conforms to what Clarke et al. (2017) describe as a "horizontal" approach, developing and reporting patterning across the dataset, in much the same way as researchers do when using TA to analyse interview or focus group data. Clarke et al. (2017) also highlight the possibility of a "vertical" approach to the analysis of SC data, where something of the storied character of the data is retained in the analysis, arguably fully realising the potential of SC data. In a vertical approach, the analytic focus is on patterning in how, for instance, the stories are structured and temporally organised, the (moral) resolution, and how the protagonist is portrayed. For example, in their SC research on constructions of male body hair depilation, Clarke and Braun (2019) developed what they call a "story mapping" analytic technique, exploring recurrent patterning in the construction of the protagonist, the main story "events," and the temporal sequencing and resolution of the stories. This technique requires homogeneity in story structure and events, which was not evident in our dataset. Narrative approaches—which *can* incorporate aspects of both "vertical" and "horizontal" into analysis—are perhaps obvious choice for analysing qualitative SC data. Yet to date only a few papers have used narrative approaches (e.g., Timpka et al., 2021; Williams et al., 2021). The exploration

and development of narrative approaches to SC data is then a fruitful area for future research.

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