A Critical Analysis of the Lived Experience of Music Therapists in Clinical Relationship

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Abstract

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This dissertation endeavors to explore and describe the lived experience of music therapists' relationships with their clients as it develops in individual music therapy sessions. Music therapy literature, reviewed with particular attention to its treatment of the psychodynamic conceptualization of clinical relationship, suggests a shaky marriage between music therapy and psychoanalytic thought, and the experience of the music therapist in this landscape has not been studied. As its data, this study relies on semi-structured interviews with 7 music therapist volunteers who provide individual music therapy, focusing on their experience of emotion, interpersonal connection with their patients, and utility of psychodynamic concepts in that work. Idiographic and nomothetic analysis revealed 4 common themes in music therapists' experience of clinical relationship, which belie an underlying sense of confusion and anxiety about important aspects of the work. The discussion of findings examines these themes in the context of the powerful impact music can have on the psyche, and makes recommendations regarding the inclusion of psychodynamic concepts in music therapy training.

Keywords: music therapy, relationship, psychoanalysis, transference, countertransference, projective identification, boundaries

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The style used throughout this dissertation is in accordance with the Publication Manual of the American Psychological Association (6th Edition, 2010), and Pacifica Graduate Institute's Dissertation Handbook (2015-2016).

Chapter 1

Introduction

Music therapy and depth psychotherapy are two disciplines with areas of overlap that are at once obvious and difficult to discern. Depth psychotherapists, concerned with the psyche and its diverse and creative ways of expressing itself, have long been interested in music and have published various thoughts about its meaning and potential use in the consultation room (Freud, 1901/1960; Moore, 2000; Reik, 1960). Music therapists, studied in music processes and the inter- and intrapersonal qualities of music, developed the area of practice known as "music psychotherapy," in which many principles of depth psychological theory, including transference, countertransference, projective identification, and resistance are acknowledged (Austin, 2008; Bruscia, 1998a, 1998b; Priestley, 1994). But despite a well-developed understanding that transference and countertransference are inexorable elements of a music psychotherapy process, the discipline has surprisingly limited discourse on more contemporary and depth-oriented understandings of the therapeutic relationship and the intersubjective field. Music therapists who discover themselves having strong emotional reactions to their patients have very few directions in which to turn for clinical guidance and support.

Depth psychotherapy certainly has something to offer to the field of music therapy; there are notable points of congruence between the two fields. Music therapists employ diverse aspects of music experience as part of their work with patients, which for some aligns with depth psychotherapy goals, including self-awareness, resolution of internal conflicts, and/or expression of unconscious affects or fantasies. The music therapy process can be a deeply relational way of working and being with patients, in

which the music becomes a third presence in the room, creating a kind of triangle of relating. The music may be present in the form of active music-making, including pre-composed or improvised music using voices or instruments, or in a listening process with recorded music. The evocative qualities of music are ever-present in a music therapy session, and when combined with the subjectivities, fantasies, and affects of both patient and therapist a truly fertile ground for treatment can be created. But arguably, the creation of such a fertile ground is also contingent on music therapists having a lens through which to understand and process what is happening within that intersubjective field.

If popular and mainstream news sources define our culture's understanding of the meaning of terms, the phrase "music therapy" can refer to anything from picking the right workout music to neurobiologists' study of how music impacts the brain to pop stars visiting and performing in prisons, hospitals, or homeless shelters. This paper is studying music therapy the professional practice, which includes particular undergraduate, graduate, and doctoral programs of study, demands field work, internship, and continuing education requirements, has its own research and clinical practice journals, and is overseen by its credentialing board. Music therapists are musicians—training programs require auditions before admission—who focus specifically on the ways that music connects humans to each other and to themselves, usually with the intention of facilitating some kind of healing.

Yet, the answer to the question "What is music therapy?" has been difficult to determine, even within the field of music therapy itself. In the third edition of his text *Defining Music Therapy* (2014), Bruscia lists over one hundred definitions of music therapy, as cited by various authors, sources, and organizations around the world and

through several decades, including six he penned himself. Bruscia's most current working definition is as follows:

> Music therapy is a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research. (p. 95)

It is hard to be more descriptive about the field of music therapy and "what" it is in practice. As Bruscia also notes, the field has great diversity in clinical practice in terms of setting and client population. He states, "Goals may be educational, recreational, rehabilitative, preventive, or psychotherapeutic, focusing on the physical, emotional, intellectual, social, or spiritual needs of the client" (p. 60). Within the United States, where there are approximately seventy music therapy university programs, music therapy students may study and practice at the baccalaureate, masters, or doctoral level, with diverse philosophies and clinical orientations, and in a diverse range of treatment settings ranging from prisons to nursing homes to public schools to psychiatric hospitals and beyond.

In some ways this diversity of practice is similar to psychologists, although there are some unique elements to music therapy practice. DeBacker and Sutton (2014a) noted that music therapy seems to be especially effective with those who are unable to participate in verbal therapy. Di Franco (2003) notes that music therapists sometimes work with individuals who "do not have direct consciousness of therapy as therapy" (p. 76). Bruscia (2014) feels that what differentiates music therapy from all other modalities

are the combined elements of "sound, beauty, creativity, and relationship" (p. 117). The therapist's identity as a musician is also part of what defines the work, and makes music therapy different from other modalities. As Nolan (2003) notes, "The music therapist has been a musician for a great deal of his/her life and has developed sensitivities and intelligences pertaining to musical expression and communication" (p. 322).

Bruscia (2014) attempts to describe and delineate differing aspects of music therapy practice by describing various elements that come into consideration for the music therapist. He mentions the distinction between "music as therapy" and "music in therapy" (p. 110): The former places music itself in the foreground of the therapeutic encounter, and the interpersonal relationship with the therapist and other aspects of treatment in the background, and the latter puts the therapeutic relationship in the foreground and the music in the background. The music in a music therapy session may be improvised music played by therapist alone or therapist and client together; it may involve the live recreation of familiar music (by therapist, client[s], or both together); or it may involve listening to recorded music. There are many iterations of how music is utilized between client and therapist, but its central presence is part of what defines music therapy practice. "In music therapy, the process of solving 'musical problems' is conceived as similar to the process of resolving 'life problems,' and the skills learned through finding musical resolutions are believed to generalize to life situations" (Bruscia, 2014, p. 120).

The degree of connection between music therapy and depth psychology varies across the field of music therapy. The music therapy literature reflects a continuum among practitioners and theorists, from those who disavow psychological concepts to

those who encourage the use of depth psychological constructs and techniques in music therapy treatment. Because this research focuses on relationship, it is necessary to focus on the literature of the latter group, sometimes known as music psychotherapists, who think of themselves as working "in depth" in ways that are parallel to depth psychotherapists. Many of these music therapists have written about transference and countertransference and how they manifest in the music therapy clinical relationship. Because music therapy practice is sometimes proceduralized into specific types of interventions (instrumental improvisation, songwriting, vocal improvisation, listening to recorded music, guided imagery and music), the music therapy literature includes discussions of how transferential phenomena might appear in these specific interventional processes (see Austin, 1998; Diaz de Chumaceiro, 1998; Nolan, 1998; Turry, 1998). Additionally, music therapy theorists have discussed the role of aesthetics in countertransference (LeCourt, 1998) and client and therapist resistance in music therapy (Austin & Dvorkin, 1998).

The ways that transference and countertransference manifest musically, through the sounds that the client and therapist each create, is also an interesting topic of study that is unique to the music therapy literature (Priestley, 1994; Scheiby, 1998; Turry, 1998). Music therapists who work in this manner explore the varied ways in which therapeutic dynamics are expressed in or as music. The specific role of music in therapeutic dynamics, however, is not a focus of this paper, which is designed to concentrate more on interpersonal dynamics, understood with a psychodynamic and psychoanalytic lens, that exist between patient and music therapist.

There are music therapists who argue that transference and countertransference are not relevant concepts to the music therapy relationship, perhaps trying to distance themselves from psychoanalysis. Turry (1998) notes that some clinicians feel that transference and countertransference "minimize the importance of the aesthetic power of music and the musical interaction, placing an artificial barrier between the music makers" (p. 163). Psychotherapists who have experienced the level of interpersonal depth that can be attained when examining transferential phenomena with their patients might wonder whether the music therapists who argue this position are sufficiently educated on these concepts. On the other hand, music therapy theorists outside of the music psychotherapy realm will present their understanding of music therapy work to readers without any acknowledgment of relationship dynamics, much less any utilization of the terms *transference* and *countertransference* (Thaut, 2005). This perspective could certainly be problematic from a depth psychology perspective, although it is quite common in the field. At conferences, in supervision sessions, and on social media, I have observed that many music therapists demonstrate little understanding of what these concepts mean and what their application might be to clinical practice.

There do seem to be some general differences between the perspective of music therapists in the United States and of those abroad, particularly in Europe. American music therapists tend to treat psychodynamic concepts in somewhat reductionistic ways, if they acknowledge them at all, whereas music therapists abroad seem to have a more depthful understanding of psychodynamics and therapeutic relationship. Hornstein (1992) documents the process of introducing European psychoanalytic thought to American psychology, starting in 1909, and notes that psychology in the United States

was firmly focused on experimentalism and hopes to be treated like a hard science. She notes:

> What united experimental psychologists more than anything else was a distrust of personal experience, a sense that feelings in particular were dangerous and had to be held carefully in check lest they flood in and destroy the very foundations of the work. They were willing to make a number of sacrifices to protect psychology from this threat, including a radical narrowing of the field to include only phenomena that could be studied "objectively." (p. 256)

Eventually, American psychologists began to rename psychoanalytic concepts in behavioral terms. This spirit of positivism, and of attempts to control and quantify concepts related to the unconscious, seems to live on in music therapy in the United States just as it does in psychology.

Researcher's Call to the Topic

For me, music has always been relational. When I was a young child, my father was a public school music teacher and community musician who loved jazz and played the vibes. My mother had a deep appreciation for popular music and introduced my sister and me to her favorite music, to which the three of us would sing and dance around the living room. When I was 5 years old, my family purchased an upright piano. I took formal lessons, but my most powerful learning about music occurred as my father and I sat behind the piano together, playing duets, singing, and, once he taught me to improvise, jamming over jazz changes for hours. Music was the most powerful way of relating and experiencing love that existed in my childhood.

I decided that my future career would be in psychotherapy when I was 10 years old, after reading *I Never Promised You a Rose Garden,* Joanne Greenberg's (1964) fictionalized account of her own psychotic break and inpatient treatment with Freida Fromm-Reichmann. When I learned about music therapy 4 years later, it seemed like a perfect combination of my interests and aptitudes. Later, as I trained in undergraduate and graduate classes and clinical work, I felt, on as deep a level as I've felt anything, the power of music as relationship. I had never been comfortable as a music performer, but making music in relationship was sublime, profound, and often ineffable. I saw how, with the music between us, I could help a patient access feelings and fantasies that had been locked inside them. As a music therapist working with medically ill patients and their families, I approached sessions with my guitar, my singing voice, my knowledge of popular and classical music, and my identity as a musician-artist-therapist along with all of my clinical skills, instincts, and knowledge. Frequently I engaged patients in identifying meaningful music—music that I/we would improvise on the fly, or familiar songs that I/we would bring alive with guitar and voice—and as we engaged in the music together I would companion and gently guide patients toward emotions and other unconscious material that was relevant to their journey. Music often had a capacity to hold emotions and fantasies that were too frightening to acknowledge outright, and as a music therapist I companioned people as they got closer to themselves. It was extremely moving and meaningful work.

Music in this context has continued to be an area where I feel immense passion and inspiration, but as I have matured within the field of music therapy I have found myself disappointed by the limited understandings of psychological depth within the

field's discourse. I have been disheartened by the voices within the music therapy field that strive to reduce music to a biomedical stimulus, devoid of relational qualities (see Thaut, 2005). But even in examining the literature of music psychotherapy, the branch of music therapy that does acknowledge relational aspects of the work, I have been disappointed. In my own clinical experience I have noted a more present and central experience of the transferential field than music therapy literature and graduate education seem to acknowledge, and in clinical discussions with music therapy colleagues I've been astounded by how disempowered music therapists feel to acknowledge their own emotional experiences within their relationships with their patients.

It was this disillusionment that led me to pursue my doctorate in depth psychotherapy, to find a clinical "home" where I could locate guidance, understanding, and a reliable lens through which to understand the processes playing out in my sessions. My interest in creating a clinical space in the music therapy field where the primacy of relationship, the relevance of the therapist's emotional experience, and a depthful understanding of the psyche could exist was thus manifested here.

As researcher, I acknowledge that my perspectives about the field of music therapy were born partially from some level of disappointment, which I certainly hold with me as I examine and explore this topic. My decision to be a music therapist whose doctoral training is in psychology, rather than music therapy, does position me as a critic who does not have two feet firmly planted in the field I am writing about. As a music therapy clinician, my experience has often included moments where music did not feel called for. Whether I was working with terminally ill adults who wanted me to visit but dismissed my guitar as soon as I pulled it out of its bag, children who turned all of my

musical instruments into (silent) characters in their play-dramas, or private practice patients who had visible moments of panic—caught between their desire to please me and their obvious psychological and physical discomfort—when I suggested we try a musical process, I have seen many clinical places where music did not come naturally or feel right. I have struggled to find the place for my music therapy expertise in my own clinical work, and as music fell away as a primary place of attention in my clinical work, the relationship and transference/countertransference dynamics moved into my field of vision more profoundly.

Undertaking this research calls upon me to look at the field from within and from without—in that regard, my binocular vision as both music therapist and depth psychotherapist is helpful. I feel curiosity about the degree to which I am already an outsider to the music therapy field, knowing that this too may have an impact on my research process and product. I am hopeful that my identity as a depth psychotherapist will empower me to own and understand my biases to the degree that I am able to do so, so I can most effectively explore and describe the essence of the music therapist's lived experience of clinical relationship.

Relevance of the Topic for Depth Psychology

Depth psychotherapy is a practice that relies heavily on its respect for and input from the arts, including visual art, poetry, myth/storytelling, dance, and music. Carl Jung immersed himself heavily in visual arts as part of his own quest to self-understanding (Jung, 1963). Freud and Jung both relied on myths as part of their understanding of the human psyche (Singer, 1994). Romanyshyn (2007) writes about the importance of metaphor and symbol and the purpose of a poetic sensibility for the depth

psychotherapist. Musical metaphors can easily be applied to consideration of depth psychotherapy, as we consider the deep degree of listening, as well as the therapist's attention to rhythm, tempo, and counterpoint (Moore, 2000). Music is also an essential expression of human creativity. This particular art has always transmitted information about human psychology, relationships, aesthetics, and our creative psyche.

Music therapy as an organized profession, connected to Western psychology and medicine, is a young field, established just after World War II. It has also remained a very small field, with approximately 6000 music therapists currently practicing in the United States, according to the Certification Board for Music Therapists. I have observed music therapists wondering why the field has not grown or attracted more interest over the years, or why many music therapists burn out or otherwise leave the field after working for relatively short periods of time (see DeCuir & Vega, 2010). Perhaps this is an area where the principles of depth psychotherapy, particularly those that acknowledge the relevance of the therapist's reactions and emotional experiences in the therapy room, can help the field of music therapy. Music therapists who can create space for their own subjectivity as part of the therapy they provide, and who have a lens through which to understand the complex emotional dynamics that can emerge when two humans and the evocative presence of music are all engaged together might ultimately be more grounded in their clinical work, and more able to sustain their vitality within the field.

Perhaps part of the problem is an unconscious minimizing of the power of music, where the need to attend to therapist emotional experiences is pushed aside as irrelevant or inappropriate as a way of avoiding acknowledgment of the primitive parts of the mind that music can access, and the lack of control that a therapist ultimately holds in a

therapeutic encounter that involves music. Freud famously disliked and mistrusted music, and Storr (1992) suggests that this was because he could not develop a psychological theory around it. The idea of music as a window to unconscious, primitive, and irrational impulses was put forth by Schopenhauer (as cited in Kivy, 2001) in the early 19th century. Schopenhauer saw music as the finest art, the art form to be most revered, because of the way that it taps into the essence of human experience. For Schopenhauer, music was the direct representation of the Will (Bishop, 2012), and music had the ability to liberate us from reason. It seems ironic that music therapy, a field ostensibly built upon the healing powers of music, would exhibit so much reluctance to let go of positivistic understandings of healing.

And yet, the impulse to flee from forces that are primitive, numinous, and uncontrollable is well known in humans. Wilfred Bion wrote about "O," the ineffable, uncontemplatable, a "constantly evolving domain that intimates an aesthetic completeness and coherence" (Grotstein, 1997). "O" is beyond knowing and, because of that, frightening. It demands that one allow familiarity with the unfamiliar, and resists positivistic understanding. Awe and terror of the ineffable keeps people on the surface level, focusing on knowledge and predictability. These may be the same forces that keep music therapists away from their own emotional experiences in the consultation room.

Statement of Research Problem and Question

Music therapy is a healthcare profession that relies on the power of the aesthetic and emotionally evocative art of music to address patient needs within a therapeutic relationship. Yet a reliable and suitably depthful paradigm for understanding the dynamics of that relationship is missing from the field's discourse. Transference and

countertransference as concepts have been acknowledged within the field's literature, but emotional connection between therapists and patients, and the affective experience of the therapist in particular within the relationship, are rarely discussed. This study attempts to explore the question of interpersonal relationship in music therapy treatment in that context, asking specifically: What is the lived experience of music therapists in the intersubjective field with their patients?

In attempting to understand the lived experience of this phenomenon, areas of the unknown that feel apparent at the outset include questions about how music therapists understand their own emotional experiences with the patients they see for individual treatment, in what ways they draw upon or discard these reactions in their work, and how they understand the relationship as a whole in the context of treatment. Potential differences and commonalities among music therapists who identify with different treatment foci (such as neuro-rehabilitative, mental health, or recreational) and philosophical orientation are also unknown and of interest.

Definition of Terms

Certain terms are essential to the ideas explored in this research, and it is necessary to establish their assumed meaning in the content that follows. The terms that demand this attention include *music therapy, transference, countertransference,* and *projective identification.* Understandings of the latter three terms are drawn from object relations, inter-subjective and relational psychoanalytic theories as well as theories of Jungian psychotherapy.

For the purposes of this paper, *music therapy* is understood to refer to professional clinical practice by clinicians who have completed specific university-level training in

music therapy and met other standardized requirements, including specific musicianship skills, that render them members of this professional community. The clinical practice of music therapy is conceptualized here as a means of working towards health or growth through any of various processes relating to music, including listening to recorded or live music, actively creating music, and discussing music. One particular defining assumption about music therapy in this research is that music therapy clinicians have a specific perspective and area of skill that is born from their particular training in music as a means of healing and growth. This clinical perspective is qualitatively different than the perspectives of other trained healers (including verbal psychotherapists, psychoanalysts, physicians, etc.) who are also highly talented, trained, and/or skilled musicians.

Transference is an expression of the patient's internal object relations that are projected onto the therapist (Racker, 1957), "a story about the patient's internal dynamics" (Stark, 2000, p. 252). Although this material will have resonance with the patient's past (or from a Jungian perspective, with archetypal material that connects with the patient's past [Sedgwick, 2001]), transferences are also a reality-based reaction to the therapist (Maroda, 2004). As Stark (2000) states, they are "also a story about the meaning the patient makes of the therapist's actual participation in the relationship" (p. 252). The therapist affects the patient, and these effects can be seen in the transference—in fact, the patient's material cannot be successfully projected without a corresponding "hook" in the therapist, a place in the therapist where that projection can "hang" (Sedgwick, 2001). Additionally, as Jacoby (1984) notes, transference has "not only a cause but also a purpose" (p. 18); the transference points to what aspects of the patient's

internal structure need to be worked on in the therapy. The work on the transference occurs as therapist and patient explore the dynamics of their ongoing relationship; as Maroda (2004) notes, any connections to the patient's past can and will be made by the patient himself once he can safely reflect on what is happening in the here-and-now.

Countertransference refers to all of the therapist's emotional reactions to the patient (Heimann, 1950; Maroda, 2010). These emotional responses are the most important tool for therapy (Heimann, 1950), the "backbone of the work" (Sedgwick, 2001, p. 48). The idea that countertransference refers explicitly and most significantly to emotional experience is worth emphasizing. The therapist's deep emotional engagement with the patient is part of depthful work. As Jacoby (1984) notes, there is a basic human need to fuse with an other—what Jung calls *participation mystique*, a strong emotional tie felt between patient and therapist. Countertransference feelings are a sign of the unconscious dynamics occurring between therapist and patient.

Racker's (1957) concepts of concordant identification, or empathy, and complementary identification are notable aspects of countertransference. Jacoby (1984) states that concordant identification allows the therapist to be wherever the patient needs her to be, so the patient can "use" the therapist however he needs to, within the structure of the frame. From this perspective, concordant identification is more a way of being for the therapist than an isolated event that occurs; it is a way of connecting deeply with the patient and his material. Complementary identification is also a way of connecting deeply with the patient, by entering into the drama of the patient's intrapsychic dynamics.

Projective identification refers to the process in which "intense, disavowed affects may be communicated unconsciously by the client and received, consciously or

unconsciously, by the therapist" (Maroda, 2010, p. 249). Bion saw projective identification as a way of establishing object relationships (Maroda, 2004). The patient learns to contain and integrate his emotional experience when his undigested "beta elements" are received by the therapist, processed, and transmitted back to him. Thus, projective identification invites the therapist to see her own internal experience as a reflection of the patient's internal experience (Stark, 2000). The patient's hope is that the therapist will be able to tolerate and respond to his disavowed affect (Maroda, 2004).

Stark (2000) states, "The therapist who is able to accept the patient's projections, the therapist who is able to let the patient have an impact on her and even change her, has access to a very rich source of data about the patient's internal world" (p. 264-265). Part of working depthfully as a therapist is being "infected" by patients' psychological material (Sedgwick, 2001). The therapist's availability for this level of deep, emotional connection is imperative.

The phenomena of transference and countertransference resist absolute distinctions about what exactly is happening between patient and therapist. Both parties bring and respond to internal and external/observable aspects of their experience in the therapy room, and because of this the intrapsychic and interpersonal are inexorable (Maroda, 2004). Clear delineations of past versus present and yours versus mine are not possible. Therapists and patients are forced to do their best to be emotionally present with each other and with the complex mysteries of relationship. As Ogden (1994) says, "the task is not to tease apart the elements constituting the relationship in an effort to determine which qualities belong to which individual participating in it" (p. 3). Any kind of differentiating between therapist's content and patient's content is unnecessary

because all of the session content is co-created. The therapist bears the responsibility to understand her internal world well enough, as a result of her own analysis, so she can respond appropriately.

Working depthfully in relationship means attending to "the experience of the interplay of individual subjectivity and intersubjectivity" (Ogden, 1994, p. 3), what Ogden (1994) calls the analytic third. All of the therapist's experiences that occur in the context of her relationship with the patient are a part of the intersubjectivity created between patient and therapist. "No thought, feeling or sensation can be considered to be the same as it was or will be outside of the context of the specific (and continually shifting) intersubjectivity created by analyst and analysand" (p. 7). From this perspective, the therapist's internal experiences that might be seen as countertransference, reverie, or even immaterial distractions are considered to be co-created psychological events that reflect the dynamics of the relationship between the patient and therapist.

Chapter 2

Review of Literature

In studying music therapists' understandings of their work with patients, and the role of the transferential field in that understanding, it is necessary to review what has already been written in the music therapy field on the topics of therapeutic relationship, the relevance of psychoanalytic concepts to music therapy, idealization, transference and countertransference, music therapy in depth, and levels of practice.

The purpose of this review is not only to establish a context and need for the current study, but also to establish the context from which music therapists likely obtain some of their own understandings of psychological depth and the intersubjective therapeutic relationship in their clinical work. Directly or indirectly, it is likely that the music therapy literature impacts the experience of music therapists in their work with patients. In that regard, it also becomes important to context the music therapy literature on this topic in terms of the contemporary psychoanalytic understandings of therapeutic relationship phenomena, as discussed in the Definition of Terms section in the previous chapter. These terms with psychoanalytic origin are used by music therapists in a variety of ways, reflecting a variety of understandings of what these concepts mean and how they should be utilized and understood.

The Therapeutic Relationship in Music Therapy

Broad differences in the ways that music therapists conceptualize and understand therapeutic relationship can be seen in the music therapy literature. Pavlicevic (1997) and Bruscia (2014) point out that some music therapists do not emphasize therapeutic relationship at all, relegating music to status as a stimulus or reward to be applied for

particular biomedical or behavioral effect. Even among music therapists who do emphasize relationship, though, there are a wide variety of perspectives. Procter (2002) specifies that British music therapy assumes "an acceptance of the fundamental importance of musical relationship arising in co-improvisation to the therapeutic process" (Musical Relationship, para. 1). Many American music therapists might also identify with this statement, although music therapists in general articulate their thoughts about the music therapy relationship in very different ways.

Bruscia, whose thoughts are prominent in the discourse about music therapy in the United States, states the following in the third edition of *Defining Music Therapy* (2014):

> Music experience by its very nature builds and is built upon relationships of all kinds. Music brings together rhythm and words, words and melody, melody and harmony, one theme with another theme, one voice with another, and soloist with accompanist, to name a few of the relationships. Within the person, it connects music with emotions, music with one's life and significant others. It integrates body, mind, and spirit. It connects people in myriad relations and anchors them in their society and culture. (p. 121)

Bruscia has much to say about music and relationships. He thinks of each client's pre-existing relationship to music as a "basis and vector" (p. 295) for intrapersonal and interpersonal relationships. Music allows a place in which to explore relationships with others, with environments, with or between objects. In therapy, "the therapist and client work through both musical and personal relationships, and these relationships and the constellations thereof provide the primary context and impetus for change in the client's

musical and personal life" (p. 301). Bruscia discusses at length many different kinds of relational elements that are inherent in the modality of music, and how music can help us to explore various types of relationships, but in this particular work he devotes only one short paragraph to interpersonal relationships. In *The Dynamics of Music Psychotherapy* (1998b), Bruscia speaks more about the therapeutic relationship: "Music psychotherapy is the use of music experiences to facilitate the interpersonal process of therapist and client as well as the therapeutic change process itself" (p. 2). This author seems to imply that the therapeutic relationship is more important in certain types of music therapy clinical practice than in others. In all of these cases, though, the term *relationship* seems to be a kind of umbrella term for various types of association with mutual input, not something that necessarily refers to an interpersonal or affective quality.

Some authors put more emphasis on the interpersonal dimensions of the therapeutic relationship. Leite (2003) states that relationship is the foundation for the transformation process in music therapy. Pavlicevic, a South African music therapist, describes her conception of music therapy as being about "negotiating, developing, and sustaining a therapeutic relationship through music…. Through the spontaneous, joint musical act, therapist and client develop and extend a unique sense of themselves in relation to one another" (Pavlicevic, 1997, p. 1). For Pavlicevic, music is the basic building block on which therapeutic relationships are created in music therapy, and the basis through which therapists reflect on what happens in session and what it means. But music is not "just" music, because it also has an interpersonal meaning, negotiated by client and music therapist, about the interaction and communication between them. The two parties "experience themselves and one another directly and intimately through the

jointly created, non-verbal sound form. This relating has many aspects to it: the nature of contact between therapist and child, the shifts between contact and non-contact, and the quality and aspects of the shifts themselves" (p. 93).

Nolan (2003) writes about the various roles of the music in a music therapy relationship. He sees the music, at times, as "a means of the client to develop a therapeutic attachment with the therapist" (p. 320). Nolan also sees the music therapy relationship as a gestalt made up of the client, music, and therapist, where the music can be both process and object. The object relationship between the patient and therapist changes and is changed by the music. In some cases, Nolan finds, the patient's transformation will be at first attributed to the music, but later to the relationship.

Austin (2008), a music therapist who works in private practice with adults with childhood trauma, also thinks of the music as a facilitator of relationship between therapist and client:

> [Music] can provide an environment where two people can play together, where the client can explore and experiment with new ways of being and relating. Sounding, singing, and vocally improvising can directly access the client's feelings and provide a means of expressing them so that they can be witnessed, shared, and accepted within a significant relationship. The musical connection can help to build and strengthen the relationship between the client and the therapist just as a trusting client-therapist relationship can deepen the musical interaction. (p. 80)

Austin seeks to align herself with depth psychologists and states that she believes the client-therapist relationship is the primary healing agent, and music is a "bridge to relationship" (p. 80).

Priestley (1994) is a British music therapist who works with psychiatric patients and "normal neurotic adults"; her view on the therapeutic relationship is as follows:

> The therapist-patient relationship is a vital factor for the growth of the patient. In my view it aims to be a committed, non-grasping but holding relationship; at the same time, it is a holding back to receive the patient's projected parts of herself that she cannot yet integrate creatively and fruitfully within her psyche. It also aims to be a warm, but non-demanding relationship, as impersonal yet personally-expanding as sunlight. (p. 67)

Priestley authored a music therapy approach called "Analytical Music Therapy," which is in some ways intended to be like psychoanalysis in aim and scope.

The music therapist's task, according to Ansdell (1995), a British music therapist, is to make music accessible, then nurture it as the basis for a creative relationship with the client, and encourage, support, and challenge the subsequent creative process. He states that "knowing a person in the phenomenal world of music is to know them significantly, and to meet them there authentically is often to meet them deeply" (p. 222). Muller (2008), in synthesizing the thoughts of music therapists on the phenomenon of presence, seems to agree about this depth of connection and suggests that "the shared music experience allows the therapist to live through the client in such a way that knowing and being known are seamless" (p. 28).

Abrams (2012) argues that music is, by its very nature, intrinsically relational, both ontologically and existentially, and that there is no such thing as 'non-relational' music, or music without human relationship. Therefore, music therapy must consider relationship one core dimension of the work. He refutes the idea that music is only a sound stimulus, pointing out that musical sensibilities can inform therapy work regardless of the presence of sound-based music, because it is felt as part of human relationship.

Some music therapists have connected their understanding of the music therapy relationship with concepts from interpersonal neurobiology. Robarts (2003) writes about the use of music as the "primary medium of relationship" (p. 46) in music therapy, which can allow for new relational experiences at the level of spontaneous musical communication. For clients with early trauma, this way of relating can support and augment interregulatory processes involved in self-experiencing, leading to experiential integration. Nirensztein (2003) also writes about these moments where therapist and client are authentically connected in the musical moment, equating these with Stern's "now moments" (Stern et al., 1998). These contribute to implicit relational knowing. Nirensztein states, "Music allows the therapist to provide a closeness that is suitable for the client at the given moment of his experience, without going through the process of symbolization and, in certain ways, of alienation of the experience in its totality, which is intrinsic in verbalization" (1998, p. 228). Hannibal (2014) also comes from this perspective in regard to his work with people with borderline personality disorder: "The music that emerges is a reflection of the here and now lived experience of playing and expressing oneself in a musical relationship. From that perspective music has unique

qualities that make the act of playing music a highway to the realm of implicit relational knowing" (p. 214).

Some authors write about the music therapy relationship with special attention to the reciprocal influence that client and music therapist have upon each other through the work. Ansdell (1995) also writes about the "musical between," a creative loop where patient and therapist are aware that they are being listened to and heard, each influencing and responding to the other. This is a relationship dynamic that he compares to Martin Buber's I-thou relationship. Birnbaum (2014) states, "The relationship created in music can be seen as an intersubjective field, the shared space in which communication and growth can take place" (p. 32), and equates this intersubjective field to Ansdell's concept of the "musical between."

De Backer and Van Camp (2014) write about the possibility of moments where client and therapist have "shared inner experience" (p. 78), which is expressed during free improvisation where both parties are attuned to the other. Two musical lines can become one whole, yet each is also autonomous. The music allows for an experience of the paradox of autonomy and psychological merger. Brescia (2005) speaks of the ways that intuition connects music therapists and their patients, and the way relationship and intuition help to move the therapeutic process forward: "The therapist's relationship to the client forms the emotional waters in which the two people swim to find their intuition" (p. 89). Storz (2014) speaks of the "music therapeutic attitude" (p. 158), in which the musical presence of the therapist holds intention to be a partner in intersubjective dialogue.

Lee (2014) studied the phenomenon of interpersonal relationships between music therapists and their adult clients with profound intellectual and multiple disabilities in Australia. She discusses the various emotional reactions that therapists identify as part of their experience of relationship, and notes that therapists who work with people with this condition must read implicit meanings in the client's nonverbal behavior. Clients and therapists become "special persons to each other" (p. 80). Rafieyan (2003) also writes about her work with individuals with severe disabilities, and states that the relationship between the client and the music therapist is the "guiding force" for the clinical work. This work, she says, "invites change and an increased level of self-awareness not only in the client, but also in the therapist. It asks us, as therapists, to begin to question our assumptions, to really listen to what our clients are presenting to us, and to meet them, over and over again, musically and in dialogues to make connections through those meetings" (p. 340).

Psychoanalytic Concepts

Music therapists also differ on whether psychoanalytic concepts and techniques, including the use of verbal processing at all, are applicable to the music therapy process, and the way that they language their work to differentiate it from other approaches is also interesting. Louise Montello was a music therapist who also trained as a psychoanalyst, and she states openly that she feels enactment and interpretation of the transference are the healing factor in her work, which she describes as "psychoanalytic music therapy" (Montello, 1998). With her patients, a group seeking less traditional and more creative depth psychotherapy services, Montello utilized a combination of verbal and music interventions, including improvisation and recreation or discussion of meaningful songs.

Storz (2014) describes "Focal Music Therapy," which focuses on music improvisation and understands the music therapy process through a psychodynamic lens that includes consideration of transference, enactment, and interpretation. Jahn-Langenberg (2003) conducts "psychoanalytically-informed music therapy" that includes consideration of transference and countertransference, and points out that moving between playing music and speaking allows the client and therapist to move between primary and secondary process. Salmon (2008) states that what music therapy and psychoanalytic therapy have in common is listening, the centrality of time, an affect-laden quality, facilitation of mourning, and inherent creativity.

Austin (2008) connects the development of her model and technique, Vocal Psychotherapy, with influences from object relations theory, trauma theory, Jungian psychology, and intersubjectivity, and cites numerous psychoanalytic authors as she explains her model, which is designed for individual work with adults. This model seems to draw more from psychoanalytic thought than from music therapy theorists in its approach to the patient and understanding of healing factors. Clients sit at the piano with the therapist, who plays a repetitive pattern of two chords while client and therapist improvise together vocally. Austin names her two techniques "Vocal Holding" (when the improvisations are made on vocal sounds without lyric content) and "Free Associative Singing" (in which the client also improvises words and client and therapist may engage in conversation through song). This model also includes times where client and therapist engage outside of the music, as well as verbally processing the music experiences.

DeBacker and Sutton (2014a) talk about what they call "psychodynamic music therapy" as "a form of psychotherapy with a focus on musical, form-giving exchange

between therapist and patient, undertaken during musical improvisation or via listening to music" (p. 16). DeBacker and Sutton (2014b) make their use of psychodynamic constructs (such as transference, countertransference, free association, etc.) apparent and discuss what these mean for their work as music therapists, stating that the application of such theories is logical because working with people demands that practitioners understand the patterns of relating that are adopted in response to each person's internal and external worlds. They elaborate: "It seems that, like poets, both psychoanalysts and music therapists are presented with a dilemma of how to translate wordless experiences into words" (p. 347). The skill of listening to oneself that musicians must develop—long before they reach the point of becoming music therapists—is compared by these authors to a psychoanalytic stance of sitting with and listening to patients.

The Bonny Method of Guided Imagery and Music (GIM) is a method in music therapy that considers itself to be a kind of psychotherapy. Clinicians who are not music therapists can be trained in this method, unlike other music therapy methods mentioned in this chapter. Bruscia (1998c) defines GIM as "a form of psychotherapy that involves the client's imaging to music while in an altered state of consciousness" (p. 407). The Bonny Method is purportedly informed by all four waves of psychology (Bruscia 2002), but can be focused on specific orientations depending on client need. For instance, Bruscia (2002) suggests that a psychodynamic approach to GIM is indicated when the patient has a psychoneurosis stemming from ages 2-7. This specific type of GIM work involves uncovering, catharsis, clarification and interpretation, corrective emotional experience, integration, and fulfillment. Bruscia's concept of psychodynamic therapy in this regard is

informed by drive theory and a repression model of the mind, where resistance is a primary consideration for the therapist.

Mary Priestley is a British music therapist who, as mentioned above, developed the method of Analytical Music Therapy, in which many music therapists in the United States and around the world now receive specialized postgraduate training. Priestley (1994) defines Analytical Music Therapy as "the analytically informed symbolic use of improvised music by the music therapist and client" (p. 3). The method relies on a specific session structure, which begins with music therapist and client talking until they identify something that they would like to explore in the music. The therapist usually chooses a subject from the client's material, then assigns the client to play (a variety of instruments are available) with her on this subject. The improvisation is audio recorded. During the music, the therapist seeks to contain and match the mood of the patient in her own musical improvising, drawing cues from the patient's music and her own countertransference. After the music, therapist and client talk about the music and listen to the recording, looking for insight about the material that was explored. Priestley cites Freud, Klein, Winnicott, Bion, Kohut, and Jung, among other influential psychoanalytic theorists, as her influences in developing her technique.

Nolan (2005) cites Priestley and other practitioners of her model as the most prolific source of literature on verbal process in music therapy. Nolan feels that verbal processing allows for integration of verbal and nonverbal aspects of experience, as well as giving the therapist additional information about the patient, although, he notes that music therapists can explore some aspects of verbal process through singing. However, Nolan feels that a reliable understanding of what it means to verbally interpret music is

still missing from the field of music therapy. "This is one of the least developed areas in our profession due to a lack of shared, agreed upon, empirically driven data base which reliably demonstrates the relationship between music behaviors, non-music behaviors, and mental processes" (p. 322).

Others have noticed this gap in our understanding of how music can be understood verbally, and some authors feel that it cannot and should not be filled. Ansdell (1995) questions the idea that music can be "about" something or that it can be symbolic. He states, "Unlike the worlds of both words and visual images, music steadily resists the process of excavation and verbalization of symbolic meanings and ambiguities—the very process that psychoanalytic principle is based on. That, in short, talking about music is difficult" (p. 172). Although psychodynamic theory might provide insight to the therapeutic situation, it cannot explain the music process itself. This perspective is consonant with Schopenhauer's position on music as a representation of the Will, pulling us away from reason (Bishop, 2012).

Creative Music Therapy, or Nordoff-Robbins Music Therapy as it is also known, was developed through its founders' work with children with severe intellectual and developmental disabilities, although it has expanded to include work with groups who are more verbal, including adults with mental health concerns. A therapist working in this model interacts with the client primarily (or in some cases, exclusively) through spontaneous, free improvisation. Ansdell (1995), who works in this model, is critical of other music therapy approaches that turn music into something that must be processed and analyzed, because he feels that in music therapy, the therapy happens without moving the process into a verbal or analytic space. Music-making alone, according to

Ansdell, inherently creates challenges to set ways of being, and calls participants into a process of listening, tolerating intimacy, and engaging in creative dialogue. Furthermore, he sees music therapy process as different from psychotherapy process. Music therapy is a phenomenological process, whereas psychotherapy is hermeneutical; music synthesizes where psychotherapy analyzes; and "only words have past tenses; music must be here and now" (p. 31). Turry (1998) further states, "Clinicians who question the relevance of transference and countertransference in the Nordoff-Robbins approach believe that these concepts result from a reductionist philosophy that minimizes the importance of the aesthetic power of music and the musical interaction, placing an artificial barrier between the music makers" (p. 163). Turry appears to be of two minds on this issue, as he does go on to write in depth about how transference and countertransference have arisen in his own work.

Some music therapists take a moderate stance or look for unconventional answers to this question, such as di Franco (2003), who suggests re-languaging psychoanalytic concepts in music therapy. He titles his work "dynamic music therapy," specifically moving away from the word *psychodynamic* because the work does not happen, in his estimation, through verbal process. He has renamed concepts like transference and countertransference, describing them as "emotional aspects and counter emotional aspects." Because some clients who receive music therapy are not consciously choosing to enter a therapy process (and instead are "going to the music room" or "visiting the music person"), di Franco questions whether these persons are investing in the therapist as a therapist, and if they are investing in the therapist at all, given that their main occupation may just be the music. These clients are "investing in many different ways

and in many different directions" (p. 76), and thus concepts like transference do not seem appropriate.

Pavlicevic (1997) calls for a balance when music therapists are considering how much to utilize theories and language from fields outside of music therapy itself. She asks whether meaning in music therapy can remain musical, or if we require words to discern it, and suggests that we borrow in ways that keep theory loyal to practice. Transference and countertransference are relevant, in Pavlicevic's view, and only considering the patient's music is not a consideration of the whole person. Staying only in the musical realm might lead the music therapist to "absent herself" and not take her own feelings into account. However, she suggests, like other authors mentioned above, that some aspects of the music therapy process, such as interpretation, can happen using music rather than using words.

Transference, Countertransference, and Projective Identification

When music therapists are discussing the phenomena of transference and countertransference, many cite Racker (1968) and apply some variations. There are also some nuances to how these concepts are articulated because of the use of music in music therapy treatment.

Bruscia highlights Freud's earliest understanding of transference as a defense mechanism (Bruscia, 1998a) and defines it as follows:

> A transference occurs whenever the client interacts with the ongoing therapy situation in ways that resemble relationship patterns previously established with significant persons or things in real-life situations from the past. Implicit is a replication in the present of relationship patterns learned in the past and a

> generalization of these patterns from significant persons or things and real-life situations to the therapist and the therapy situation. Essentially the client reexperiences in the present the same or similar feelings, conflicts, impulses, drives, and fantasies as she did with significant persons or things in the past while also repeating the same or similar ways of handling and avoiding these feelings, persons or situations. (Bruscia, 1998b, p. 18)

He goes on to specify that "certain transferences are non-pathological and facilitate therapeutic relationships and processes, and others are pathological and hinder them" (p. 21). A pathological transference, according to Bruscia, is one that is resistant or negative—only when the patient experiences positive feelings towards the therapist is his transference considered healthy and nonpathological. He also describes the transference, in some cases, as being the patient's conscious choice. Bruscia feels that all transferences can be classified as interpersonal or intrapersonal, pre-Oedipal or Oedipal, neurotic or healthy, positive or negative, specific or generalized, involved or remote, and verbal or nonverbal. Bruscia's emphasis on transference as a defense mechanism, rather than as a mode of and vehicle for engagement, is not consonant with contemporary understandings of transference (see Gill, 1982). To this researcher, his framing of this phenomenon seems to suggest that patients are to be blamed for any negative reactions to the therapist, and that somehow a therapist's correct categorization of the phenomena is the most important response. Emotional attunement with the patient's experience of transference is not mentioned in Bruscia's writings on transference and countertransference.

Several writers address the manifestations of transference and countertransference in the Bonny Method of Guided Imagery and Music (GIM). In this method of music

therapy practice, the client can project transferences onto the therapist, the music, and the imagery that forms in his mind during the music listening part of the session. Summer (1998) states that the purpose of the transference is to repair the patient's ego through restructuring when in relationship with a more reliable object—the therapist. She also writes about the "pure music transference," which she defines as follows:

> A therapeutic relationship in which the music serves the essential therapeutic functions in the therapeutic process, including serving as the primary transference relationship. The therapist's role is secondary: to establish and further the client's relationship with music while serving minimal therapeutic functions for the client. (p. 434)

For Summer, a goal in GIM is to move all clients toward pure music transferences, rather than to have a "split transference" where the projections move toward the therapist and the music both. This allows the client to avoid being dependent on the therapist, which she believes allows the client to take more ownership over their gains in therapy. The music can be more neutral than the therapist, which makes it a better blank screen for receiving projections, according to Summer, and the way the music and imagery move and change allows for material to be catalyzed more quickly. The music transference gives the therapist more emotional freedom from transference and countertransference. This final point seems to indicate that Summer assumes that transferential phenomena will be burdensome to therapists. In general, her perspective on transference seems to reflect a preference for emotional distance between therapist and patient.

Scheiby (2005), who works in a different model of music therapy, defines the musical transference, referring specifically to the way that transferential phenomena arise in improvised music:

> Musical transference consists of the sound patterns expressed by the client that reflect feelings, thoughts, images, attitudes, opinions, and physical reactions originating in and generated by the client as unconscious or preconscious reactions towards the past or present. (p. 11)

Interestingly, this definition of transference does not mention the therapist or the therapeutic relationship. Generally, thinkers like Bruscia and Scheiby agree with Priestley (1994), who is often seen as the foremost music therapy expert on topics like transference and countertransference. Her view is that the goal of therapy is to resolve transferences. The patient must learn that they are projecting material related to their relationships with their parents and understand and work on that material. This will stop transference feelings, "ultimately relieving [the patient] of the necessity of acting this way in the present in place of remembering the past" (p. 77). Nolan (1998) agrees, and talks about helping the patient to move away from their transference in order to have a working alliance and "a real relationship."

Priestley (1994) also talks about how the therapist can behave in certain ways to evoke certain kinds of transferences:

> Of course the behavior of the therapist is very important in evoking certain kinds of transference. Reassuring motherly behavior, including the giving of advice, engenders regressive behavior in the patient. Siding with her defenses ensures getting nowhere comfortably. Cold, supercilious behavior may evoke a negative

> transference or the sudden departure of the patient; on the other hand an overwarm approach may frighten some patients too, and engender a negative mother transference. (p. 78)

Priestley's comments seem to suggest an attitude that the transference is something tangible and controllable that can be made fully conscious and wiped away or manipulated according to the therapist's aspirations for it. Bruscia (1998a) takes this idea further:

> The second step in containing transferences is for the therapist to do whatever possible to create positive rather than negative transferences or to create positive ones that are stronger than the negative ones... . Within even the briefest period of work, clients invariably reveal which qualities or behaviors in others they love and hate... . Once the therapist knows what these qualities and behaviors are, the first challenge is to exhibit whichever positive qualities are authentic and to avoid the rest to the extent possible. (p. 45)

Other writers speak of "managing" the transference:

> As transference may be conscious or unconscious, it is not in bringing them into awareness that is key. Rather, it is through understanding and managing transferences that, as therapists, we gain greater understanding of the client's problems and needs. (Hadley, 2003, p. 14)

Viewing the transference as a conscious phenomenon, and one that can be controlled by the therapist, runs the risk of minimizing the influence of the unconscious in treatment. This perspective reflects more of a cognitive than depth psychological approach to

relationship dynamics, since the latter relies explicitly on its consideration of the unconscious.

The music therapy community also seems to differ on whether transference is worth attending to at all. Priestley (1995) warns that when it comes to transference, a therapist ignores it “at his peril” (p. 79), and Pavlicevic (1997) asserts that the transference is always present and impacting the therapist whether it is acknowledged or not. Bruscia (1998a) states that in therapy situations where "uncovering and working through the emotional origins of the client’s problems are not priority goals" (p. 44), such as when patients have "psychiatric problems" (p. 44), the transference is less relevant: "Though always present, transference is neither the core concern in every form of psychodynamically oriented therapy nor relevant to every client population" (pp. 44-45). Scheiby (2005) states, "I do not think that every music therapist has to incorporate conscious work with countertransference techniques in order to work effectively" (p. 14).

Hornstein’s (1992) account of the history of psychoanalysis in the United States seems relevant here. Like members of the American Psychological Association who renamed and revised psychoanalytic concepts under behavioral terms, music therapists seem to be repurposing core depth psychology constructs. Transference is thus reinvented for music therapy, this time as a concept that is not a core concern, and not relevant with psychiatric patients.

This can also be seen with countertransference, which generally seems to receive more attention from music therapists than transference does. Priestley (1994) repurposed definitions of different kinds of countertransference described by Racker (1968), and her terms are generally utilized in the music therapy literature, at least within the United

States. Racker's complementary identifications were renamed by Priestley as "c-countertransference" and concordant identifications were renamed as "e-countertransference," with the intention of clarifying the differences between these two and the countertransference that is thought to be based on the therapist's distortions. This last form of countertransference, as Priestley repeatedly emphasizes, causes problems in the clinical space. She describes it as follows:

> The music therapist will probably first be aware of countertransference as an intimation that the emotions in the therapeutic dyad are becoming unmanageable. He finds himself in the grip of feelings that he cannot understand and yet he feels controlled by them. He cannot get the case out of his mind, it intrudes into his free time and the twilight hours. He may feel that he has to justify himself and his handling of the case and he finds that he is having inner arguments with himself about it at odd private moments. (pp. 83-84)

The important next step, according to Priestley, is for therapists to withdraw the projection that led to these feelings, which will achieve the desired effect of eliminating the countertransference. She describes c-countertransference as potentially helpful but generally unnerving, and e-countertransference as very helpful. There is, in fact, a sense that she sees e-countertransference as something special, of which therapists who can sense it should be proud. But experiences of transference and countertransference, as Priestley describes them in her case examples, seem to be acted on and resolved very quickly—within a single session in many cases. There is a sense of simplicity, as if everything can be tied up fully and with immediacy (see examples in Priestley, 1994, pp. 93-94, 96-97, 102).

Other authors seem to have the same feeling about countertransference. Turry (1998) talks about noting his countertransference with patients, analyzing its autobiographical connection, and then being freed of it altogether. He states that "usually after we discover our own unconscious processes we gain a renewed sense of creative freedom and more focused clinical direction" (p. 171). Depth psychologists may see this perspective as rather ego-led, suggesting that once a cognitive (ego) understanding is established the unconscious can no longer impact the work in unpredictable ways.

Bruscia's (1998g) definition of countertransference is as follows:

> Countertransference occurs whenever a therapist interacts with a client in ways that resemble relationship patterns in either the therapist's life or the client's life. Implicit is a replication in the present of relationship patterns in the past, a generalization of these patterns from one person to another and from real-life situations to the therapy situation, the casting of the client and/or therapist within the past relationship, and a reexperiencing of the same or similar feelings, conflicts, impulses, drives, and fantasies through identification. (p. 52)

Bruscia (2014) states that countertransference is always present, and that therapists should focus on determining whether it is rooted in the past or in the present (Bruscia, 1998g). Contrary to the psychoanalytic literature that focuses on the usefulness of countertransference and the therapist's emotional content (Heimann, 1950; Racker, 1957), Bruscia considers any activation of a therapist's personal content in session as a contamination of the therapeutic process. After introducing countertransference identifications, introjective identifications, and therapist contaminations, Bruscia (1998g) adds this point: "Of course, all three types of therapist responses are grossly distorted

identifications that are extremely dangerous to the client and the therapeutic process" (p. 60). This view is not in line with contemporary psychoanalytic views of the transferential field, in which countertransference is considered to be a communication, not a contamination (see Maroda, 2004; Ogden, 1994; Sedgwick, 2001; Stark, 2000). Countertransference can only become a contamination in a therapist who has not developed an understanding of their own internal world through a depth-oriented treatment as patient, and it is intended to be utilized only by those who have done their own work.

Scheiby (2005) advocates for music therapists to understand their own internal worlds and reactions to patient interactions, and she emphasizes using music as part of unfolding this process. The vignettes of supervision sessions that she offers are very encouraging of music therapists in making contact with their emotional experiences, but her ultimate position focuses on the need "to minimize possible future countertransference" (p. 9) or to use music in "identifying and overcoming whatever countertransference responses our clients evoke in us" (p. 15). Other authors speak of “managing” or “neutralizing” countertransference, as if it is a threat or an unruly employee (see Hakvoort, 2014; Nolan, 1998).

Scheiby (1998) defines countertransference as it appears within the music improvisations as follows:

> Musical countertransference consists of the sound patterns that reflect or evoke feelings, thoughts, images, attitudes, opinions, and physical reactions originating in and generated by the music therapist, as unconscious or preconscious reactions

> to the client and his or her transference. The medium through which these countertransferences are conveyed is the music played in the session. (p. 214)

In Scheiby's work, she says, countertransference that arises in music is often detected after the music-making has finished, when listening to recordings of the music that patient and therapist improvised together. The therapist would use any countertransferential material noted during the listening process to inform future interventions. This process might be compared with Casement's (1991) concept of the internal supervisor.

Turry (1998) notes that, when music therapy occurs primarily through music improvisation between therapist and client, countertransference can appear in various aspects of the music created, including tempo, ostinato, rhythm, dynamics, harmonic choices, dissonance, register, melody, and musical perception. Again, many of these countertransferential aspects are noted in analysis of recordings after the session, and Turry comments that the therapist's impression in the moment could be reconsidered as incorrect once the recording has been viewed and "a more objective view of what happened" (p. 189) is apparent. This seems to reflect an emphasis on analytic, cognitive processes in understanding countertransference, rather than looking deeply at emotional content. A depth psychologist might argue that countertransference experienced after the session (when, for instance, viewing recordings of session content) does not render the previous countertransference wrong or less important, and that countertransference relies on subjectivity, not objectivity.

Jahn-Langenberg (2003) refers to countertransference as "the most important instrument of treatment" (p. 361). To use countertransference as an instrument, the

therapist should focus on “bringing inner experiencing to the realm of associative fantasy, as well as bringing the realm of musical ideas into the playing. As a result, at first the music therapist and the patient experience the affective significance of the problem being treated” (p. 361). Montello (1998) says, “I use myself as a sounding board for the ‘inner music’ of the patient and mirror this back to him when it seems appropriate” (p. 301). She uses this approach when bringing up and working with object relations issues.

Austin (2008) states, “in vocal psychotherapy, countertransference is used by the therapist as a primary instrument to gain understanding, information and knowledge of the client as well as to increase empathy and strengthen the therapeutic partnership” (p. 88). Like Jahn-Langenberg, Austin refers to the idea of using the self as an instrument—this seems to be a very useful metaphor for music therapists. Nolan (1998) also discusses the importance of countertransference for increasing empathy for the patient, and how accepting and understanding the therapist’s own feelings “can eventually lead to hypotheses that if pursued will bring a wealth of information about the client and the therapeutic relationship” (p. 398).

Austin counters some others in the field when she states, “I have found that even when the countertransference is related to my own unresolved issues, my feelings and reactions are intimately involved with the therapeutic interaction and can be extremely useful in understanding the client” (p. 331). In an apparent contradiction to some of her other statements, Scheiby (1998) also acknowledges that even "classical countertransference" (Mary Priestley’s term for countertransference that is solely based on the therapist’s own distortions), which other music therapists warn against most strongly, can sometimes be an aid to the clinical process when it occurs in the music.

Other music therapists discuss phenomena related to the transferential field without calling upon definitions of the terms *transference* and *countertransference*. Leite (2014) describes her conceptualization of what happens in the relationship in her individual music psychotherapy work with adults: "The symbolic power of music allows for the creation of a metaphoric realm of experiencing, whereby early relationship patterns can be re-experienced by the patient and transformed with the help of the therapist" (p. 226). Interestingly, this perspective seems to de-emphasize the role of the therapist in the patient's process of re-experiencing relationship patterns.

Birnbaum (2014) cites theories of the intersubjective field and states, "Music psychotherapists recognize that their own subjective emotional responses, both conscious and unconscious, are expressed in musical interactions and are a vital component of these interactions" (p. 32). She continues, "How a therapist feels about a client, both consciously and unconsciously, influences what and how the therapist plays…. Making effective clinical interventions is not just about learning a new technique or acquiring a new resource, but also discovering how we are feeling about a client and how this is influencing our music" (p. 34). Birnbaum is describing a clinical situation in which the therapist tunes in to her own emotional experience and considers how she and the client are impacting each other in an ongoing way, all the while improvising music together.

Storz (2014) discusses work with paranoid psychotic patients, in which the focus is the acting out of conflicts with their therapist. The therapist's actions and reactions are a way of understanding what is happening in the therapeutic relationship. "The patient's life story and life situation are explored in therapeutic interviews, but the transference becomes perceptible and audible much quicker in the musical interaction than it does in

therapeutic interviews. We can safely assume that improvisations show how the patient creates relationship as well as what his basic expectations are" (p. 152). Transference can be detected by noting the patient's selective attention to the therapist's music and what comments or interpretations the patient has about the therapist's music.

Several music therapists have also written about projective identification, utilizing diverse definitions of this phenomenon. Bruscia (1998c), for instance, states that a defining feature of projective identification is the element of sabotage from the patient. He goes on:

> Projective identification is such a distorted and insidiously powerful experience for both client and therapist that it literally brings to halt whatever was happening in the interaction at the time, whether it be a more helpful transference or a working alliance, effectively detouring the therapeutic process itself. The chief aim of projective identification is to keep repressed material from entering consciousness by disrupting any aspect of the therapeutic process that seems to be threatening. As such, it is always a form of resistance. (p. 40)

This rather pathologizing view stands in contrast to perspectives from the depth psychology literature, which emphasizes the importance of projective identification as a means for patients to communicate with the therapist in depth-oriented work. In Bion's (1962) concept of "normal projective identification," the therapist receives the patient's undigested beta elements, processes them in her own reverie, and returns them as metabolized alpha elements through unconscious to unconscious communication. This is an essential aspect of understanding and then working with projective identification, taking on the patient's content together. Bion's perspective, which is shared by many

authors (Grotstein, 1997; Maroda, 2004; Ogden, 1994; Stark, 2000, among others), implicitly encourages the therapist's compassion for and deep interpersonal connection with the patient, which is not reflected in Bruscia's conception of this phenomenon.

In a similar vein, Muller (2008) writes about the danger of inductions in his study of music therapists' experience with presence. Muller feels that therapists must resist inductions because they will remove the therapist's agency. This runs directly counter to depth psychologists' perspectives on the importance of allowing psychic infection, of letting the patient impact the therapist, and of engaging in deep, mutually emotional relationship.

However, there are other perspectives. Austin (2008) describes projective identification as a potentially disturbing experience for the therapist, but she adds the following:

> It is also a way to learn about the client's inner world on a gut level, to walk in their shoes so to speak. More than a defense, projective identification provides the client with a means to communicate important information about the self, information that is too unbearable to consciously know about and express in any other way. (p. 91)

Kim (2009) describes "musical projective identification," in which the therapist's improvised music in the session can be recognized by the client as having in some ways come from what he projected into her. DeBacker and Sutton (2014b) describe how projective identification and Bion's conception of containment can come alive in the music:

> Music therapy offers the patient a possibility to express these fearful and unbearable experiences with and through musical instruments… . The therapist can also react through the musical interactions. The expression of the named sensations is after all chaotic, confusing, fearful, or aggressive. The patient himself is often caught off guard by this emotional outburst and does not know how it will evolve. The music therapist does not need to undergo all of these passively, but will try to guide and structure these expressions. It is as if he stretches a skin around the experience of the patient—an acoustic skin—that holds together and gives form to the expression of chaos. (p. 344)

Other voices speak of the experience of leaning into the chaos of deeply emotional, interpersonal work as well. Jahn-Langenberg (2003) mentions the importance of music therapist and patient experiencing together the affective significance of the patient's problem. DeBacker and Van Camp (2003) discuss their experience of making music with patients who are psychotic, and feeling an inability to connect and at the same time feeling drawn in by the "hypnotizing" repetitive rhythm common for psychotic patients. This seems like the kind of engagement that allows for the therapist's emotional connection with the patient, regardless of how vulnerable it might make her. Di Franco sums this up beautifully: "If we say that music is a way to get in touch with the inner world of the other, it is necessary to discuss the emotional reactions between the therapist and the client" (p. 74).

These comments start to give shape to how music therapy work can be depthful, and also to a wondering of how such wide gaps in understanding of psychic phenomena can exist within one field. It seems that some music therapists—typically, those

practicing outside of the United States—have some level of comfort with the unpredictability of psychic processes and the level of presence that this work calls for. Others speak of working in depth and accessing the unconscious, but their approach may rely more on ego analysis.

A common warning in the music therapy literature is that therapists should avoid moments where they might not be able to differentiate between the patient's feelings and their own. Austin (1998) shares these thoughts:

> When the client's feeling states are induced in the therapist, the challenge for the therapist is to differentiate between the client's feelings and her own. The intimacy of creating music together is especially challenging in this regard because of the medial quality of the music. The unconscious contents for both client and therapist are easily accessed through music, and client and therapist can affect each other on a deep level that goes beyond words. Two people involved in singing and/or playing music together cannot be separated so neatly. (pp. 331-332)

This passage beautifully portrays some of the music therapist's dilemma. On one hand, it is hard to disagree with Austin's assertion that music touches a very deep place, and music-making together with a patient perhaps even more so. Having a clear, ego-led delineation of whose feelings are whose can be difficult in a deep treatment situation without music-making, but in the music it may be even more challenging because of the way that music brings us into contact with primitive parts of the psyche, what DeBacker and Sutton (2014b) describe as "the psychic level itself, a level that is found mostly in a

rough or almost uncultivated form" (p. 41). And yet, this lack of clear delineation is exactly what music therapy theorists warn against, over and over again.

In his phenomenological study on presence, Muller (2008) made the following statement about emotions in music therapy work:

> When emotion enters the experience, being present requires the therapist to live through it long enough and deep enough: to determine its source (client or therapist), to discharge or defer its energy as needed to maintain or restore balance, and, to satisfy the client's need to be known. (p. 31)

It is very interesting to consider the idea that emotion is not always part of the experience of therapy, whether it's being expressed or not. But Muller's work emphasizes the idea of objectivity, and the ways that his music therapist participants wished to remain objective while relating to their patients. He and his participants felt that if interpersonal boundaries between patient and therapist become diffuse, then presence will not be maintained—the opposite position from the one taken by depth psychologists like Maroda (2004), Ogden (1994), and Stark (2000).

Bruscia conveys a strong voice of warning about the danger of feelings. He states that when the therapist cannot differentiate between her own feelings and her patient's feelings, it creates a resistance to change (1998e), and that if the therapist gets "stuck" in the patient's emotions, then she will lose her effectiveness as a therapist (1998f). He also feels that that when the therapist's own material is stimulated by the patient's material, it is "extremely dangerous to the client and the therapeutic process" (Bruscia, 1998g, p. 60). In such situations, he recommends that the therapist go to therapy, go to supervision, and/or stop working with this patient, although interestingly he also warns of the dangers

in too much self-inquiry (1998f). The therapist's emotional reactivity is related to boundary problems and should be carefully monitored (Bruscia, 2014). Bruscia (2014) also puts great emphasis on the idea that the helping should not go both ways, and therapists should not expect to experience their own personal growth through the therapy that they provide. Kim (2009), a Korean music therapist, offers the only description that I have been able to locate of deep and diverse feelings arising in music therapy, without caveats about the danger of these feelings. She writes of feeling overwhelm, discomfort, fear of the sexual, smothered, and ashamed. This level of personal affect disclosure in music therapy literature is seemingly otherwise unheard of. The question of whether the dearth of literature describing music therapist affect is influenced by the literature containing warnings against it is certainly intriguing.

To prevent any problems of contact between patient's and therapist's material, Bruscia (1998f) recommends a procedure of "moving consciousness" (p. 96), or in other words, to deliberately and consciously empathize in turn with client, self, and self-as-therapist throughout the session so as to keep various reactions and emotional experiences separate. According to Bruscia, this process is "essential to being an effective therapist" (p. 96). For a depth-oriented psychotherapist, this methodological, procedural approach to doing therapy might seem like it would just serve to impede the therapist's presence in the moment, as she focuses on a procedure rather than allowing her mind to go where it will, based on whatever is stimulated by the interpersonal situation. But it seems that many music therapists look primarily to logic to understand and guide their work. Brescia (2005) noted in her phenomenological study of intuition

that therapists tend to use their intuition to connect with clients when a logical means is not working.

Kwan (2010), in studying music therapists' experiences working with adults in pain, found that music therapists question how present or detached to be when trying to provide musical support to patients who are acutely suffering. She talks about the need for awareness of countertransference, but also talks about "creating a healthy distance to continue the work" (p. 56). Summer (1998), in her discussion of Guided Imagery and Music, states that the GIM therapist must model respect for the complexity of feelings, but in the same chapter talks about the benefits of encouraging a music transference over a transference to the therapist because it gives the therapist more emotional freedom, suggesting a kind of mixed message about whether feeling feelings is really so valuable and important. Lee (2014), in her study of music therapists who work with clients with profound and multiple disabilities, found that some of these music therapists feel that revealing emotions to their clients, including feelings of attachment, "is not a professional behavior" (p. 72).

Professionalism seems to be part of the languaging that music therapists use when talking about keeping emotions—or other aspects of experience that are not ego-led—out of the therapy experience. Bruscia (1998a) emphasizes that the working alliance is a rational relationship, "a peer, adult-to-adult relationship wherein the client takes responsibility for working through his/her problems and deriving all possible benefits from therapy" (p. 45).

A few music therapists do advocate for a more inclusive understanding of the affective experience in music therapy. Procter (2002) questions whether music therapists

allow their therapeutic relationships to be “a two-sided affair,” and notes that the therapist’s music is not often examined in music therapy discourse—only the client’s. Salmon (2008) advocates for an acknowledgment of the importance of affect in music experiences: “Music encodes affect in its melodies, rhythms, and harmonies. It also serves to express a wide range of feeling states, even suggesting diverse emotions simultaneously.” Kenny (2003), however, is the most direct in her position on this subject, which seems to be responding to some of the other viewpoints mentioned above: “We tend to think of intersubjectivity as a problem. It is so difficult to come to terms with our subjective experience that we like to wrap in caveats and qualify it, to protect it, to control it, to temper it” ("Intersubjectivity," para. 1), but she maintains: subjectivity must be primary in this work. The subjective space between client and therapist can have no rules. She states, “Many therapists consider themselves as non-expressive beings in this space because they view themselves only as reactive to patients’ expressions, never spontaneously offering expressions of their own” ("Intersubjectivity," para. 1), but both therapist and patient are subjects.

Contextualizing Music Therapy as a Depth Approach

In their discourse, as music therapists attempt to delineate the boundaries of their practice and what distinguishes and differentiates them from other ways of being with and helping people, there is sometimes a tendency to idealize the music, or music therapy practice in general. Sometimes this idealization comes in the form of devaluing other approaches to therapy, and in other places the idealization can be noted simply because of the apparent absence of more difficult aspects of therapeutic relationship and practice.

Bruscia (2014) states:

> Music is a medium par excellence for empathy. In fact, in many ways, it is unmatched by any other medium. When we sing the same song together, we live the same melody, we share the same tonal center, we articulate the same lyrics, we move ahead according to the same rhythm—moment by moment, sound by sound, through an ongoing awareness of the other, and through continuing efforts to stay together and thereby become one within the experience. Meanwhile, we are also receiving the same feedback as we listen to ourselves: We hear the same sounds and words as we sing them and feel the same ebb and flow as we shape each phrase. When the song is sad, we share that sadness, we live through it together in synchrony, and when the song is joyful, we celebrate together, we share the same occasion to rejoice. Our actions are timed in relation to one another, our bodies resonate to the same vibrations, our attention is riveted on the same focus, our emotions are reflected in one another as well as in the music we are making, and our thoughts are one. (pp. 156-157)

Although Bruscia beautifully articulates some of the potential joys of being with another person in music, it is difficult not to question some of his generalizations. Ongoing awareness of the other and efforts to become one are not everyone's experience of group music making. Undoubtedly, the experience of merger can be euphoric, but merger and empathy are not the same, and they serve different purposes. Bruscia's idealization of music later goes in an interesting direction as he describes the power of music in therapy: "The implication is that the music and the music experience can extend beyond the potential of both parties in its therapeutic effect and that the music experience can serve as therapist independently of the therapist as person" (p. 300). It is difficult to reconcile a

purported centrality of the therapeutic relationship with a statement such as this, which also brings into question the meaning of the term "therapy," particularly in the context of a volume designed to define a professional practice.

In the same volume, Bruscia comments on music psychotherapy, the branch of music therapy concerned primarily with relationships. Where music psychotherapy differs from verbal psychotherapy, according to this author, is that psychotherapy "as conventionally practiced" is "an essentially verbal experience" (2014, p. 387). This description differs significantly from descriptions found in the greater psychotherapy literature, where the deeply emotional, visceral, imaginal, and nonverbal aspects of psychotherapy treatment are described (see Casement, 1991; Maroda, 2010; Sedgwick, 2001; and Stark, 2000). It appears that the author is framing the value of music therapy specifically in terms of perceived shortcomings of psychotherapy.

However, many music therapy authors have taken his approach. Some seem to feel that psychotherapy is lacking in emotional connection and depth of relationship in comparison to music therapy. Statements to this effect appear to be more a matter of personal opinion than substantive claim. Priestley (1994), in describing her method of Analytical Music Therapy, states that "unlike in analysis, there is a lively, emotional reciprocity between therapist and client through the musical duet improvisation, and this carries over to a certain extent into their exchange in words" (p. 6). Although playing music together is a unique way of connecting that can be quite profound, the suggestion that lively emotional reciprocity does not happen in psychoanalysis is not substantiated. Priestley's volume contains numerous comments that reflect this idealization of music therapy and devaluation of psychoanalysis. Expressing aggression in music is more

likely to lead to health than expressing it directly (p. 8), mirroring of the patient's emotional state is only effective through music and therefore not doable in the realm of verbal psychotherapy (p. 100). The psychoanalytic literature certainly suggests otherwise (see the works of Heinz Kohut).

Yet, music therapists with an orientation to the psychoanalytic literature still further this perspective. Priestley is certainly familiar with influential psychoanalytic thought, as she cites familiar names and psychoanalytic concepts throughout her book, but she does not discuss any of the potentials for deep interpersonal connection in psychoanalysis. In fact, she emphasizes the opposite: "Verbal communication can be a cold, lonely business" (1975, p. 223). Scheiby (2005), a practitioner of Priestley's method who cites theories from intersubjectivity in her writing, echoes this sentiment:

> I look at the music therapeutic relationship as a more mutual relationship than the typical relationship in verbal psychotherapy. Because the music therapist also plays music in the work, there is always the possibility of healing for the therapist as well, even when this is not the therapist's intention…. It is a unique aspect of music therapy that the products of the client's and therapist's unconscious can be directly examined in the therapy process itself and understood in the context of the process. (p. 10)

Certainly, many psychoanalytic writers have demonstrated that their own healing has been a part of treatment at times, and that their unconscious is present and understood in the context of the work. In her contrast between music and verbal interaction Priestley (1975) also states that verbal interaction "is not a united expression like music and fighting and love-making" (p. 223) and discusses the ways that music can be holding and

containing. This sentiment likely rings true for depth psychologists, who understand the depth of music and its potentials. However, Priestley goes on to state that, while music-making, one "expresses herself completely and yet feels that she is part of something greater. Aware and whole and yet apart, it is a good feeling" (p. 223). This seems like a gross idealization of music that would not be to the benefit of therapists or patients. Playing music does not automatically mean expressing oneself completely, and playing music together doesn't always feel "good." Nor should therapy always feel good. The complex dynamics of merger and separateness are not so easily navigated in the therapy space as this quote seems to suggest. But these specific words express part of what seems to be a trend of idealizing music in music therapy and attempting to elevate music therapy above other approaches to treatment.

Paul Nolan (1998) also seems to want to establish the unique superiority of music therapy: "No other form of therapy contains simultaneous expressions between therapist and client(s)" (p. 389). This comment seems to reflect an idealization of music therapy and a desire to elevate it above traditional psychotherapy, but also a lack of understanding of what psychotherapy processes are. Since such statements are published in scholarly journals and compilations describing music therapy clinical practice, these thoughts influence music therapists, music therapy students, and other members of the clinical community and public.

Descriptions of music therapy clinical practice can also be idealizing without devaluing psychotherapy. Reading music therapy case reports and theoretical descriptions, a depth-oriented reader might be struck by the lack of conflict, anger, and struggle within the therapeutic couples presented. Deep connection is described, but that

deep connection generally only leads to joy. When clients are resistant to engaging with the therapist, that is understood (in a generalization made by Austin, 1998) as a fear of intimacy and resistance to the positive transference. To other writers, music can be thought of as a transitional object that holds the maternal transference, so therapists can be confrontative without threatening the loss of the containing object and causing the patient distress (Dvorkin & Erlund, 2003). Bruscia (1998e) comments in another essay that "love is the main commodity of the therapeutic transaction… with it, therapy is joyful and uplifting" (p. 83). This comment does not seem to seek to elevate one kind of therapy over another, but it does seem to whitewash the therapeutic process. The value of a certain kind of love between therapist and patient is hard to dispute, and it is true that therapy can be joyful and uplifting at times, but it is certainly not quite so simple as that. This seems particularly misguided in a discussion of music therapy, because music certainly can lead us to core emotional truths, and those emotional truths can be painful. As Yalom (1989) states, "therapy and a state of love-merger are incompatible because therapeutic work requires a questioning self-awareness and an anxiety that will ultimately serve as guide to internal conflicts" (p. 12).

There are music therapists who have noted the tendency towards idealization among music therapists. Turry (1998) mentions the tendency of music therapists to idealize music and use music to keep interactions between therapist and client beautiful, avoiding challenge and conflict. However, within the same essay, Turry makes this comment: "Once a child begins to relate to the creative music therapy situation for what it is and starts to tap into inborn music sensitivities, however, relationship factors can become less relevant… the musical part of the child is not necessarily affected by

relationship" (p. 186). There seems to be a wish for music therapy to be all things therapeutic at the same time. This is most directly illustrated by Street (2012), who describes a music therapy treatment that combines "psychoanalytic techniques" with music therapy functional techniques designed to improve physical gait. Street has a confusing notion that one can be a psychoanalytically oriented therapist while also being an "instructor/trainer" who encourages performance and measures results, and that a six-week treatment of 20 minutes per week (plus 50 minutes of working on gait) could be considered psychoanalytic.

LeCourt (1998) further explores this phenomenon, citing a tendency among music therapists to see music as having a magic ability to solve problems or give relief. Music therapists have a tendency to pursue consonant harmony in improvisations with patients, reflecting a desire to turn pain into beauty rather than helping the patient learn to bear their pain. Patients can thus be seduced into a denial of reality or a distancing from issues through the aesthetic power of music. There is a temptation and danger for the therapist to present herself as the "aesthetic ideal" (p. 155).

Austin (2008) notes that music therapists can use music defensively "as a resistance to going deeper into the therapeutic process. This can be due to their lack of knowledge and training in verbal processing. They may be defended against feelings of inadequacy by acting on the impulse to do something they do well" (p. 129). Conversely, Austin also warns against hiding defensively in the "illusory sense of control or mastery" (p. 130) that can be found in words, and avoiding the deeper process that she feels is only accessible with the music. For music therapists, who apparently struggle to identify ways

to establish clinical depth without music, this may be true, although for psychotherapists there may be other ways of accessing deeper work.

Some music therapy theorists have openly expressed their argument with some of the aforementioned attitudes towards verbal psychotherapy and the elevation of music therapy above it. Pavlicevic (1997) firmly establishes that verbal psychotherapy, from her perspective, is not "just words" as other music therapists have suggested. LeCourt (1998) is openly critical of Mary Priestley's attitude toward psychoanalysis, and her assertions that music therapy nurtures deeper connections: "What is different is merely the form of participation and interaction, not the depth of the process" (p. 148). LeCourt feels that the mutuality that Priestley and other writers emphasize is seductive and idealizing, and reminds readers that when the patient responds to music that the music therapist has chosen, it is a reaction to the therapist as much as to the music, and should be responded to thusly. This assertion has some basis in the reality of music therapists' experience as well: Kwan (2010) found, in her interviews of music therapists who treat adults in pain, that the music therapists interviewed question whether it's the music that helps these patients, or if it is more the rapport between patient and therapist.

Several music therapists have attempted to represent some of the darker aspects of music therapy practice. LeCourt (1998) notes that music can be primitive and/or full of unresolved dissonances, although in a pilot study she found that music therapists tend to disapprove of such music. Hakvoort (2014), in discussing music therapy work in forensic psychiatry, notes that music therapists can find themselves enacting the role of abuser with patients by, for instance, engaging the patient in an improvisation experience and playing unpredictably. Primadei (2014) discusses work with persons with learning

disabilities and notes that, for those who are accustomed to feeling incapable, music can be threatening and "felt as both dangerous and unreachable" (p. 186), and music therapists may receive the projection of the destructive superego. The potential for accessing darker aspects of the psyche, and more challenging aspects of therapeutic relationship, in music therapy is clear.

Still, the music therapists who write about less idealized aspects of this work are in the minority, and it seems likely that music therapists who can even acknowledge and work in the less idealized aspects are also in the minority. Comeau (2004) conducted a phenomenological investigation of how and when music therapists experience themselves as effective, and found that music therapists felt ineffective when they felt vulnerable, angry, helpless, or tense. Feeling effective was associated only with "positive" affective states including relaxed, confident, spontaneous, receptive, aware, connected, excited, and emotionally moved. In observing this need to control and avoid the negative in theorists and clinicians alike, it seems that music therapists tend to back away from the power of what happens when music brings the unconscious alive in therapist and patient.

Music Therapy in Depth

There are several writers whose description of music therapy treatment feels more depthful than what is commonly published in the music therapy literature, introducing ideas about music and depth that may be new to a depth psychology audience, and some of these writers' thoughts are summarized below. Primadei (2014) talks about his "musical imagination resonating with" the patient (p. 191), which seems like a beautiful metaphor for what this work can be.

Pavlicevic (1997) focuses on what is different about the music-making that happens between music therapists and their patients, and what sets it apart from other kinds of musical engagement. She identifies that the therapeutic work is about "meeting and matching the client's music in order to give the client an experience of 'being known'" (p. 117). Music therapists are trained to recognize musical phenomena that in some situations would seem to indicate a lack of musicality—"distorted inter-timing, interrupted fluidity, and collapsed reciprocity" (p. 115)—but music therapists can learn to see this as an interpersonal dyssynchrony, attributable to either client or therapist not being present.

Nirensztein (2003) leans on Winnicott's theory and states that Winnicott's ideas of mirroring and holding happen in music therapy because the music creates the eyes and arms, so being seen and held happens nonverbally. In this way, patients can have an experience of merging with the maternal figure through the music. Music-making allows for an experience of affective attunement that is nonimitative but still connected to the intersubjective exchange, helping to lead towards the creation of a sense of subjective self, as defined by Daniel Stern (1985).

Again referring to the musical space created between therapist and client, Robarts (2003) notes that music can be an "aesthetic creation of a place to think" (p. 152), allowing for regulatory processes and leading to containment and transformation. She further comments:

> The music therapist is a particular kind of accompanist and listener, who can also "digest" what the child is feeling and provide ways of shaping and forming structures that become safe "vehicles" for her senses to be carried into emotional

> expression. This is the musical-psychodynamic pathway from motivation to meaning. (p. 173)

Robarts is incorporating Bion's alpha function as part of her work, and doing so entirely in the realm of the music. She uses music to hold the client's anxieties or fragmented communication, and prepare to hand them back when the client is ready to receive them.

DeBacker and Van Camp (2003) describe their work with patients who are psychotic, who, as cited earlier, tend to play hypnotizing, repetitive rhythms. They call this music the "psychotic sound object" (p. 277), which is described as a kind of "endless iterative playing" (p. 279). These patients "cannot experience this music as something from themselves; there are only sounding sounds in which they are not implicated" (p. 279). This description speaks to a fascinating phenomenon of relationship, exploring what it means to relate to someone who refuses to be present in their own expressive "language." Sutton (2014), writing about her work with severely disturbed adults in an outpatient setting, also writes about what it's like to improvise musically with a patient and see that patient's struggles and pathology in what emerges: "What is played out in clinical musical improvisations enables us to hear and experience the patient's mind in the present, as it is linked, enmeshed or confused with their past" (p. 96).

Kim (2009) works from an object relations perspective and describes her treatment with a young boy struggling with the coming birth of a younger sister and her experience of being an idealized object for him. She notes that the music created together can give the child a feeling of having created a baby with the therapist, due to the feelings of union, and the sense that the music-making is an act of love. She beautifully describes her handling of her young patient's sense that he was "leaving a music baby inside of

me." She advocates for allowing the music in music therapy to have its own drama that unfolds in time, and that both therapist and client can learn from and grow in.

DeBacker and Sutton (2014a) also write about using music therapy with patients who are traumatized, and the different kind of presence that music therapists are called to have, so as to be personally and musically receptive to the patient's traumatic content. Allowing the primary process experience to happen although it is unknown is one of the things that they talk about. When the therapist can match or resonate with the patient's trauma in musical improvisation, the hope is that a new musical theme would emerge from patient and therapist together. The therapist also has to know how to be with the patient in the silence, and join as part of that experience. "As therapists we must find ways in which to come to terms with the unbearable nature of the life experience of our patients, in order to remain present when traumatic material fills the therapy room" (p. 55).

Consideration of Levels of Practice

Considering the limitations in the ways that many music therapists talk about the therapeutic relationship and the emotional experience of the therapeutic process also demands a look at the field of music therapy and whether a deeper level of practice can be expected. In the United States, music therapists can still be certified and practice at a bachelor's level. Additionally, some graduate level education programs do not provide coursework or guidance in advanced clinical practice, but treat the master's degree course requirements as a place to learn about conducting research. When the wide berth of clinical orientations and philosophies previously mentioned are taken into consideration

as well, it is clear that music therapists have a wide range of qualifications. Bruscia (1998e) has the following comments about competence in the field of music therapy:

> Competence is a particularly rampant countertransference problem in music therapy for a variety of reasons. Being a music therapist requires tremendous breadth and depth of knowledge, ability, and skill, so as one may expect, very few music therapists are fully qualified in every area of competence and practice. Also, music therapy is a very young field, and this brings its own form of general professional insecurity. (p. 85)

Questions arise of whether this general professional insecurity is well founded or if it connects to a lack of empowerment from the field's leaders. Should music therapy literature be written with warnings about appropriate levels of experience and training necessary to carry out certain kinds of work? Should so-called "advanced practice" be described without caveats for therapists who may not be advanced? Music therapy seems to have taken that approach. Montello (1998) writes about her work with traumatized individuals and gives frequent warnings about "the risk of retraumatizing patients through our spontaneous musical involvement with them" (p. 299). There seems to be a fear that someone will read her description of her work and attempt to apply it as technique without a full understanding of the dynamics at play.

Music therapists in Europe are calling for renunciation of technique in favor of focusing on the transference (DeBacker & Van Camp, 2014, DeBacker & Sutton, 2014b), and some American music psychotherapists are noting that music therapy work is deepening, moving out of its old activities-based approach, and consequently receiving more recognition from other fields (Austin & Dvorkin, 1998). Yet, the purportedly

comprehensive volume *Guidelines for Music Therapy Practice in Mental Health* (Eyre, 2013) contains no content focusing on therapeutic relationship or emotional experience, including no substantive mention of transference and countertransference, focusing instead on methods and techniques.

In her introduction to this volume, Lillian Eyre (2013) defines psychotherapeutic levels of practice, based on the thoughts of Kenneth Bruscia. There are three levels. The augmentative level of practice refers to the kind of work where therapists focus on helping their clients make use of existing resources, establish equilibrium, build ego strength, and strengthen defenses. At this level, the music experience is thought to be more significant than the therapeutic relationship. At the intensive level, music experience and therapeutic relationship are equally significant, and goals include helping the client to expand internal resources, find new ways to solve problems, gain insight to unconscious processes, find self-expression, adapt to change, and use defenses in a healthy way. The third level is the primary level, in which therapists help their clients to work through all defenses, resistances, transferences, and make changes in the personality.

Observing these levels of practice, a depth psychologist might note that the work described at "intensive" and "primary" levels of practice for music therapists is work that requires that the therapist has participated in her own extensive psychoanalytic preparation through participation as a patient in a depth-oriented therapy or analytic process. A therapist cannot help another person to gain insight to unconscious processes without having had her own personal therapy/analytic process that focused on connecting with her own unconscious.

It might be argued that some of the depthful ways of working sought after by this writer are not appropriate to encourage for a significant portion of music therapists in the United States. On the other hand, we know that relationship dynamics, including transferences and emotional attitudes toward each other, exist between patient and therapist whether they are being acknowledged and examined or not. This study may find that music therapists are encountering depthful experiences in their work with patients, perhaps unwittingly and without appropriate training to handle such moments therapeutically.

Chapter 3

Methodology

Research Approach

"The questions themselves and the way one understands the questions are the important starting points, not the method as such" (Van Manen, 1990, p. 1). This study will approach the topic from a depth psychological perspective, embracing the inherent nonlinearity therein, and embracing the chaos and confusion that comes with the formulation and integration of a new perspective. "There is always that gap between what one says and what one wants to be spoken, between what we are able to make present and what remains absent" (Romanyshyn, 2007, p. 34), and in considering and studying music therapy, this research also acknowledges the truth that some things are ineffable and not expressible in words.

Coppin and Nelson (2005) suggest that inquiry "is a relational art in which researchers and the object of their interest influence one another" (p. 12). In this study of relationships, there is an acknowledgment of the relationship between researcher and topic, and researcher and research process. My research topic came to me because of my own practical, ego-driven desires, interests, and aptitudes, but I additionally acknowledge the presence of my own complexes in my desire to study relationships in music therapy, and the ways that this topic and this research has claimed me. As Romanyshyn (2007) suggests, "in re-search, the topic chooses the researcher as much as, and perhaps even more than, he or she chooses it" (p. 4). Situated in a depth psychological and phenomenological perspective, I enter this research understanding reality as something that is co-created by observer and observed (Romanyshyn, 2007).

Phenomenological research is grounded in the philosophical perspective founded by the Czech philosopher Edmund Husserl, and looks for common meaning in the lived experience of a phenomenon (Creswell, 2013). Phenomenology is based on philosophy rooted in subjective openness, where attention is paid to what appears in consciousness, and phenomenon means "to bring to light" (Moustakas, 1994, p. 26). As a philosophical and research approach, phenomenology has evolved and been understood in some ways that differ, but it holds lived human experience, and the researcher's wonder about a phenomenon, at its core (Van Manen, 2014). The main goal of phenomenological research is that the nature or significance of a phenomenon can be seen in a new way (Van Manen, 1990).

The phenomenological approach seems to intrinsically call for a deep relationship between the researcher and the phenomenon being studied. Van Manen (1990) states that "phenomenological research is a being-given-over to some quest, a true task, a deep questioning of something that restores an original sense of what it means to be a thinker, a researcher, a theorist" (p. 31). The relationship between the researcher and the phenomenon must be strong, motivating, animated. I feel that this level of passion exists for me in the topic of music and clinical relationships, and as I read theorists' perspectives on the importance of this passion, phenomenology seems like an important choice and structure within which to explore my research question. Van Manen continues: "To be oriented to an object means that we are animated by the object in a full and human sense. To be strong in our orientation means that we will not settle for superficialities and falsities" (p. 33). This orientation towards passion and wonder on the part of the researcher toward the work has historical roots; Husserl landed in philosophy

after studying science and math because he developed a passion and fascination after attending a lecture (Van Manen, 2014). Later, his writings on phenomenology were saved from the Nazi's during World War II and devotedly translated in a long labor, due to the large volume of writings, again demanding great commitment and passion (Van Manen, 2014).

Husserl defined phenomenology as "a descriptive philosophy of the essences of pure experience" (Van Manen, 2014, p. 89). His perspective evolved around the idea that the true reality of an object can't be known, but one's experience of it can be. Although this idea is easily illustrated with a physical object like a cube or die, it is also demonstrable with a more abstract "object" like a relationship. We cannot know an objective reality of a clinical relationship, but we can learn about music therapists' experiences of their relationships. Husserl's ideas were influenced by thinkers such as Descartes, Kant, Hegel, and Nietzsche, and were later built upon by phenomenologists like Heidegger, Merleau-Ponty, and many others (Van Manen, 2014). Studying lived experience requires strong orientation toward the question of meaning, and to bring the mysteries of meaning more fully into consideration (Van Manen, 1990), which various phenomenologists have done in diverse ways.

Husserl's concept of essence seems applicable to this study (as cited in Moustakas, 1994), pointing the research toward the Real and the non-real, "a unity of the real and the ideal" (p. 27). As has been noted above, Bruscia's (1998a; 1998b; 1998d; 1998e; 1998f; 1998g) seminal writings on transference and countertransference draw punitive lines around how the music therapy relationship develops and operates in effective treatment. To work in contrast to this approach to the relationship, a method that

emphasizes "surrender to a state of wonder" (Van Manen, 2014, p. 27) and Heidegger's focus on allowing the concealed to show itself is particularly fitting and in line with this study's aim to allow more depth, nonjudgmental openness, and the mystery and chaos of human relationships in music therapy to come to light. Phenomenology distinguishes between appearance and essence, bringing up the things that we don't tend to see in our natural, everyday attitude (Van Manen, 1990).

As Romanyshyn (2007) states, "phenomenology begins with our entanglement with the perceptual world, the world that makes sense as we sense it" (p. 88). In a phenomenological study, the researcher sets out to describe the phenemenon as it is, as it might exist before we reflect upon it and bring in our preconceptions and biases. Heidegger talked about the meaning of an object's being rather than factual knowledge of it (Van Manen, 2014). This research approach focuses on our human experience of phenomenon rather than something about phenomenon that can be measured or judged as right or wrong. To be with the question of music therapists' experience of relationship with their patients, such a stance seems valuable and most likely to uncover insights that the music therapy literature has not touched upon.

Merleau-Ponty's (1945/2012) thoughts about meaning and the intersubjective experience are also relevant to this study. Through dialogue with an other, additional thoughts and meaning can be discovered; two people can become "collaborators in perfect reciprocity" (p. 370). As Van Manen (2014) summarizes, "It is in relation with the other that thought finds itself" (p. 130). This idea that perception comes through relation to others and the world is germane to this study, which seeks to explore the lived experience of a certain kind of relationship, the clinical music therapy relationship to

which affect is central, by establishing another kind of relationship, the relationship between researcher and participant, or interviewer and interviewee. Coppin and Nelson (2005) reiterate the focus of phenomenology on the intersubjective field: "Phenomenology begins to describe consciousness as more than personal. It represents relationships of intentionality in which things of the world want to show themselves at the level of their essence" (p. 33). This approach, in which the process of discovering essence is an intersubjective experience, is ideal for exploring the research question in a significant and depthful manner.

Research Methodology

Van Manen (1990) suggests that phenomenological research methods are borne of the research question, because phenomenology as a philosophy avoids fixed procedures that might govern or control the research process. In this study, which sets out to explore the lived experience of music therapists' relationships with their patients, it seems natural to speak directly to music therapists about their lived experience. Many authors (Van Manen, 1990, Coppin & Nelson, 2005, Moustakas, 1994, Merleau-Ponty, 1945/2012) have emphasized the creativity and creative process involved in phenomenological inquiry, which may be considered a match for a study involving professionals who have chosen the creative arts as their modality for serving others.

Creswell (2013) states that the type of problem best suited to phenomenology is one in which a need has been identified for understanding of common experiences of a phenomenon. The current music therapy literature does not adequately address the phenomenon of relationship between music therapists and their patients; a natural question that arises, then, is what is music therapists' experience of those relationships?

Certainly the relationships exist whether they are discussed or not, and this study aims to explore the contours and lived experience of those relationships, from the therapists' perspective. This necessitates a focus not only on the observable aspects of each music therapist's work with her patients (as seen through that music therapist's eyes), but also on her thoughts, fantasies, and internal musings about that work and the dynamics of that relationship.

An important part of conducting this phenomenological research will be my own process of bracketing and Epoche. Moustakas (1994) defines Epoche as freedom from suppositions, and identifies the Greek etymology as "to stay away from or abstain" (p. 85). Van Manen (2014) describes his perspective on Epoche as a withdrawal from the usual attitude and everyday world. The Epoche directs the researcher to avoid the "knowing" that is habitual in human life, and to attempt to put aside biases so as to see things as if for the first time. This relies upon the researcher's attempt to be transparent to herself, so all aspects of the experience can be made apparent, and the ideas and prejudices of others can be kept away.

Bednall (2006) suggests that the conscious and intentional process of setting aside biases and suppositions has a particular feeling to it when the researcher shares experience with the respondents. As a music therapist, I have worked primarily with individual patients (rather than in group settings), and I have many of my own memories, feelings, and perspectives on the clinical relationship, including dynamics of the transferential field, so I do have a personal connection with the experience about which I will be interviewing others. Bednall suggests that Epoche is an ongoing process, while bracketing, the process of setting aside biases, happens during the process of data

interpretation. Van Manen (1990) emphasizes that bracketing is not about trying to forget or ignore what is already known, but making those things explicit so they can be held at bay. Creswell (2013) mentions including a discussion of the researcher's personal experiences with the phenomenon as part of setting them aside so as to focus on the data.

The Phenomenological Reduction, as conceived by Moustakas (2004), is a part of data interpretation that involves describing the process, the experience, what is seen literally and figuratively. The task is to attend to whatever presents itself to consciousness. Receptiveness is emphasized in phenomenology, because a meditative process of self-dialogue prepares the researcher to receive. The reduction is a way of constituting meaning, and is the moment of returning to the world as shown in consciousness (Van Manen, 2014). The researcher is setting out to find "the thing itself" (Moustakas, 2004, p. 91) using prereflection, reflection, and reduction, to describe the essential nature of the phenomenon. This additionally involves returning to the researcher's own subjective experience and attending to the meanings that arise.

Another important aspect of phenomenological methodology is the task of Imaginative Variation. According to Moustakas (2004), the intention of Imaginative Variation is:

> To seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions. The aim is to arrive at structural descriptions of an experience…. How did the experience of the phenomenon come to be what it is? (p. 98)

It is during Imaginative Variation when the researcher uncovers essences. Moustakas points out that it is through this process that the researcher sees the multiple roads that lead to truth, and the many influences that are connected with the meanings of an experience. Bednall (2006) concurs and encourages researchers to note that phenomenological evidence is the whole of the data, not one aspect of the story. Phenomenology is an interpretive process (Creswell, 2013), and the researcher's task is to look at all the data and make interpretations as to the meaning of the lived experience.

Participants

Participants for this study will be music therapists who work individually with their patients. Inclusion criteria for participants includes the necessity of working individually with patients, and being in practice for at least five years. Exclusion criteria will disqualify clinicians who work only with groups or families, and those who have been practicing for five years or less. Participants must also be able to articulate their experience in working within therapeutic relationships; however, it is not necessary for them to be able to articulate this experience using psychodynamic terminology.

In an attempt to gather diverse perspectives, recruitment will focus on identifying music therapists with diverse experience levels, clinical orientation and specialization, philosophies of music therapy, and geographic distribution. Although music therapists who identify as having a psychodynamic orientation to their work may have more familiarity with concepts like transference and countertransference, attempts will be made to recruit participants with other orientations, who may also encounter transferential phenomena even if it is not a focus of their work. This study will attempt to include perspectives from music therapists who may not consider the therapeutic

relationship to be a primary consideration in the process of healing in music therapy, such as those with behavioral orientations. Geographic distribution is valuable because of the popular conception among music therapists that certain theoretical orientations are primarily ascribed to by music therapists in certain American regions. An additional consideration is that music therapy is a field that allows bachelor's-level entry. Many music therapists have a great deal experience without having a master's-level education, and so this study intends to be open to including those who have received formal education exclusively at the bachelors level. This study will involve at least seven participants.

Research Procedures

The process of recruitment of participants will take place through networking and social networking outlets, including music therapy listserv and online discussion boards from sites like Facebook. Seidman (2013) suggests that the interviewing relationship begins the moment that participants hear about the study. Recruitment materials will specify that participants are needed to volunteer for a research study about the experience of music therapists who work with individual patients. From those who respond, an initial screening will attempt to assure the participants' diversity of perspective by requesting potential participants' education, experience level, clinical orientation and any specialization, philosophy of music therapy, and geographic location.

After participants have been selected, semistructured interviews will be utilized to explore each therapist's experience of relationship with his or her individual patients. Interviews will take place in person or possibly via video conferencing technology such as Skype. Interviews will be recorded and transcribed, with participant approval. A

phenomenological reduction will be applied to the transcripts, including clustering into themes, in order to arrive at a distilled, in-depth description of the essence of the experience for these music therapists.

Procedures for Gathering Data

After potential participants have been recruited and selected through the screening procedure, data collection will begin with an audio recorded, semi-structured interview conducted in person or via a video conferencing platform such as Skype. Seidman (2013) addresses the question of long-distance interviewing, which has potential pitfalls. Seidman states, "By not seeking their participants out in person, researchers are emphasizing the utilitarian aspect of their relationship with their participants, rather than developing the more equitable relationship that can be developed in a face-to-face interview. At that level, they are giving less back to their participants than they are receiving from them" (p. 113). Researchers who choose to conduct interviews in this manner, which Seidman condones only when the interview cannot be done in person, must consciously work to bridge this gap and convey their interested, respectful presence.

Multiple authors (Smith, Flowers, & Larkin, 2009, Seidman, 2013, Moustakas, 1994) emphasize the importance of establishing a rapport with participants in order to help them feel relaxed, open, and engaged. As researcher and interviewer, it is my responsibility to help each participant to feel comfortable, so they can be most honest and comprehensive in responding to interview questions. Moustakas (1994) recommends beginning the interview with a social interaction or meditative activity to help facilitate the participant's comfort. Although persons who are well-known to me as colleagues or friends will not be selected as participants for this study, music therapy is a small field in

which I have had some visibility through conferences and other professional activities. In conducting interviews with participants who are my peers in the field of music therapy, I acknowledge the possibility that participants and I will have loose familiarity with each other, and an opening social conversation will be appropriate and necessary to honor the truth of our association with each other.

The opening moments of the meeting with participants, before the interview begins, will also include a discussion about the nature and purpose of the study. Seidman (2013) recommends doing so in as broad a context as possible. I do not intend to specify in advance that this study is focusing on relationships, or to mention terms like transference and countertransference. Because this study is intended to describe the experience of music therapists, not only music therapists of a certain theoretical orientation, it is important to use language that will be germane to therapists of various orientations. An explicit focus on relationships might feel immaterial to therapists who are behaviorally oriented, and terms like transference and countertransference might raise anxiety among those who are not familiar with this particular aspect of relationship phenomena. During this opening conversation I will review informed consent, including consent for recording, and ensure the participants' confidentiality. Additionally, I will provide guidance for the participant on what to expect from the interview, and what the responsibilities are for each of us. Smith, Flowers, and Larkin (2009) suggest specifying that there are no right and wrong answers in the interview, that I am interested in the participant and her experiences, and that the interview should be "rather like a one-sided conversation" (p. 64).

"Unless one has engaged deeply with the participant and their concerns, unless one has listened attentively and probed in order to learn more about their lifeworld, the the data will be too thin for analysis" (Smith, Flowers, & Larkin, 2009, p. 58). Entering the interview process, my intention will be to facilitate the participants' process of entering deeply into their own stories about their individual work with patients in music therapy. I will also attempt to enter their stories deeply along with them; Smith, Flowers, and Larkin suggest that being very attentive allows the researcher to focus more and be less distracted by their own presuppositions, leading to more effective bracketing. At the same time, I acknowledge that an interviewer also brings meaning to the interview (Seidman, 2013), in part because the meaning that arises in each participant's stories will come through our interaction. Merleau-Ponty (1945/2012) also emphasized this idea, that it is through dialogue that the other can draw thoughts that I did not know I had.

Interview questions will be semi-structured and follow the flow of the conversation with the participants, seeking in-depth descriptions of their experiences with the phenomenon. I intend to begin the interview by asking the participant to tell me about the workplace in which she is employed in individual work with her patients, and what her general experience being a music therapist is like. Smith, Flowers, and Larkin (2009) recommend beginning the interview with a question that can be answered descriptively, and whose answer will come fairly naturally for the participant. The remainder of the interview questions will intend to include points similar to those below, in some cases starting from general open-ended questions and moving into specific experiences organically, or with follow-up questions that emerge with the flow of the interview.

1. How do you understand your role as therapist in your sessions with individual patients?

2. How do you use your feelings to work with a patient, and can you give me specific examples?

3. How do you understand your work in the context of psychodynamic concepts like transference or countertransference, and how do these concepts inform your work?

4. How do you make use of your own emotional responses in the session? Do they inform how you understand the patient's experience?

6. What impact does music have on the relationship between you and your patients?

7. What do the relationships that you develop with your patients mean to you?

8. Is there a particular patient who you feel has been most challenging to you in the interpersonal space, and can you describe your experience?

9. How do you understand or find grounding or a reference point for processing your emotional experiences of sessions?

Following suggestions of Bednall (2006), I will complete on my own a feelings audit before each interview, to acknowledge and set aside the preconceptions that are with me about the phenomenon on that day. I will also journal my impressions and feelings after each interview to provide grounding and orientation to elements of the data that were apparent to me during the interview process, as recommended by Bednall and also by Smith, Flowers, and Larkin (2009).

Recordings of interviews will be transcribed by me. Smith, Flowers, and Larkin (2009) note that transcription itself is a form of interpretive activity because of all the

things that may or may not be selected for transcription, such as pauses, nonverbal utterances, or nonconventional words. These authors suggest that all of the above are included on transcripts, which allows for a fuller acknowledgment of the participants' stories.

Procedures for Analyzing Data

Data interpretation is an iterative and inductive cycle, a dialogue between researcher, her coded data, and her psychological knowledge (Smith, Flowers, & Larkin, 2009). Interpreting the data, including interview transcripts, feelings audit, and journal entries, calls for a process of phenomenological reduction. This study will, in other words, utilize a multilevel analysis in which meaning units are extracted from the transcripts—with the final product including a write-up of each participant—and an aggregate description is developed, identifying the lived experience. Smith, Flowers, and Larkin suggest beginning this process with a conscious, active engagement with the data, striving to enter the participant's world by reading and rereading the transcript.

The next stage of actively engaging with the data calls for identifying significant statements as part of iterative reading—those that answer the interview questions and provide an understanding of their experiences (Creswell, 2013; Bednall, 2006). Smith, Flowers, and Larkin (2009) suggest making specific notes about identified passages, and including those comments that are descriptively significant, linguistically significant, and conceptually significant. Linguistically significant moments would include those that stick out because of voice and language, including tone, fluidity, metaphor, pronoun use, repetition, pauses, or laughter. Conceptually significant passages would engage the researcher's interpretation of meaning.

With my notes, I will then establish topics of significance and thematic linkages in the material, what Creswell (2013) calls "clusters of meaning." These will focus on "phrases which speak to the psychological essence of the piece" (Smith, Flowers, & Larkin, 2009), and will reflect my interpretation as well as the participant's thoughts. Bednall (2006) then suggests a reintegration of what was set aside in the Epoche, a kind of "debracketing" that allows for a fusion of the researcher's perspectives with the data, an "interpretive fusion" that can lead to conclusions. This is part of creating what Creswell (2013) calls the textural description.

I will employ Imaginative Variation as part of my phenomenological reduction, hoping in this process to uncover essences of the music therapist's experience in relationship to her patients. Phenomenological evidence is the whole of the responses, so the essence, the common experience of all the participants, will be united into one single narrative on the nature of the phenomenon, without one story dominating over the others (Bednall, 2006).

Ethical Considerations

This research requires the review and approval of Pacifica Graduate Institute's Ethics Committee, due to its reliance on data from interviews with human participants, which is intended to ensure that ethical principles of research will be upheld. Although the interview questions listed above inquire about the participants' professional rather than personal lives, the work that happens within clinical relationship is often quite intimate. As has been established in the Definition of Terms section of this research, clinical relationship calls upon clinicians to make contact with vulnerable, emotional aspects of themselves, and engaging the participants in discussion of this aspect of their

work could stimulate similar feelings of vulnerability. For this reason in particular, all participants will be provided with a thorough statement of informed consent, which they will be asked to review prior to giving their agreement to participate.

In order to provide further protection, in the final presentation of this research, the identities of the participants will be concealed with pseudonyms and with some altering of other identifying information that might be shared during the interview process. Participants will be offered opportunities to amend or redact passages of the interview transcript that they are not prepared to release for use as study data. The statement of informed consent also details this procedure for the participants in writing, and it will be reviewed verbally prior to the start of each interview.

The statement of informed consent includes acknowledgment of the sensitive content that may be stimulated through the interview process, and informs participants that referrals for psychotherapy or clinical supervision are available through the researcher if needed. If participants express an interest in further learning related to issues of clinical relationship dynamics, they will be informed that the researcher can also recommend literature that may be elucidative.

As has been mentioned earlier in this chapter, participants will not be informed directly about the depth psychology lens through which their contributions will be understood in this paper. Such information may be anxiety-provoking to music therapists who do not understand their work through a psychodynamic lens, or who are unsure about the meaning of such concepts. Participants will also not be informed of the researcher's position of critical analysis that emerged in this research through the

examination of the literature, in order to ensure that their interviews are not unduly influenced by any reactions they might have to the researcher's critical stance.

Chapter 4

Findings

Overview

This chapter presents the findings obtained from the interviews with seven music therapist participants, including idiographic and nomothetic analysis identifying major themes. The seven music therapists who volunteered and participated represent experience levels ranging from five years, the minimum requirement for inclusion, to more than thirty years. Most of the participants have been music therapists for fifteen years or less. Although gender was not a qualifier mentioned in the methodology chapter, it seems important to note that six of the seven participants were women, which generally matches gender representation in the field at large—just over eleven percent of music therapists identify as male, according to the 2015 American Music Therapy Association Workforce Analysis. All seven of the participants have a master's degree in music therapy as their highest level of education, and five of those seven also completed a bachelor's degree in music therapy. Of the music therapists who volunteered to participate in the study, very few resided outside of the northeast region. Five of those interviewed practice in the northeast, and two practice in the Midwest. Three of the participants identified their philosophical orientation as humanistic, three as a combination between humanistic and psychodynamic, and one as cognitive behavioral; however, several included a note that although they may primarily identify with one or two orientations, they considered their practice to be eclectic and sometimes encompassing other orientations as well, in order to allow them to meet all of a given client's needs. The therapists interviewed worked in a variety of settings, including

clients' homes, outpatient clinics, hospitals, long-term care facilities, and the music therapist's private practice office. The specific client groups that the therapists work with in individual music therapy included adults and children with developmental disabilities, elders, adults with mental health challenges, and adults and children with medical illness.

The interview process was a semistructured interview as described in the previous chapter, with five interviews taking place in person and two conducted via Skype. All of the participants reported, unsolicited, that the interview made them think about aspects of their work that they may not have considered before in quite the same way. One participant followed up after the interview to request recommendations for further reading on the topic of transferential phenomena, and two other participants asked that the researcher explain these concepts during the interview. What follows is a summary of emergent themes from each individual interview, presented in the order in which the interviews were conducted.

Participants

Pam.

Pam's work with individual music therapy clients includes adults with mental health concerns whom she sees weekly in a private office (similarly to psychotherapists), and children with developmental disabilities whom she sees primarily in their homes. She identifies as working from a humanistic and psychodynamic philosophical orientation. The following significant themes emerged in the idiographic analysis of Pam's interview.

Significance of her work.

Pam frequently referred to the significance and weight of her work, often in the context of trying to answer questions about emotional experiences. When asked about

what might be informing her clinical decision making when she is trying not to think too much, Pam responded, "I think it's many things. I think part of it is my ability to really be present in the music experience, to just be present with my client, my beliefs, my kind of core beliefs as a music therapist, as a therapist, as a person, about the work that I do, about the importance that it plays, about the role and the significance of the experiences that I facilitate for the people that I work with."

Regarding helping an adult client process a stressful time using toning (vocalizing sustained, spontaneous tones on open vowel sounds with one or multiple others), Pam spoke about a "different emotional place" that her client was experiencing. When asked what felt different to her as the therapist, Pam stated, "So I guess what I was feeling was kind of the weight of that moment… it felt to me very significant that she was able to be that present with me and with herself… I was just feeling the weight of it, if that makes sense, and then afterward she was sharing that she was having all of this really powerful imagery as we were doing it… But it felt so… like time stopped almost, and this is someone who, if I let her, would just come in and talk for the entire hour. Without a problem. So it just felt very significant."

Dialectic between grounding and emotional overwhelm.

The tension between grounding and emotional overwhelm seemed to be another important aspect of Pam's experience as a music therapist in individual sessions. Being "grounded," with a strong capacity for clinical holding, is a strong value for her as a therapist, seemingly part of her clinical identity. She contrasts this with moments of emotion that occur in the clinical space, for instance, in the context of describing a feeling of annoyance with one of her clients:

> It was hard to admit to my supervisor, because I'm always this calm grounded therapist, to be able to—I mean, it makes sense, I know that, I'm a person, my client's a person, and people annoy other people. But it's kind of along the same lines, when people say 'I'm a therapist and I should be able to handle my own problems,' but it's not necessarily so.

Being grounded and having an emotional experience seem to feel mutually exclusive.

Somatic experience as signaling device.

Somatic experience was an important aspect of Pam's reported experience providing therapy. She frequently spoke of body sensations and experiences as a way to describe her emotional experience. She reflected on a meaningful experience in session as follows: "I remember feeling very grounded and very in my body, which I normally do when I'm working with someone." Regarding another experience with a client who was struggling in session, Pam stated, "In those moments I'm aware of how deeply I feel," and when asked what she was feeling specifically, she responded, "It's a combination of reflecting that for her, so feeling that, feeling that 'oh my god, I'm going to crawl out of my skin and I don't know what to do'… It's a balance between that and… feeling like, you know, it's hard to explain, feeling that, and then also feeling—remembering to breathe and feeling my groundedness." In a third clinical example with another client, Pam was describing an intense musical experience, and when asked, "Do you remember what you were feeling?" she responded, "It was just this kind of… I remember being really conscious of my body and of my voice… part of me was just in awe." Pam herself summed up her reliance on somatic experience as a clinician when asked what lens she uses to understand her own emotional experience in session. She stated:

> Oh! My body, basically… Looking at it in the context of my body and where I'm feeling it, kind of through the lens of what's going on at that moment, what am I picking up… to kind of look at what's happening emotionally within the context of what's happening in the session, and grounding my own reactions within that.

Tolerating difficult feelings.

Pam spoke about difficult emotional experiences that have occurred with her clients and her reactions to them, often with some ambivalence about tolerating those feelings. She spoke about her fear, before confronting a client about self-destructive behaviors, and how that impacted the work:

> I felt like I was almost doing her a disservice by kind of, I don't know, maybe, I can't think of another way to say it, like stroking her ego kind of, and perhaps being a little bit afraid of what would happen if I said, 'It is time to go deeper,' almost like when a teenager throws a temper tantrum.

As was also noted above, she additionally spoke about how her feelings of annoyance with this same client were difficult to admit to in supervision, "Because for me annoyance feels very short and kind of stilted, like if I were to play it, it would be very fragmented." Reflecting on the way that she languages her annoyance, seemingly a natural reaction to the client's behavior, her words are evocative of self-blame and disapproval of that emotion.

Anger is a particularly difficult feeling to tolerate. Regarding another client that she had seen earlier in her career, Pam stated, "When she was angry at me it was hard, and I remember needing support from my supervisor. In general it's hard for me to have people angry at me, um, in my regular life, a lot. It's something that I've gotten a lot

better at since then, this was a while ago." Pam said about her present clinical work in regard to anger, "I've had to learn how to sit with things that are hard for me on a personal level, and also to be able to, when appropriate, to join them and to actually access my feelings of anger and frustration, so they're not playing this huge thing and I'm just sitting there looking at them, which sometimes is appropriate and sometimes I have to go there, and I'm remembering…. There have been clients in the past year. I remember hitting the drum so hard, or last week kind of being worried that I'd break the cymbal stand… that wasn't rage though, I don't know what that was." Pam also spoke about times when "it would look and sound like [my clients] were angry with me" and how those times were "a little hard. The first time it happened it was like… okaaayyy… but then I realized in that particular instance it wasn't about me."

Anxiety about boundaries.

Sometimes Pam's descriptions of emotional experience and her ambivalence about it seem to also reflect some anxiety about boundaries. Regarding an experience with a child client, she stated, "I don't know, it's really hard to find words for just feeling the intensity of it. It's just such a raw, overwhelming flood of emotions. Sometimes she's crying, sometimes she's not, sometimes she's right on the edge… um… so it's really what I was saying before. I always have that duality of being able to hear that and sit with that and hold that, and also that I make sure that I don't get lost in it." The fear of being overwhelmed by the client's emotions, that this could be an unsafe violation of boundaries, emerged more than once in regard to the same client, as Pam reflected, "Being aware enough of her distress and being able to feel that, but not getting so

overwhelmed by the distress that I couldn't then be like a safe containing space for her, like a touchstone."

Worries about boundaries also emerged in regard to strong positive feelings that Pam has towards her clients, particularly adult clients: "It's weird, I think there's a hesitation to, when you're working with a child I have no problem saying that she's one of my favorite child clients, but it's almost weird saying that about an adult, and I feel maybe on some level, I don't know if I was ever consciously told this or not, but we're not supposed to have favorites. The fact that that happens… I don't know, I mean I feel really lucky to get to work with her."

Pam directly described a struggle with boundaries earlier in her career, when she had a boundary-pushing medically ill client:

> I remember sitting with my supervisor and her saying, "You have to draw firm boundaries with her, she doesn't have them and you have to be firm." And so I had to be thinking, what are boundaries, it's less about how you're not going to ask me what I did with my fiancé last night, but what did boundaries mean to her in a greater sense, like losing all boundary of her body and control over herself… so I had to be really clear with her, that if you miss your session then I can't see you whenever. You know what I mean, and it was hard for me at the time, I was… I was young.

Difficulty in being a projective identification accepting object.

In describing her experience with countertransference, Pam focused on concordant identification, without acknowledgment of complementary identifications, as Racker (1957) described. For instance, when asked to say more about an experience with

a client that felt "difficult" to her, Pam stated, "I think that perhaps I was just picking up from her that it was difficult. Unlike it is for me, for her it's something that is not familiar, comfortable, or something that she'd really ever done before." She later spoke more generally about interpreting her emotional experiences and how they inform her understanding of the client's experiences: "I believe that if there's something that I'm feeling and we're in the same experience, then it's probably akin to what my client is feeling, at least in the same ballpark. I do tend to feel things very deeply, so if I'm either not feeling anything or… actually when I'm not feeling anything that sometimes for me can mean that I'm disconnected and that can mean that the client is disconnected from what they're saying or playing, or what they're saying or playing is not really getting to the heart of the matter."

Focus on external world rather than internal experience.

As Pam described her experience in session with individual clients, she often focused on external factors of the session, more so than internal reflections, thoughts, feelings, or fantasies (countertransference). This came up repeatedly, in the context of several different clinical situations that she described, although it first emerged as she spoke generally about "holding and nudging," or supporting the client in their present state versus nudging them to grow or examine themselves. To decide whether holding or nudging might be appropriate at a given moment, she relies on "my intuition, how well I know them, how far along they are in the process." She associated to a specific client, and how with this client the decisions come from:

> listening in a different way…. She's so in the moment, and so in the music that the talking seems extraneous, she's able to have this fluid conversation, so it's

> really about listening at that level. And allowing myself to, to kind of quiet the chatter, because it will come up every so often and sometimes it's useful, like "what should I do, what is she doing, what should I do now"… and just being in the moment with her.

When asked about using her feelings to work with her clients, Pam spoke about "using" her feelings in an external way—specifically in the context of verbally sharing her internal experience, and using herself as a "model." When asked about how countertransference and transference inform her work, she immediately spoke about "naming" and sometimes talking about this phenomena with her clients. Although the internal experience of transferential phenomena is not discounted, the emphasis in Pam's description of her experience is on what happens externally. For instance, with a client who stimulates a feeling of annoyance in her, Pam focuses her description of the countertransference on her client's behavior and her outward response:

> Noticing how when she acts like that it kind of gets under my skin, and holding her accountable, in essence really like her parents never did, for noticing her own feelings and reactions and responses to things, and really being able to feel things rather than just kind of self-soothe in very unhealthy ways.

Pam brought up the topic of vulnerability, and how music creates "an even playing field" between client and therapist because it makes her vulnerable. Her experience of this vulnerability seems to revolve around worries about judgment, either the client's or her own, for not being perfect: "I think it's important for them to see, there is a lot written and spoken about the wounded healer, and I think it's important for my clients to see that I am not perfect." She continues:

> Relationship at its best incarnation is about being able to see someone else's vulnerability and be okay with it. As the therapist I don't air all my dirty laundry, but music is the way that, that we can kind of explore what it means to be vulnerable and what it means to show someone else that you don't know what's going to happen and that you can be in that place together.

Conflict between performer and therapist identity.

Part of the vulnerability that Pam describes is connected to having her musical skills judged by her clients, especially clients who might be musicians themselves:

> It can feel particularly vulnerable because they may or may not be, they sometimes are, better at a certain instrument than I am, or I'm afraid they're going to ask me to play a song by memory that I've never heard of… to be so transparent about the fact that while I think I'm a good musician… it doesn't mean that I know every piece of music ever.

Carl.

In his interview, Carl references his individual work with clients with varying needs, in a variety of settings from his current and past music therapy experience, including children and adolescents with medical illness, adults receiving medical and addictions treatment in a clinic, adults who come to his private practice for mental health treatment, and elders that he sees in their homes. He identifies his philosophical orientation to music therapy as humanistic. The following significant themes emerged in the idiographic analysis of Carl's interview.

Transferential material not acknowledged.

Carl was clear, in his interview, that he does not usually consider the influence of the transferential field in his work with clients. He did learn about psychodynamic concepts during his graduate education and has addressed those concepts with some clinical supervisors in the past, but purposely does not attend to them in his current work. As he described his experiences with his individual clients, however, the influence of the transference was clear, sometimes to Carl himself. Regarding an experience he had with a past client, where his own unconscious behavior had become clear to him and been very impactful on his feelings about the work and the client, Carl said, "maybe it's something that I should be thinking about more, this whole countertransference thing (*laugh*). I don't know, I don't know why I don't think about it as much, you know?"

Carl also described working with a woman with a personality disorder who may have been trying to communicate with him via projective identification. He described her repeated sexual provocation of him during their work together, and told me that in response, "I felt annoyed. Yeah. Because, um… because I felt that it was coming from a place where she wanted to throw my balance off." Another patient whom Carl worked with would use music to incite certain feeling responses: "Sometimes when he plays the drums he gets really loud, and aesthetically it can be a little harsh. So you know, it makes me less emotionally attached. So it's a little bit more difficult to connect." Carl talks about sensing some of these interpersonal dynamics, but does not acknowledge them in a psychodynamic context or handle them clinically from that lens.

Difficulty describing emotional experience.

Carl's descriptions of his experience working with his clients gave an impression of deeply emotional work in which Carl finds a lot of meaning. However, as he was asked to elaborate more on his experience, it seemed that it was difficult for him to find words for the more emotional aspects of his experience. He spoke enthusiastically about his excitement in making music with one client, but when asked to say more about that feeling, he responded, "Um… it's hard to describe… it's like… it's raw, genuine, present… I mean those are not really feelings, but… I can't… like, it's very expressive. I can't say that it's one or the other feeling, it's a lot of things, it's multilayered feeling." In other moments, Carl would respond to questions about how he was feeling with musical terms that may be more evocative of physical sensation than emotion. For example, when asked how he felt when playing music during a specific clinical situation he described, Carl responded, "There was a lot of groove, of rhythm."

Focus on external rather than internal world.

Perhaps in connection with this difficulty describing the intimate emotional and ineffable musical experiences, Carl's experience in session with individual clients does seem to focus more on external information than on internal reflections—although the internal is acknowledged in a sort of unformulated way. For instance, he stated the following about his musical work with one client:

> So we would improvise music and it was… it was very intense, like he was a fantastic musician, and um… physically he—there was such change in him. He—I mean you could tell musically that he was really feeling it, and we had a great connection, but also physically you could see how he moved and got so excited,

> and how he made faces that seemed to match the emotional components of the song… it was very intense. And meaningful, because that's one of the only things, if not the only thing, that he could do, where he had—where he could make choices, you know, and interact.

When asked to talk about a time when he was juggling all of the elements of a session, including his feeling experience, Carl spoke about this experience with another client: "I'm thinking about just musically, how to… uh… facilitate for her to make music… for her to have as many choices, and for her to be as engaged as possible in music. So I'm thinking like, 'Oh, let me repeat this part, let me slow it down, let me bring it up, let me change the chord,' all that sort of thinking. I'm also thinking about where she may be emotionally, because in spite of what sometimes the aides think about music therapy, it's not there to make her happy or sad. I just want to be with her however she is. So I try to be careful about that, and match her. But sometimes… sometimes I think I make clinical decisions where I made sure to bring her slowly to a better mood, or to be more engaged, so there's the emotional aspect to it." His description almost suggests that the process of facilitating this music-making experience draws him away from conscious attention to his own internal world. He mentions the client's emotional experience, but with much less specificity and emphasis than the more external, observable elements of the session.

Carl also spoke about a young female patient in the hospital who had told other staff members that she had a crush on him. When asked how this made him feel, his response was, "Eh, I don't think it changed much in the session… we didn't really

explore it in any way because it just didn't come up. If she had brought it up maybe I would have said something."

Discomfort with certain emotional states.

There are specific feelings that, Carl shared, he does not feel comfortable handling in a clinical context. In reflecting on an interaction with a client, he stated:

> I don't know, maybe it's hard for me to go to that level of aggression, I guess. I don't know. There's a bar that a few times he has—I mean he's definitely more energetic than me. So I don't know, the way you said it made me think that maybe I wasn't able to go there with him. It was a little—yeah, do you know what I'm saying? It was those times—it was hard for me to be with him because it was a little too aggressive.

Another time, a client reacted to him in a way that was competitive and rejecting:

> "With him it was hard, because also I like him in many ways, but I also feel like, Tsk! This guy thinks that he's the man here or whatever! And he doesn't care about me… and you know, not 'because I'm the therapist, obviously it doesn't affect me'… it affected me."

Conflict between performer and therapist identities.

Carl's reflections on this patient brought up a notable aspect of his experience providing individual music therapy: the challenges of merging his musician-performer identity with his music therapist identity. Considering the rejection of this client, Carl reflected on the ways that the clinical couple struggled over who was the musical leader in their jam sessions. The client felt that he was the more accomplished musician, and this felt like a challenge to Carl's authority, as well as a hurtful blow: "To me, one of the

worst things, like whenever I feel the worst about myself is if there's something in the music that I'm not—that I feel bad about… If you call me a bad musician, it can really hurt me." In moments like this one, it seems as though the therapist's client can, at times, become like the performer's audience member. Carl described improvisational music-making with another client who sometimes seems annoyed if Carl doesn't play the right thing. He reflected:

> I feel like I'm doing something wrong. Which, in a way, I am. Sometimes I'm messing it up or something, the music. I think when that happens my musician side takes over and I… like… become critical of myself. As opposed to using it in a therapeutic way, which is what I should do.

Desire for validation.

A desire for validation also came up frequently in Carl's description of his experience. He noted that early in his career he was so excited to engage musically with clients that he barely thought about his own role in the clinical interactions. But, he said, "I feel like now I need those types of things more for some reason. Like, I need the validation more right now, than then."

Anxiety about boundaries.

Carl expanded on this theme with several vignettes that brought up vulnerable feelings for him. Validation came up in the context of his quality of musicianship, as mentioned above, and also in anxiety about boundaries. He noted, "It annoys me when I have to set boundaries for some reason," and as he explored this feeling further he realized, "It makes me worried that he or she is not going to like me anymore. That's what it is." He reflected more on worries about validation in the context of boundaries:

> That's the feeling, that I'm scared that they're not going to like me. Not just with that patient, that happened to me a lot in this place. Like… when I had to not let people in [to session] if they were late [per the rules of the facility], or just talk to them about something that they did or something like that.

Carl's anxiety about boundaries arose in other contexts of his experience as well. He spoke about his feelings about an elderly client with dementia who once seemed to mistake him for her husband:

> I was a little nervous, because I didn't want her confusing… I didn't want to confuse her too much… Emotionally I felt for her, you know? She misses her husband, she's elderly… I know from my grandmother how sad or how difficult that can be. And at the same time, I was… a little nervous about it. Like, I didn't know exactly where the boundaries are in that."

He later admitted that the presence of a patient's romantic feelings toward him—something he has experienced multiple times—is "something that makes me a little nervous."

Carl was open about his struggle with boundaries—with holding them, and with helping his clients to develop them. He remembered a time in his career when he "had to be really strong about structure… I was a person who could show up on time, who could make sure that things happened. You know." When asked what it was like for him to be that person, he responded, "That was hard, because I didn't want to be that person, I wanted to be the person who plays music with him." He later reflected:

> I guess in my mind I wanted everything to just happen naturally. Maybe that's why it's hard. Maybe that's also why it's hard for me to, like, work with people

> on boundary setting, because I just want things to work out… just having a relationship that works naturally.

Anne.

Anne describes her work with children and adults with various developmental disabilities, neurological concerns, and mental health conditions in an outpatient clinic. She identifies her philosophical orientation as humanistic and psychodynamic. The following significant themes emerged in the idiographic analysis of Anne's interview.

Filing away feelings that come up in session.

Anne described rich relationships with her clients, and she clearly experiences a range of emotional reactions to those relationships. However, she repeatedly spoke about the importance of not allowing feelings to be part of the in-the-moment interactions with her clients. When asked about her intense emotional experience with a particular client, Anne responded, "I just have to remind myself to put that aside; you go into the session and you focus on the here and now." There is a way in which Anne's own emotional experience is taken out of the here and now.

Anne answered similarly when asked about how she understands her work in the context of psychodynamic concepts like transference, countertransference, and projective identification:

> When that happens, I just try to… again, not act on it. I try to file it away. If it happens in a session, I'm aware of something, a feeling towards a client that just sort of comes out of nowhere, it could be very positive, it could be negative… and then look at it later and say "Why did I feel strongly?"

Anne identified an interesting differentiation regarding feelings and their place in the clinical space—on the one hand she speaks about the importance of feelings, and on the other she really emphasizes their unsuitability for the interpersonal clinical space:

> I think it's very important to allow yourself your feelings. I always tell students, you know, let yourself have all your feelings, reactions to your clients, but file them away and look at them later, don't act on them in the session.

Conflict between performer and clinician identity.

In considering how music impacts her clinical relationships, Anne reflected about how self-judgment about the quality of the music she creates can invade the clinical space:

> It's always tension in any session, even though I've been doing it for so many years, of what should I play and is it going to be good enough. There's always that tension. And sometimes I like what I played and sometimes I don't like what I played.

Anxiety about certain feeling states.

Anne described clinical work that is frequently emotionally intense and challenging, and talked about how she feels it is important for her to "stay positive" in the face of suffering and sadness. When asked about this idea of staying positive, Anne responded:

> Well to stay positive for me—to go into each session fully present. And fully engaged. Because if you're not… positive… then you might just withdraw. And I don't want to withdraw from my feelings for him. I want to be 100% present in our session, to, in our time together, give him everything that I have.

The dichotomy of positive and negative also arose in Anne's discussion of her clients' feelings. Regarding working with children with oppositional defiant disorder, she stated, "I want to build a relationship with them, but I don't want to overwhelm them and bring out the negativity." There is a sense that negative feelings, or interpersonal difficulties like power struggles, are not part of the clinical interaction, but a barrier to the clinical interaction. Even in considering her contributions to this study, which were rich and courageous, Anne was concerned: "I think I've talked a lot about the negative things, and I don't want to come across as feeling negative about the work."

Client projections unacknowledged or avoided.

In her interview, Anne frequently described the projections of her clients, but without acknowledging them as projections, or in some cases acknowledging the projection but framing it as potentially destructive to treatment:

> Some children I just wanna scoop them up and take them home, you know? (*Laughs*) What is that about? Why are they bringing out the nurturing mother in me, and uh… is a child deliberately avoiding working so they can get taken care of, and am I gonna fall into that pattern?

With children she described who might induce more of a negative reaction, Anne seemed to take more distance from the projection. "I've experienced enough where I can kind of separate my own feelings of, um… you know, annoyance or anger that this child is… lashing out at me, 'cause it doesn't feel good when someone is doing that even though I know it's not about me, it's more about my role in the session." She acknowledges that the anger, experienced by herself and the child, exists in the interpersonal space, but she still keeps distance from it rather than engaging in that

emotional space together. When describing a child client who sometimes became violent and stimulated anger in her, Anne reflected:

> Yeah, it was unpleasant. I didn't look forward to sessions with him, because I didn't want to have to deal with that. Um, it was unpleasant for me during that period. I had to protect myself, I had to protect him… I felt that I had to do all these things that had nothing to do with music therapy, but I couldn't even get to the music therapy. He was not allowing me to do it.

The projections of adult patients were also unacknowledged. One client came to mind for her when she was asked about her experience with transference, and Anne reflected, "He would ask me questions about my personal life, he asked me out on a date once—*(laughs*)—um, out for pizza I think it was. I don't know if it was his transference for me, it was more his desperation to connect with people." Regarding a young woman with a traumatic brain injury, she again noted strong feelings without acknowledgment of the projective element:

> Yeah, I have a lot of feelings towards her—you know, motherly feelings. But part of me, I'm just realizing now, actually sitting here, that I feel in a way angry that she took those drugs… So then I think, am I blaming her for what happened to her? Not really, because she had no idea of course, it was just horrible luck, and nobody knows what really happened.

This particular client insists that she never gets angry, and Anne is working to help her acknowledge all of her feelings. At the same time, Anne talks about putting her own feelings (some of anger) aside before she enters the sessions:

> It's just something that you do, it's like swallowing medicine, you just do it 'cause you have to do it. I can't go in there and bring all my sadness and frustration in, you know, I have to be a warm, supportive presence for her.

Concern about boundaries.

Anne seemed to experience a tension between her strong feelings for her clients and an implication that strong or genuine feelings indicate a potential boundary violation. When asked how she makes use of her emotional experiences in session, Anne responded, "I try to be genuine in my reactions, but there's of course a boundary." In considering countertransference, boundaries were one of the first things that came to mind for Anne:

> There's always some clients you're more drawn to than others, and there's something… but you don't want to act that out, at all. That's the boundary for countertransference… So I just try to look at it later, and try to understand. And once you understand, then the intensity dissipates, and um… it doesn't become a problem.

Reflecting on what her clients mean to her, Anne associated to termination: "Some I feel like I really miss; they're people I enjoy spending time with. Not that they're friends, but they're part of my life, they have a role in my life." The implication that enjoying time with her clients might mean that she sees them as friends rather than clients is notable.

Feelings acknowledged without connection to clinical relationship.

In the ways that Anne acknowledges and reflects on emotional responses in session, both hers and her clients', they frequently seem to be interpreted as separate from or irrelevant to dynamics of the clinical relationship. When asked about how she works

with her own frustration, as it came up with a particular client, Anne responded, "Well, it's not overwhelming. So I just kind of… assess the situation and kind of say, you know, I don't really need to do the self-talk at this point, I just kind of say, 'Okay this isn't working, so don't keep trying what's not working.'" When asked if that frustration tells her anything about what her client might be experiencing, she stated, "Well, I interpret it as them feeling a lack of control. And they want control, and I understand that, so I can empathize with that feeling, even though I don't—you know, it's frustrating to have your hands pulled off the piano. But I understand the feeling." The feelings are present, but they are not used to further explore or understand the clinical relationship.

With another client, Anne related this dilemma: "When he engages, in those kinds of directions, I feel good, I feel like something is happening here. Something real is happening. When he's more scattered, and just wandering around the room, then I kind of feel like I've lost him, and how can I get him back. So it depends on the day, some days he's much more focused and he'll stay for 20 minutes and play. So those sessions are the good ones. And other sessions I feel like I struggle to engage him, and nothing seems to work." There is a focus on external factors, of getting the treatment to "work," but although Anne's emotional experience is acknowledged she dismisses her feeling of disconnection and having "lost him" as if those are not relevant clinical communications from the client.

Reflecting on her relationship with a client that she worked with for many years, Anne stated, "I had that power over him in a sense. But I felt that he had a lot of power over me, 'cause he could just reject everything that I said or did. So um… it was more frustration than a power struggle; I don't think he felt it as a power struggle. I don't think

he rejected me even on purpose—he couldn't. He couldn't take it in. You know, he liked me. So um… but I couldn't be the supporter/helper that I wanted to be with him, 'cause he was… he couldn't let me."

Lynn.

Lynn's work with individual music therapy clients takes place on the pediatric wards of a medical hospital. She describes her clinical orientation as cognitive behavioral. The following significant themes emerged in the idiographic analysis of Lynn's interview.

Desire for validation.

A major theme of Lynn's experience providing therapy is the desire for validation, or positive reinforcement, about the impact of her work. When asked how it feels for her to provide musical support to a patient in distress, she responded:

> It's a positive feeling. In terms of me, because I know in that spot I'm being effective. I believe I'm being effect— she gives feedback afterwards so I know, yes, that was good, come back next time. But it seems the staff as well gets relaxed, gets calm. And there's been instances where the staff will give feedback saying, you know, that's how you sometimes calm us as well, so it's positive reinforcement for me in that what I'm doing is working. Continue to do what you're doing.

Reflecting on a patient who specifically identified Lynn as the therapist she wanted to see, rejecting other staff members, Lynn said, "Of course it feels nice, to hear 'you're the one that I want, you're the one that I want to be with. You're the one that I

want to provide support.' So that is a good feeling, it makes you feel like you're doing something well, you're doing something right."

The other side of this desire for validation is some anxiety when immediate validation is not available. Lynn described this interaction with a different patient:

> She wasn't giving me a lot at first. So that's when I was feeling like the… what path am I supposed to take? Does she not really like—does she not want to do music? Is that not gonna be her outlet? Is she just really upset and that's why she's not talking, which is completely understandable? Is she fearful of why am I here, what am I doing? So I was going through the uncertainties of 'I'm not sure which route to go, I don't know what the right route is to go, what's the path to take.' So for me, I was trying to understand what she was feeling, what she was thinking, but it's not anything I could possibly relate to. So… I couldn't come up with those feelings.

For Lynn, the need for validation also extended into supervision and peer support. She relies on supervision for grounding in understanding her reactions to her clinical work, but when asked what is most helpful to her about supervision, she responded, "Validation of the feelings. Support… but I think a big part of it is validation of the feelings."

A need to keep emotions out of the session.

Lynn acknowledged that emotions are an inextricable piece of the emotionally intense work that she does, but she feels that it is important to keep her feelings outside of the session. She related the following in regard to her experience with a patient that she knew well and with whom she had a strong relationship, who was dying:

> For me, for my own personal experience, it was sad, it was emotional. I was upset about the death that was coming. Um… but the patient had their own needs at that point, the patient needed some support from whatever they were going through. And being able to provide in that situation, take my own feelings and put them in that box outside of the door, and keep them separate from that moment, to be able to support the patient.

Lynn spoke about a time when her feelings, in this case of grief, did arise in session with a patient who was declared brain dead. She had known the patient well, and as she played for her she felt her own feelings and was uncomfortable. When asked if she knew why she was uncomfortable, she responded:

> I think because it is often taught to us, be present for the patient, be there for them, and certainly having our own moments, but outside of the session. Whether it's in peer supervision, in supervision, in your own time exploring that.

She went on to relate another experience with a different client, in which she acknowledged feeling sadness but focused instead on the feelings of the dying patient's mother. When asked what then happened to her own emotional experience, she responded:

> I think it's kind of put on hold a bit. It's still present; it's still—I'm very aware of it, but in those situations, again, Mom's right there, I'm able to not—tears aren't flowing, I'm able to remain more present in the session. I think for the family.

There is a feeling that being with her emotional experience would cause her to be less present, rather than more present, to the family's suffering.

Another moment came to mind for Lynn in which she did allow herself to be emotionally expressive in a session, and she shared her anxiety about that moment:

> I think that was one of the first times that I did have tears come through in a session, and it was almost a validation of, 'Oh, it's okay, this is okay to happen, sometimes real emotions are real,' and I think the person I was talking with saw that, appreciated my feelings towards their difficult situation, um… but it gave me that, I think an okay, a validation of it's okay to have those emotions… Because it was okay. Nothing bad happened that I shed those tears, nothing was wrong with it, it was a real moment and real moments happen.

Again, the desire to keep emotions out of sessions can extend, for Lynn, to her supervision sessions with co-workers. After an intense and emotionally challenging session, she related:

> I got back in and my coworker said, 'Do you need to talk?' and I went "Tomorrow." 'Cause I knew I couldn't right then. I was emotionally upset. So that was a "We'll talk tomorrow," and it was the end of the day, so it wasn't a day that I just had to leave, but it was the end of my shift and I left, and that was my time. I needed my own time where I went to my car, I cried in my car, and then the next day I talked it out, 'cause I knew I still needed to talk it out with somebody.

Focus on external rather than internal world.

Lynn's experience as a music therapist focuses strongly on the external over the internal world. She made this clear in the first few minutes of the interview, when she described her role in sessions; she described that role as a list of procedures that helps her

to determine "how can I help [my patients] to improve in some way." She elaborated, speaking of the referral and assessment processes: "What do they need, what's… why are you sending music therapy in there. And then of course the actual patient themselves. Once I get in there, what do I see, what do I assess the situation to be, so taking all those different pieces in." Lynn also evaluates her effectiveness through external observation, and this is "part of the reason why I do love what I do. It's because I can see the success. I can see what happens. I can see that it makes a difference. So it gives me that reward of kind of affirming what I'm doing. Again, the positive reinforcement as a professional."

This search for external cues in treatment can sometimes come up short, which is frustrating. Lynn reflected on her early sessions with a young patient who had just survived a traumatic experience:

> I think it was hard… knowing before I walked into the situation, I was aware, I can't suddenly fix everything… you do have a huge now difficult time ahead of you, that's gonna be coming once everybody's healed and everybody's medically okay. It's gonna be difficult, it's gonna be emotional. But this is the immediate aftermath, it just happened, and I knew walking into it I can't just change that, I can't just fix it, but what can I do? And trying to figure out how can I provide support… I think it can be frustrating. As if there's certain things you want to be able to fix, but we have to know that you can't fix everything. So it can be frustrating if you have that occur.

The experiences that Lynn described seemed to fall into one of these two categories—either a clinical encounter provides observable evidence that her treatment

efforts were effective, leading to feelings of validation or pride, or there is an absence of that for one reason or another, which leads to frustration. An experience in which the patient was "receptive to music therapy, who was incredibly calm, incredibly relaxed" leads to feelings of pride. A situation in which a very sick patient was abandoned by her family, and no efforts could get the family to come be with her, was "Again, frustrating. It was hard. I couldn't fix it."

Confusion about transference and countertransference.

Lynn identifies her philosophical orientation as cognitive-behavioral, and would therefore not be expected to engage actively with psychodynamic concepts in her work with patients. She was familiar with these terms, however, and could speak about times that she was able to identify the phenomena in her work. She also spoke of other moments in which transferential dynamics were apparent, but not recognized as such by Lynn herself, thereby causing some confusion.

When asked about whether her feelings can give her information about what the patient might be experiencing, Lynn's answer reflected a partial understanding of transferential dynamics:

> I think it… it can… I don't remember where I first heard it, but if you're in a session and you're starting to feel bored, or starting to feel uncomfortable, that might be a sign that the person you're working with is feeling that as well… trying to assess, are they still very engaged or is this just me having my own feelings of "do I need to change it up, do I need to keep it consistent, are they in this moment, do they need something changed?" And trying to identify that. Is it just my feeling, is it my feeling that they're feeling as well?

This confusion about how emotional states may or may not be transferred between patient and therapist was also reflected as Lynn described a situation in which a very sick patient's family stopped visiting. Sitting with the patient, Lynn felt angry about this abandonment, but when asked whether she thought the patient might have sensed that she was angry, she responded, "I don't think so. I don't think I showed that and presented that in the sessions. I think I validated her feelings, and I understand that it's hard."

As Lynn considered feelings that might arise in session, a topic about which she had conveyed some anxiety (as mentioned above), she stated the following:

> I think when you're with the people and there's emotions coming up, it's because there's some kind of a strong relationship. It's… I think the sessions where I've had those emotions come out in the moment are the ones that have the relationships that have existed, or just developed quickly and they're strong, versus I've been in sad situations maybe that the family and the patient are new to me, and the relationship's not as strong, so I have, like I think I mentioned earlier, it's the situation that I'm sad over… So I could in that situation be more so, not necessarily disconnected, but not as involved in my own personal emotions. When there is a stronger relationship, my personal emotions are involved.

Without a full understanding of transferential dynamics, Lynn is left questioning clinical events, unsure of their meaning. Regarding a patient who refused to engage with any other staff member besides her, Lynn shared her confusion:

> Why is that? What's going on there? So we were start—I think it was trying to analyze, is it just the music? Is there something in me that's connecting with her? Is it the role that we're having right now? Is it purely that I play music and she

> likes that piece of it? Is it a combination? And it's one that I don't think we ever really got to a conclusion on.

When asked, Lynn said that she was not sure if transference was part of why this patient was so drawn to her and so rejecting of other staff members.

Concern about boundaries.

Concern about boundaries seemed to be connected to Lynn's understanding of transference dynamics. Regarding the possibility that she could remind patients of someone else in their life, she stated:

> It depends on the relationship it creates. So if I remind them of someone that happens to provide a comfort in that space, then that's okay. That's fine. If that's what is used to help them with something. And it certainly, if I was aware of it, would want to stay conscious to make sure that the relationship stays in the appropriate, you know, therapist to client relationship and nothing is changing in that space because they connect me with somebody else. I think that's an important piece of it… let's say I reminded them of their sister, or a close cousin. I wouldn't want them to start seeing me in that cousin space, or in that sister space, and maybe start to get too attached or too connected. 'Cause I… I think that could create a lack of boundaries.

Jane.

In her interview, Jane describes her individual music therapy work in a residential facility serving adults with developmental disabilities and mental health concerns. She describes her philosophical orientation as humanistic and psychodynamic. The following significant themes emerged in the idiographic analysis of Jane's interview.

Therapy as therapist's work rather than client's work.

Jane's reflections on her work reflect the assumption that the therapeutic encounter primarily relies on the therapist's active work, more so than the client's. In describing her role as she sees it in individual sessions, Jane commented:

> Ideally, my role is to help the client, to make the best choices that he can for himself. And to help the client to understand his being in the world. And to take responsibility for himself, and his own treatment. That's ideal. Um… unfortunately that's not always possible, so I have to be a little bit more… um… directive.

Several of Jane's comments about specific clinical experiences reflect this same perspective from other angles. For instance:

> I just felt like crap when I left his sessions, like 'why am I here?' So after some supervision, and that role, I was trying to just be very supportive and encouraging and 'what can I do for you.'
>
> We processed different ways of becoming unstuck. And he was… um, he was able… so I asked him, what happens when your car gets stuck somewhere. So he was able to identify that it needed something rough to grab onto, um, so that it could get out. And so we kinda talked about it, and I suggested that I was something rough and I would provide different interventions.
>
> No matter how hard I try, because I worked with him for a long time, I tried a lot of different avenues to try to really get him to just understand himself, and it just isn't going to happen.

> It was very hard for me to not make the grade, if you will… Not make the grade, just kinda, not be enough for him. Not provide what he needed, because I didn't know what he needed, because you couldn't tell me what you needed. That was really hard for me.

Jane's feeling that she must be the one to work and produce an outcome, whether to meet the client's expectations or her own, leads her at times to feelings of disempowerment and self-blame.

Validation.

Jane spoke openly about her need to have an observable response from her clients to her interventions, in order to feel like her work is having an impact. In describing her work in general, one of the first reflections that came to mind was the following: "That's something I struggle with as a music therapist, like, how are you benefitting if you're not engaging with me in any way, if I'm not seeing any type of response." After she described a very intimate clinical interaction with a client, about which she expressed a lot of positive feelings, Jane stated, "It's nice and it's validating. That is validating, because it shows that it works for me. That there's an impact being made."

In reflecting on her relationships with her clients, Jane associated to the challenge that she feels with clients who want to receive music therapy treatment but are reluctant to engage in any music processes:

> Those times really suck, because they challenge me… I enjoy being challenged but they challenge me to… feel that I need to be there, if that makes sense. Because I don't feel like I need to be there. You're kind of on one hand saying, 'I need help and I want help and I want you to do it and I want you to help me,' but

> you're not willing to help me help you. So that's… it's really hard for me to feel that way because I feel… um… helpless. Yes.

The clients who come to session but don't demonstrate their in-the-moment desire to engage with Jane musically cannot provide validation and therefore elicit this feeling of helplessness.

Jane also expressed ambivalence in recognizing her own desire for validation. She described a clinical vignette in which she and one of her clients became embroiled in a lengthy back and forth discussion that allowed her to see some of his struggles in a new way. When asked how this was for her, Jane responded:

> It was partly validating, which is really bad… Because I know that I was right, and that's not what I think we aim to do as therapists, to be like 'I knew it!' But also kinda sad, because there's no changing it, because I just don't think he has the capacity, the impulse control, to change it and to stop himself.

Anxiety about boundaries.

Boundaries relate, in part, to Jane's struggle to find and feel comfortable with her role as the music therapist. When asked about her role, Jane related a clinical example, and described her role as changing between supporter, teacher, and eventually:

> I became kind of the leader of his own process. The director of his process. The conductor in the music session… it's kind of uncomfortable for me, because I feel that if I have to give you the answers then you're not really being able to find the answers. If that makes sense… So I'm not comfortable in that role, because I don't think the clients are really integrating any of the information. So even once

> I start in that role, I'm gonna back out of that role, and encourage the client to work for himself. I can't do the work for him.

Because she frequently conducts long-term work, Jane has clients that she has had the opportunity to know and develop relationships with over the course of many years. She described several cases in which some intimacy had been created between herself and her client, and in that context she also disclosed some anxieties about that closeness. Most frequently, she expressed worry about impinging upon the client's internal world. In describing some struggles with a client who had difficulty articulating what he needed, Jane described her approach, of "supporting and following your process, and being present. So if there is anything you need, I am here, but I'm not gonna… I wouldn't… invade his space in this process." This same worry also came up a few times as Jane described her work, when at several points in the interview she confused the words "directive" and "intrusive." She stated, "I guided the process a little bit more, and I was a little bit more intrusive. Intrusive? Is that the word? Directive. Intrusive and directive are not the same! (*Laughs.*)"

Jane's fear of unintentionally violating boundaries and somehow becoming too intrusive with her clients also came up as she spoke about a clinical interaction that was clearly extremely meaningful to her. She and a client engaged together in music-making that she described as "beautiful," "magical," and "our own little bubble of music." But when asked to say more about what the experience was like for her, Jane began to question herself, and again to worry, this time that she may have been somehow forcing the patient:

> It was like there was no one else in the room. As far as I'm concerned, and I imagine, since he was engaged, and I was, you know, it's not like I was forcing him to do anything or whatnot, he just—he wanted to do it. So I imagine it was very soothing, and I don't know.

When asked what her relationships with her clients mean to her, Jane responded:

> I have very rigid boundaries. Um… so my relationships are therapeutic relationships, they're not necessarily fun relationships, they're—I don't go—I go above and beyond as a clinician but not as your friend, type of thing. Um… what do they mean to me? I think they give me a reason to keep working.

Disempowerment of feeling experience.

Jane described feeling experiences in her sessions, but usually expressed doubt about whether her feelings could tell her anything about the client's experience, or reluctance to engage those feelings further to explore. Regarding one client, who elicited strong feelings in her, she commented, "I was like 'I wonder if this is his way of telling me something,' but I didn't feel okay with asking, so I just let it go." When asked later about specifically using her feelings to work with her clients, she responded, "I don't know if I can tell you—if I can answer the question. I can answer the question, but I don't know if I can tell you if it informed me as to what was happening with the patient."

In describing another clinical example, she shared the extreme sadness that she felt as she sang a song her client had chosen. But she was disappointed that he did not sing along with her, and she said that she didn't feel that he felt any of the sadness laden in the music, which was resonating within her.

> I feel like if he sang the song then he might have… I was putting away my feelings and I was just thinking, just thinking, I have a tendency to do that. And I really wanted him to connect, and I don't think that he did. And then that makes me sad, and then that makes me feel like, well, you don't know what you're doing and blablablah.

In this case, disempowering her feeling experience also led to self-doubt and blame.

Focus on external.

Jane's reflections on her work tended to focus on external, observable factors rather than aspects of the internal world. She summarized this most succinctly, perhaps, when she stated at the end of her interview:

> The challenging part, you know, nothing is really true unless the client can verify. Maybe verify is not the right word. Unless the client can tell you that it's true. So I think sometimes, a lot of times, I think our guessing is really just guessing. It's kind of a game. Especially where I work, my clients are not able to tell me, "Yeah, that's exactly how it is." It's kinda challenging.

Jane at times described countertransference reactions, with a focus on translating any feeling experience into direct action. For instance, with one client who talks a lot, she sometimes finds that her mind is wandering during session. When she notices this in herself, and believes that it is a response to what's happening in the session: "I'll just [say] 'Whoah, stop.' And just stop. 'What's going on? What are we talking about?'" She continued:

> He's projected onto me his own confusion and lack of awareness of stuff going on. And I'm just like, "Whoah, hey." So he's feeling he needs to be stopped,

> sometimes, I feel like, and somebody needs to help him to clear it up. It's not so easy to do that for him, but I try. (*Laughs*) Like, "Hold on a second! Wait" Um… I feel that he's often misunderstood. So I do my best to understand him, and when I stop understanding him I'm like, okay, we need to go back to… something.

She describes noticing the projection and then immediately acting, rather than reflecting on the internal experience of the patient or herself and considering the dynamics from that perspective. In regard to another clinical vignette, she voiced a similar idea:

> "I wanted him to recognize, and I think I was just using my own experience and feelings in that moment to try to get him to understand and to recognize what was going on. But I don't think that it did anything."

Confusion about transference and countertransference.

Jane openly shared that she has confusion about transference and countertransference and what these concepts mean. When asked how psychodynamic concepts inform her work, she responded:

> "I've been asking myself a lot of these types of questions. Because I think there are a couple of different schools of thought. Um… there are more than a couple! And… um… just recently somebody actually, um, used the term 'countertransference' in tandem to intuition, and chocking it up to, basically, that's it. Um… and that was really interesting concept for me, and it made it a lot, kinda easier for me to understand. Because I kinda feel the same way… I had never thought about it that way. It took me years to kind of understand and wrap

> my head around this concept of countertransference. So, thinking in terms of intuition—hey, that's pretty simple, right?"

Much of the confusion that Jane identified as coming up for her in the transferential field was connected to her attempts to manage the emotional aspects of the work. She described it as follows:

> I enjoy having feelings in a therapy session. Um, whatever. But, I use them as information as to what the client also is likely experiencing. So with the client, we'll go back to the client that would make me angry in the sessions. The client then didn't make me feel good enough, that I didn't know what I was doing… Useless, and what's that word? Helpless. And not… um… not important, not necessary… I started to kinda use that to inform myself in that maybe he's feeling that way, he's kind of transferring those feelings onto me. Um… so I… just tried to be like, "okay Jane, put your own stuff aside and, what do you think"—what can I do to maybe help the client in this process of not feeling okay? Not being enough. So I just turned around and tried to be very patient, and supportive. And realizing that it's not me… Like those feelings are not me. They're his. Sometimes… um… like, it's confusing. So not holding onto those feelings that I felt in the moment. And recognizing, I really think that he's transferring all his stuff onto me and it's… it's more of a transference-countertransference than it is my own stuff. But maybe that's me in my head.

With another client Jane described, she found herself embroiled in a 30-minute argument about the client's need to have the last word—and she realized later that she, too, was trying to have the last word:

> So I guess that really right there was exactly, he was just feeling like I didn't want to listen to what he had to say, I didn't value what he had to say, and I wanted him to hear what I was having to say… I didn't catch that until like the 30 minutes, that I was like, "Okay, this has been going on for a long time." Isn't that interesting? But I don't think I used it appropriately in the session, because I just—I wasn't able to really internalize his feelings as in not feeling validated. But that really is the gist of what it is.

Jane seems to focus on understanding this interaction as concordant identification (Racker 1957), rather than as an enactment of the client's internal dynamics, and it leaves her feeling confused and as if she did something wrong.

In regard to some clinical vignettes, Jane talked about "using" her feelings as a means to simply say that she felt feelings, although this also led her to some confusion. She spoke about a client with whom she felt tremendous sadness, and her sadness was intensified because the client lacked the expressive language abilities to verbally process the content that was arising in the music. After relating the clinical example, she commented, "How did I use my feelings? I just kinda was okay with just sitting there with him, I guess. That's an excellent question. One that I'll continue to ponder. (*Laughs.)*"

When asked specifically about transference, Jane referred to a client she had mentioned who was "transferring his stuff. Of not being good enough, and me having to feel not being good enough. And holding onto that." When asked if she believed that the client was seeing her as not good enough, she responded, "I don't think that he does. I could be wrong. But also I don't think that he realizes that he makes me feel that way."

Racker's (1957) concordant identification seems to be the transferential phenomenon that is most familiar, and other aspects of projection and transference are less familiar and therefore interpreted mostly as concordant identifications.

Intolerable feeling states.

As Jane spoke about feelings elicited in sessions, she often described how intolerable these feelings were to her in the clinical moment. Regarding one client's use of the computer to make musical loops, she commented:

> Inside I was just like, "Oh god, this has to stop, please make it stop, please make it stop." It was terrible… It was loud, and it was annoying, and it was—and I was just like, "Ugh, gosh!" And this went on for like 30 minutes… it was horrendous! It was irritating and I was—I was—just kinda like "argh, make this stop it's really annoying!"

Another clinical example came to mind when Jane was answering a question about describing a time when she had interpersonal conflict with a client. She said:

> I don't tend to have conflict with my patients. With my clients. I just don't. There was one client that I worked with for a number of years. I don't think that he would recognize any conflict. But I finally had to discharge him because I was like, "enough is enough, I can't stand being around him, it irritates me, he's gross, he's annoying, I just can't be with him anymore."

This led, eventually, to termination of treatment, and when asked to say more about termination, she responded:

> The impetus was just the way that I cringed when he came to sessions. So for me there was a dynamic, like I hated working with him, and I put myself through it

> enough. I just wasn't going to do it anymore… It's like I give give give give give give. And just not being able to care enough about himself. I think. That… I just like, I can't care for you, for you. You have to care for you, and if you don't… yeah. It was just—got to be unbearable, I couldn't stomach it. I just can't anymore.

In one instance, the recognition of her own powerful countertransference led Jane to feel that she needed to terminate treatment with a patient. "I listened back to a recording that we had made, and my voice came out like 'ROAR!' Just overtaking him in the music. I thought, 'Wow, that is bad. I think I shouldn't be working with him anymore.'"

Rose.

Rose describes her individual music therapy work with elders and their family members who are receiving hospice services at home or in long-term care settings. She identifies her philosophical orientation as humanistic. The following significant themes emerged in the idiographic analysis of Rose's interview.

Intensity of music experiences.

Rose spoke at length about the powerful impact of musical experiences, and how sometimes this intensity can be overwhelming:

> I think music catches people off guard a little bit, like we're not as used to putting on our… the same kind of masks that we might wear. …So music is a way to… get to what's really… what's really real about somebody, what's really, like, the most vital part of themselves, and I recognize that… I recognize that that can be difficult, I recognize that um, sometimes people don't even know how much they are opening themselves up or how much they are being seen.

Rose also reflected on her own experience of the intensity of music, which she confronted in a graduate school course that required some personal work through music. She said:

> [It] really opened me up to how powerful that was for me, even though I went in expecting there to be… a lot of emotion there, and a lot happening there… sometimes it was still more than I could… than I could handle. So that—I don't know, those personal experiences really make you… realize… if it was this powerful for me, and I think I'm a healthy person and I'm pretty well in control and I, you know, I know myself pretty well, and I think, you know, I'm pretty emotionally healthy… that if it's this powerful for me, think about somebody who doesn't even know that it's coming, and that it, and that is in a vulnerable place.

In regard to her clinical work, Rose noted how the intensity of music can increase the intensity of interactions with her patients. After recounting a difficult session, she commented:

> When I left the session, I um… needed to recover. Like, that was a really intense kind of session. So I guess that's another piece there, as with that… with the intensity of the music comes this intensity and this relationship and… that's something else to be respected and to… that we can't minimize, lest we totally wear ourselves out.

When asked how music impacts her interpersonal relationships in individual sessions, Rose had an interesting response that seemed in some ways to counter her previous comments about the intensity of the music experience. She said:

> I think often music is that… um… that third… it's not really a person, but that third person in the room who's there to keep it from being just this intense person-to-person interaction. Sometimes it's there to smooth things out, or to provide some grist for the mill, like some way to start a conversation or to interact or to move past something or to move deeper into something that you wouldn't have otherwise.

Confusion about transference and countertransference.

Rose explained directly, when asked about how she understands her work in terms of psychodynamic concepts, that her understanding of them is "fuzzy," even though she had referred to her own countertransference spontaneously earlier in the interview. She was taught about the meaning of terms like transference, countertransference, and projective identification in her graduate training, but "I don't feel like I really learned what all those things really mean, in real life… I'm not very comfortable with those terms… Transference. I don't know how I would describe transference at all, actually (*laughs*), in my music therapy relationships." She later reflected:

> I wish I had had the opportunity to learn more, although I'm not sure how relevant it would be, or how helpful it would be… I don't know why I feel like I didn't really come out with a solid… a more… a firmer grasp… it really feels like something that you have to… I mean, you can talk about it, but then you don't really understand it until you can experience it and have someone else help you see that going on.

When given a short reminder of the definitions of transference and countertransference, however, Rose was able to recall experiences with patients that felt germane, and that revealed broader clinical questions that she had already been sitting with. She mentioned a common occurrence in work with medically ill elders, confusion, and reflected:

> "I don't really think about working with transference, but sometimes people think—sometimes when my clients think that I'm somebody that I'm not, sometimes it's helpful to correct them and sometimes it's not helpful to correct them. Sometimes I don't… like, I don't know… Sometimes I wonder if it—if it matters if they think that I'm part of their family, or if all they—if they just know that I'm somebody who is kind to them, and who wants to help them, and who loves them on some level, that that's really all that matters, that they understand that I'm that kind of person for them."

Misunderstanding projection leading to disempowerment of the therapist.

When asked about how she uses her emotional responses in a session, Rose explained that her first priority is to determine "is it me, are these my feelings? Or is this something here? …I'm trying to figure out where those feelings are coming from and who they really belong to." As she continued to associate to this idea, however, she seemed to be talking more about observing external evidence of her patients' feelings rather than noticing her own feelings. "It's the people who don't express much, or don't give you much in terms of you know, understanding where they are, that… Those are the really hard sessions, I think."

She went on to describe her work with a patient who was bed-bound, unable to open her eyes, and unable to verbally communicate, and how difficult that was. "I remember in sessions with her, just trying to grab onto anything, any inkling of how she was feeling… and what a struggle it was just to try to connect somehow with her." Speaking more about this experience, however, Rose began to speak about her own feelings of frustration that the patient's room was so noisy, "frustrated on behalf of my patient that she couldn't, you know, get a moment of quiet even if she wanted one. And also, then, feelings of helplessness." These feelings of helplessness, unrecognized as a projection of the patient's own experience communicated unconsciously, then turned into self-criticism: "am I really doing any good here? What does this even mean that I'm here with this person? …Why am I here, why is this… is this making a difference?" Rose's distrust of her feelings and her work is further reflected in her next association, which came after it was pointed out to her that she had started out saying there were no feelings in the room, and it turned out she had had quite intense feelings: "Now I'm thinking… how much of that am I making up in my head to justify my presence there, and how much of that is… somebody really understanding what this person is experiencing, because they're experiencing life even if there's not any outward manifestations of that." Notably, she shifts to much less personalized language, where she herself becomes "somebody" and her patient becomes "this person." This might be understood as an effort to take some distance from what was possibly a painful clinical experience.

Rose later returned to the same idea of separating her own feelings from her patients' feelings, when asked what lens she uses to make sense of her emotional reactions in session:

> "Is this my stuff or is this their stuff?" I think that's probably the first question that I ask myself. And then just try to figure it out from there… I want to be careful that I'm not assuming anything about them based on who they are, that I'm not stereotyping or… making a prediction or a judgment based on a previous session or a previous interaction. So I just… that's the main part, is I want to make sure that I'm not, um… projecting my own stuff onto them.

She seems to be conflating the holding, and acting from, information she knows about the patient with projecting her own unresolved material onto the patient.

In another example, Rose spoke of a difficult session in which she was working with a family that was grieving and experiencing conflict: "there were points in the session where I felt myself—like I wanted to just stop and go away, 'get me out of here' kinds of things." One family member wanted Rose to play meaningful music that would facilitate the grieving process, while another (a granddaughter with whom Rose later admitted she felt irritation and anger) was insisting that the session should focus on "happy music." Rose described her reaction: "So there was resistance in me, from… going with the patient—going with this patient's wife deeper into the music rather than listening to this granddaughter who wanted to take things in a different direction." Eventually, several family members seemed to engage with the music as a means to facilitate grieving, and Rose felt that the session was meaningful and successful. However, she did not understand her feelings of irritation and anger as being a projective identification, and also did not feel empowered to ally herself with a healthy therapeutic goal of facilitating the grieving process. Instead, she described her reluctance to bend to the granddaughter's will as "resistance." She also shared that after this session she

"needed to recover" emotionally, which is understandable given the amount of intense emotional material flying around, unrecognized as projective elements.

Setting feelings aside for later.

Rose describes sessions, like the one just mentioned, in which she strives to be emotionally present to her patients and therefore has a range of emotional reactions to session content, but when asked what it is like to observe herself reacting emotionally, her first response is to focus on action to mitigate those reactions rather than entering them more deeply: "Observe how I'm reacting and then be able to keep doing my work anyway. So there's that part of acknowledging and things that are helpful, going with that, and things that are less helpful, setting them aside to deal with later." Regarding the case just mentioned, she elaborates:

> So I had my own grieving, I mean my own feelings of loss, coming up, and that was helpful to some extent but then it was also, like I was tearing up at one point of the session, which makes it very difficult to sing. I have mixed feelings about tears in sessions because I think it's helpful for the family to see that, you know, I really loved your person too, but then on the other hand, you can't be a mess and needing other people to support you… I'm feeling the loss of this but then knowing that I'll be able to grieve in my own way later, but right now my job is to support this family… that's probably… Also, like with the granddaughter, there were definitely some feelings of irritation and some… feeling a little judgmental, of "why are you acting this way when your grandmother obviously is in pain here, and you're being horrible to her?" (*laughs*). Things like that, the irritation, anger—not helpful. So, you know, acknowledging that I feel that way, but it's

> not something I can fix, it's not my main responsibility here, you know. Setting it aside and then processing that later with somebody else, not there in that space.

Focus on external rather than internal world.

When asked how she uses her feelings to work with patients, Rose describes something like concordant identification, but with much more emphasis on the external, observable world than on an internal sense:

> Especially with my clients who don't have speech… a lot of times I'm using my feelings to gauge how they're feeling, or how the music is landing with them. They can't tell me how they feel, so all I have to go off of is… what I'm seeing nonverbally, what they're doing musically—which might not be very much if it's very advanced dementia—and then, my own countertransference, like my own, what I'm experiencing.

Rose went on to share a clinical vignette in which a patient with dementia was visibly anxious:

> She was wringing her hands and um, I could tell she had been crying. I asked her, you know, what's going on, how are you doing, and she couldn't find the words but she started crying, and I'm holding her hands… I was… kind of, you know, putting myself in her shoes, kind of feeling how she's feeling.

Rose described the clinical decision that she made next—to sing something soft to help the patient feel connected and less anxious, and "it felt like she could breathe then, it felt like she could turn her attention not into everything that was going on internally with whatever she was worried about or whatever was causing her to wring her hands." What

Rose describes here clearly reflects empathy and caring, but clinical decision-making is focused on first, the observable problem, and second, the outcome or solution.

When Rose was asked about what she was feeling during this encounter, she replied:

> So I was feeling her anxiety too. I was feeling her… I was upset that she… I was feeling upset because she was so upset, and I didn't know why. I knew there was nothing I—there was no way I could fix it, I didn't have enough time in that setting to figure out all the things… feeling like music wasn't gonna be enough to do anything (*laughs*), right? So I was having that feeling. Um…. No idea if she had that feeling, what she was thinking.

Again, there is a hint of concordant identification, but Rose doubts her sense of that and shifts immediately to the observable and to a need for her own action. When the observable isn't producing helpful information, action isn't helping or available as an option, and the patient's feeling state is overwhelming for her, Rose turns to self-blame and feels helpless.

Self-blame, or guilt, as Rose names it, arose in the context of another clinical vignette that came to mind when she was asked to recall a patient with whom there was interpersonal conflict. This particular vignette involved a patient who, when Rose attempted to engage her in music-making, became insulted, calling the improvisation "kids' stuff." Rose reflected:

> I think my immediate feeling was, like, guilt (*laughs*) at asking her to do something that she didn't want to do… I think that's the part of me that thinks I should be able to read peoples' minds and predict what they want, you know, and

> fulfill their expectations… a guilt that I can't make things better, or that I'm not there when they need me, or that I'm not doing things as best as I can, or that I'm not… um… maybe that I'm not as present as I could be.

Kate.

In her interview, Kate described individual music therapy work primarily with adults and children receiving hospice or palliative care and their families. She identifies her philosophical orientation as humanistic. The following significant themes emerged in the idiographic analysis of Kate's interview.

Struggling with confidence and need for validation.

As Kate spoke about her work, a theme that came up repeatedly was her desire to get it "right" and the ways that she seeks validation from her patients, even knowing how this struggle can impede her work. She stated, "Sometimes I want to say the right thing or do the right thing, and so I'm… I'm thinking a little too much, and I'm, you know, that can cause me to be less authentic than I want to be. Because I'm just—I'm overprocessing it instead of just being."

When asked about whether her feelings ever helped her to understand what her patient was experiencing, Kate associated to feeling like she did not remember enough of what she learned in school, because she relies on an "instinctual" approach to her work now. She stated:

> I sometimes have trouble justifying… why I'm doing what I'm doing. I can't just tell somebody, "This just feels right, this just feels like the right thing to do right now." It needs to be… it needs to be sound clinical and it needs to be… um…

> like you said, grounded in terminology and research, and… so that's a big pitfall. It's a huge pitfall.

She later continued, "I think about everything. Like I'm—I'm—I'm—my brain never stops (*laughs*). I'm one of those brain going all the time kind of people, so everything I do always, I'm second guessing and thinking about everything I'm doing."

In describing a clinical situation in which her patient became emotional and then withdrew, Kate shared her feelings of vulnerability and anxiety:

> I didn't know what to say. I didn't know… I didn't know how to comfort her, and I didn't know what the right… the perfect thing was to say in that moment… I had so much trouble, um, engaging her throughout the entire session, that when she finally did open up and I didn't know what to do with it, I was like… I wanted to do something with it, but I didn't know, like I didn't know what to do with it, and… and I don't think that what I did… I hope that what I did wasn't wrong, because just being quiet and being with her, I don't think that was wrong. Yeah. But I… I… But I can't help but think to myself, like… was there something I could have done better?

In considering this situation, Kate became tearful, her feelings about potentially having failed her patient were so painful.

Kate recognizes that she looks for validation from her patients:

> I feel that sense of… my own anxiety if I'm not helping them when it's a person, for example, a child with autism, or a kid who… who just can't really give me a lot of response. Who can't verbalize their enjoyment. Or an adult. It could be anybody who, due to whatever condition or circumstance, can't give me that

> positive feedback. And I have to check myself because, you know, it's not about me.

She associated to an earlier position in a psychiatric hospital, where patients were required to attend her music therapy groups, and often attending against their will.

> That was a challenge to me, because like I expressed to you already I want positive feedback (*laughs*), and I want to know that I'm helping people, and if the whole group is sitting there like this and not looking at me, and not putting much into it, then I'm not getting any positive feedback, so that was a challenge for me.

Reflecting on this need for validation, Kate continued:

> I'm constantly second guessing everything I'm doing and saying, and wondering if I'm doing the right thing, or if I'm doing something good or if I'm just… doing something neutral, or… bad! You know, like I'm constantly thinking and overthinking and second guessing everything that I do. Just until I get some glimpse of… um… 'this is benefitting the person I'm working with.' …It's anxiety-producing, and I think that that's one of the… one of the things that… you know, makes being me (*laughs*) as a music therapist, makes me being a music therapist hard, because, because I… because sometimes I lack that self-confidence and I have skills and I have, you know, an ability to help people, and I just am always looking for that outside reassurance that I know what I'm doing. You know? Instead of the internal reassurance. And that's my own thing, you know. That's something I have to work through.

Discomfort with intense feeling states.

Kate's approach to her work is in some ways very emotionally led, but she also struggles when patients reveal intense feeling states. Describing the termination with a beloved elderly patient with whom she'd worked for some time, Kate reflected:

> It was really hard for me because I knew it was gonna make her tearful, and it was hard. Like, for me to know that I was making her cry, you know? But I also knew that it was coming from… her feelings towards me, and her love for me, and that… and it wasn't like I was hurting her. Or hopefully I wasn't hurting her, but you know what I mean? It was still really hard to do that.

In a session with a different patient, Kate was at first very encouraged by how much the patient opened up after mentioning a meaningful song. But when the patient started to cry, Kate became overwhelmed, and then self-critical when the patient withdrew:

> It was hard, it was really hard, because I… I didn't know exactly what to do with… um… with her tearfulness. And I didn't know exactly what to say. And my instinct in the moment was, well, to sit with her. Just be with that for her. And you know, sometimes I… I want to know, like, the perfect thing to say in the moment, and I don't… So I felt uncomfortable, I was like, I don't know what to say to her right now, so I'm just gonna sit and I'm just gonna be with her, I'm gonna try to show her that I care about what she's saying, and um, and show her that it's okay for her to cry right now and that I'm open to her telling me her feelings… But she shut down… so there's this big part of me that's like, "I really hope I didn't screw it up!"

Kate also reflected on her struggles with people who may be expressing feelings of agitation or "grumpiness," even when it may not be related to session content:

> I have had people that were just, like, grumpy. And just… didn't… didn't really want me to be there, and so… um… and so I probably didn't stay very long because it seems like, well, they don't want me here and it's agitating to them and… it's making me uncomfortable. So… so we'll just all… we're gonna cut this short now.

Projection of own needs.

Kate spoke several times about the ways that she uses her own reflections and perspective on life experiences to generalize to her patients' experience. As she cautiously shared this perspective, her frequent pauses may have reflected the affect-laden quality to what she was trying to communicate:

> I know in my own interpersonal reactions with clinicians, when there's that… clinical barrier that… that feels impersonal and um… cold, and clinical… it makes me feel like a patient. You know, it makes me feel like a… like… like a number. Like I don't matter to that person. You know? And… and… I think, especially in hospice, they're so vulnerable because they have so much going on medically, and they need that extra care. Um… and so, when I open myself up to being emotional in that relationship, I think it helps them. I think they feel it, whether or not they can put words to it, I think they can feel it and it helps them to open up too.

When asked to describe a time where she opened herself emotionally with a patient in this way, Kate spoke about a time where she allowed herself to become tearful when a

patient she had known well was actively dying and the daughter was also in the room. "And I don't know if she saw that, but I hope that she sensed… my feelings in that moment. Just because I wanted her to know that… that I wasn't just a clinician that came in and saw her father and worked with him and that was it."

In a clinical situation with a specific client, Kate had a similar reflection, which this time she applied to treatment planning:

> I remember walking in and seeing her, just… just miserable, and in that moment, I… just wondered, I think I thought to myself, 'If I were in her position, if that were me, I'd be miserable, and I'd be depressed, and I wouldn't feel very good about myself.' So my feeling towards her was 'I want her to feel… good about herself, and I want her to feel… um… positive, and identify the positives about herself and her life.

Kate spoke throughout her interview about the depth of feeling that she has for her patients, and the vulnerability that she feels in that.

> I also want my patients to know that I care for them a lot, and I'm there for them in every way that I can be, when I'm there and when I'm not. So I feel like I have a lot of… (*sighs*)… professional love. (*Laughs)* I have a lot of love to give, and of course in a professional way. And I—and I try to, um, exude that in all of my sessions. Just love and caring, and just openness.

The difficult part of this level of emotional vulnerability is the pain of losing patients, frequently because they are dying or treatment is ending for another reason. Kate feels these losses acutely, in part because of the reciprocal exchange that she hopes to cultivate. "I want people to… be happy that… they have music therapy in their life and

that they have me in their life, and I want them to… 'cause I do feel really strongly about my patients, and I want them to feel very strongly about me."

Anxiety about boundaries.

When asked to speak about psychodynamic concepts, Kate immediately associated to boundary concerns, and some of her anxieties about boundaries that have arisen in the past:

> I definitely have had experiences where… I start to feel… uncomfortable. Because of certain um… certain things that are said, or certain ways that I start feeling, or um… I can… I can tell that there's a boundary that's maybe about to be crossed, or could be crossed, and I, I've been aware of those.

She went on to describe the relative of an elderly patient who would monopolize her time and ask her invasive personal questions.

> When I first saw this patient and experienced this, um, interaction… I was really worried, and I was—I felt really uncomfortable, and I was thinking I don't want to go back (*laughs*) because I don't want to deal with this! But like I said, once I realized how to deal with it, and it was just who he was, then I actually felt very fondly toward him.

Confusion about transference and countertransference.

Kate's experience with the case just referenced came to mind when asked about transference and countertransference. In bridging the connection between these concepts and her anxiety about boundaries, Kate said:

> It was one of those situations where I felt kind of uncomfortable. I felt a little, um… I felt a little bit of boundary crossing happening, and I felt like the

> boundaries were getting approached, and I felt like um… it would be really easy for me to get into… um… those personal conversations with him. If he… if he had pushed it. And… and if I hadn't had my barriers up.

When asked if she meant that her uncomfortable feeling was countertransference, and the intrusive relative's apparent romantic interest in her was transference, Kate responded:

> I think that that… that's definitely part of what was going on, and without having the terminology at the time, not really understanding exactly what was going on, I just felt uncomfortable. And… but thinking about it now, yeah. I think… I definitely was picking up on his own, uh, feelings. And his response to me, to my presence, and then I was responding to it and… and… I'm just glad that, you know, I was able to… keep it.

Kate explained that she had learned the concepts of transference and countertransference in her graduate training, but "they're not really solidified in my brain as to what it would look like or how it would feel or anything like that."

Focus on external for clinical decision making.

While Kate clearly engages her emotional self in her clinical work, part of not understanding the psychodynamic concepts also translates to not using her feelings clinically. She stated, "Unless it's really intense, I'm not necessarily… thinking about… um… 'This is what I'm feeling and this is why I'm feeling it' within the session, at least consciously. And I would do that more after I left."

Kate also reflected on her approach to the work in sessions:

> I do think a lot about, you know, what's gonna happen, prior to a session. You know, I'm leading into a session that I go into, I think, "What can I bring to this

> person that might benefit them today?" or, you know, "how might this session go?" and so I think about it in that way ahead of time. And in the moment, when I'm with my client or my patient, it might change or I might stick with the plan. Sometimes, though, I feel like when I have a plan, and I'm stuck on it, that's when I'm least authentic.

Nomothetic Analysis

Nomothetic analysis of the themes identified in the preceding section revealed four major themes that arose in all seven interviews. This section will present each major theme, with examples from the interview transcripts to support their relevance and importance to the phenomenon of music therapists' experience working with individual patients.

Complexities of being with emotional experiences in the clinical space.

The music therapist participants all expressed some feelings of struggle, confusion, or ambivalence about being with emotional experiences in the clinical space with their clients. Rose may have summarized one possible reason for this most aptly, as she spoke a great deal in her interview about the intensity that music brings to clinical interactions. She noted her own response to some personal work she had done in music: "even though I went in expecting there to be… a lot of emotion there, and a lot happening there… sometimes it was still more than I could… than I could handle." She continued, "if it's this powerful for me, think about somebody who doesn't even know that it's coming, and that it, and that is in a vulnerable place."

Rose provided further insight about this in the context of the clinical interplay between music therapist and client. When the intensity of the music experience is

combined with clinical relationship, the music therapist may be left with emotional experiences that are very difficult to integrate:

> When I left the session, I um… needed to recover. Like, that was a really intense kind of session. So I guess that's another piece there, as with that… with the intensity of the music comes this intensity and this relationship and… that's something else to be respected and to… that we can't minimize, lest we totally wear ourselves out.

Perhaps responding to this same complication that Rose identified, other participants shared the ways that they attempt to mitigate the complexities of emotion in the music therapy clinical space. Anne, Lynn, and Rose all spoke about the importance of setting aside their own emotional reactions that might come up in session, rather than engaging with them as part of the work. Lynn explained, "I think because it is often taught to us, be present for the patient, be there for them, and certainly having our own moments, but outside of the session."

The complexity of allowing oneself to engage with intense emotions in the clinical music therapy space was apparent in the language that some participants struggled to find to describe that experience. Pam and Carl both identified their own difficulty in articulating answers to questions about their feelings. Carl stated, "Um… it's hard to describe… it's like… it's raw, genuine, present… I mean those are not really feelings, but… I can't… like, it's very expressive. I can't say that it's one or the other feeling, it's a lot of things, it's multilayered feeling." For Pam, somatic descriptions would often take the place of feeling terms when she was asked to describe her emotional experience beyond identifying that she was feeling "deeply," for instance:

> It's a combination of reflecting that for her, so feeling that, feeling that 'oh my god, I'm going to crawl out of my skin and I don't know what to do'… It's a balance between that and… feeling like, you know, it's hard to explain, feeling that, and then also feeling—remembering to breathe and feeling my groundedness.

In this context, Pam uses the term "feeling" to refer exclusively to somatic experience rather than emotional experience.

The music therapist participants also spoke directly about discomfort with certain feeling states, sometimes referencing particular types of feelings. Anne, for instance, spoke several times about wanting "negative things" to be avoided in the clinical space, both by herself and by her clients. She and Pam both shared their difficulty with tolerating feelings of anger from clients, and Carl spoke about struggling to tolerate his clients' expressions of aggression. Rose shared a clinical experience in which she was experiencing "some feelings of irritation and some… feeling a little judgmental… Things like that, the irritation, anger—not helpful."

Jane and Kate shared experiences of more general overwhelm when intense feelings were involved. Kate spoke about struggling with clients who might be "grumpy," as well as those who might become tearful: "It was hard, it was really hard, because I… I didn't know exactly what to do with… um… with her tearfulness. And I didn't know exactly what to say." For Jane, what seemed to be most intolerable were what she identified as her own emotional reactions to session content: "Inside I was just like, 'Oh god, this has to stop, please make it stop, please make it stop.' It was terrible."

Concern about boundaries.

Boundaries were an important theme that arose in every interview, although none of the interview questions mentioned or focused specifically on clinical boundaries. Boundaries and where they should be drawn seem to be a pressing concern for music therapists conducting individual sessions, one that is capable of eliciting considerable anxiety.

Several of the participants spoke about their own difficulty in setting boundaries. The difficulties in setting those boundaries are connected to personal insecurities. Carl shared, "It annoys me when I have to set boundaries for some reason… It makes me worried that he or she is not going to like me anymore." Kate said, about a clinical interaction:

> It was one of those situations where I felt kind of uncomfortable. I felt a little um… I felt a little bit of boundary crossing happening, and I felt like the boundaries were getting approached, and I felt like um… it would be really easy for me to get into… um… those personal conversations with him. If he… if he had pushed it. And… and if I hadn't had my barriers up.

Carl and Kate both easily identified the anxiety and the emotional tone of being confronted with the need to set boundaries.

For other participants, the concern about boundaries came up in a fear of being too close, or of developing an inappropriate amount of fondness for their clients. Jane expressed worries about impinging upon her clients' psychic space: "So if there is anything you need, I am here, but I'm not gonna… I wouldn't… invade his space in this process." She also expressed concerns about becoming emotionally close: "I go above

and beyond as a clinician but not as your friend." This sentiment echoed in other interviews. Kate said, "I feel like I have a lot of… (*sighs*)… professional love. *Laughs.* I have a lot of love to give, and of course in a professional way." Anne commented:

> I try to be genuine in my reactions, but there's of course a boundary… There's always some clients you're more drawn to than others, and there's something… but you don't want to act that out, at all. That's the boundary for countertransference.

Pam reflected, about having favorites:

> It's almost weird saying that about an adult, and I feel maybe on some level, I don't know if I was ever consciously told this or not, but we're not supposed to have favorites. The fact that that happens… I don't know.

Lynn, on the other hand, expressed her concern that if the client developed too much fondness for her, this would also be inappropriate. She states:

> I would want to stay conscious to make sure that the relationship stays in the appropriate, you know, therapist to client relationship and nothing is changing in that space… Let's say I reminded them of their sister, or a close cousin. I wouldn't want them to start seeing me in that cousin space, or in that sister space, and maybe start to get too attached or too connected. 'Cause I… I think that could create a lack of boundaries.

For Lynn, it seems that allowing attachment and connection with her clients feels unsafe or clinically misguided.

The four themes that emerged across the interviews overlap with each other. Pam shared some of her own anxieties about boundaries that connect the complexity of the

emotional experience in music therapy with the music therapist's concern about boundaries: Sometimes the experience of the therapeutic couple in the music is so intense that the music therapist fears her own overwhelm, and must focus on boundaries as a way to stay safe: "I always have the duality of being able to hear that and sit with that and hold that, and also that I make sure that I don't get lost in it… Being aware enough of her distress and being able to feel that, but not getting so overwhelmed by the distress that I couldn't then be like a safe containing space for her, like a touchstone."

Rose also spoke to this same concern, that having feelings in session would be so overwhelming that she would become ineffective as a therapist: "I have mixed feelings about tears in sessions because I think it's helpful for the family to see that, you know, I really loved your person too, but then on the other hand, you can't be a mess and needing other people to support you."

Several of the participants thus spoke directly of their boundary-setting strategy to keep their emotions outside of the session. Anne commented, "I always tell students, you know, let yourself have all your feelings, reactions to your clients, but file them away and look at them later, don't act on them in the session." She later said more about this: "It's just something that you do, it's like swallowing medicine, you just do it 'cause you have to do it. I can't go in there and bring all my sadness and frustration in." Lynn and Rose both expressed very similar sentiments. Lynn phrased this as "[I] take my own feelings and put them in that box outside of the door."

Struggle to attend to internal world of self or client in the clinical space.

The participants articulated their struggle to attend to the internal world in a variety of different ways. This struggle was seen, in part, in a focus on the external rather

than internal experience, even in the context of psychodynamic concepts like countertransference. It was also apparent in the participants' confusion about these psychodynamic concepts. This theme was present in all seven participants' interviews.

Some of the participants were clear that the internal world is not part of their clinical consideration when they are sitting with a client in session. For Lynn, describing her role as a music therapist meant describing what she does and observes:

> What do they need, what's… why are you sending music therapy in there. And then of course the actual patient themselves. Once I get in there, what do I see, what do I assess the situation to be, so taking all those different pieces in.

Kate shared directly that she does not think about her own internal world during sessions: "Unless it's really intense, I'm not necessarily… thinking about… um… 'This is what I'm feeling and this is why I'm feeling it' within the session, at least consciously."

Other participants spoke of an intention to attend to their clients' internal worlds and their own, but their descriptions of how they do this leaned more heavily on the external and observable than on internal experience. Carl described his thought process during a music-making experience:

> I'm thinking about just musically, how to… uh… facilitate for her to make music… for her to have as many choices, and for her to be as engaged as possible in music. So I'm thinking like, 'Oh, let me repeat this part, let me slow it down, let me bring it up, let me change the chord,' all that sort of thinking. I'm also thinking about where she may be emotionally, because in spite of what sometimes the aides think about music therapy, it's not there to make her happy or sad.

Rose offered a similar description:

> Especially with my clients who don't have speech… a lot of times I'm using my feelings to gauge how they're feeling, or how the music is landing with them. They can't tell me how they feel, so all I have to go off of is… what I'm seeing nonverbally, what they're doing musically… and then my own countertransference, like my own, what I'm experiencing.

Pam and Jane both referenced their own internal worlds as part of the clinical picture, but spoke of concretizing any identified internal sense into immediate (external) action. When Pam spoke of her internal experience, she focused on the ways that she shares her countertransference, or other internal experiences, with her clients, or how she acts based on that feeling: "Noticing how when she acts like that it kind of gets under my skin, and holding her accountable, in essence really like her parents never did, for noticing her own feelings and reactions and responses to things." Jane shared a similar interpretation of a clinical event:

> He's projected onto me his own confusion and lack of awareness of stuff going on. And I'm just like, 'Whoah, hey.' So he's feeling he needs to be stopped, sometimes, I feel like, and somebody needs to help him clear it up. It's not so easy to do that for him, but I try.

Ultimately, this focus on the external may reflect a lack of solid understanding of psychodynamic concepts like transference, countertransference, and projective identification, and the participants' confusion about these concepts was apparent in all seven interviews. Carl, Jane, Rose, and Kate all expressed this confusion directly, and Rose may have most aptly described the discomfort that others also alluded to:

> I don't feel like I really learned what all those things really mean, in real life… I'm not very comfortable with those terms… I don't know why I feel like I didn't really come out with a solid… a more… a firmer grasp… it really feels like something that you have to… I mean, you can talk about it, but then you don't really understand it until you can experience it and have someone else help you see that going on.

For most of the participants, their understanding of psychodynamic concepts was limited to concordant identification (Racker, 1957), and most transferential phenomena was interpreted through that lens. Pam articulated this in a generalized statement about how her emotions inform her understanding of the client's experiences: "I believe that if there's something that I'm feeling and we're in the same experience, then it's probably akin to what my client is feeling, at least in the same ballpark." Jane and Rose expressed similar ideas, equating countertransference with intuition, or with an experience that most closely resembled empathy.

None of the participants shared experiences of transference that were clear to them, and projective identification was more unfamiliar still. Projection seemed to be the most elusive concept for the participants to speak to or identify in their work. Several of them described clinical situations with emotional tones emblematic of projective identification, not recognized as such by the music therapist. Carl described his feelings about a patient's music in this way: "Sometimes when he plays the drums he gets really loud, and aesthetically it can be a little harsh. So you know, it makes me less emotionally attached. So it's a little bit more difficult to connect." For Carl, seeing this interpersonal

experience as a projection seemed not to cross his mind; for Anne, there is more a feeling of the projection being rejected outright:

> I've experienced enough where I can kind of separate my own feelings of, um… you know, annoyance or anger that this child is… lashing out at me, 'cause it doesn't feel good when someone is doing that even though I know it's not about me, it's more about my role in the session.

Several other participants also used this phrase "it's not about me" when they spoke about being the recipient of clients' negative projections. This seems to belie an avoidance of the negative transference. Pam spoke about times when "it would look and sound like [my clients] were angry with me," and how those times were "a little hard. The first time it happened it was like… okaaayyy… but then I realized in that particular instance it wasn't about me." Jane said the following about a client who was eliciting feelings of anger and helplessness in her: "What can I do to maybe help the client in this process of not feeling okay? Not being enough. So I just turned around and tried to be very patient, and supportive. And realizing that it's not me."

Perhaps most notable about this theme and how it emerged for the participants is the way that the struggle to attend to the internal world, when thwarted by confusion, unfamiliarity, or discomfort, can lead the music therapist to self-reproach and disempowerment. Jane spoke about a time when she felt extreme sadness making music with a client, but while she thought it would be helpful for him to feel that sadness as well, she was sure that he did not:

> I feel like if he sang the song than he might have… I was putting away my feelings and I was just thinking, just thinking, I have a tendency to do that. And I

> really wanted him to connect, and I don't think that he did. And then that makes me sad, and then that makes me feel like, well, you don't know what you're doing and blablablah.

Rose related a clinical situation that elicited feelings of helplessness, and those helpless feelings, rather than providing her with a connection to the patient's emotional experience, led to this self-doubt:

> Am I really doing any good here? What does this even mean that I'm here with this person? …Why am I here, why is this… is this making a difference? How much of that am I making up in my head to justify my presence there, and how much of that is… somebody really understanding what this person is experiencing.

The music therapist interviewees tended to be very hard on themselves when they felt that they had not done the right thing with their clients.

Need for validation.

The desire for validation of some kind was a powerful theme in the interviews, with varying degrees of emphasis and influence. Some of the participants were very clear that observable evidence that they somehow "got it right" with a client was important to their self-confidence as a therapist. Others referenced what may be a unique struggle for music therapists—that their musicianship and identity as a music performer, and the ways that insecurities around the quality of their musical product could undermine or confuse their therapeutic focus.

Lynn clearly articulated the importance of positive reinforcement for her work: "It's a positive feeling. In terms of me, because I know in that spot I'm being effective. I

believe I'm being effect— she gives feedback afterwards so I know, yes, that was good, come back next time. But it seems the staff as well gets relaxed, gets calm. And there's been instances where the staff will give feedback saying, you know, that's how you sometimes calm us as well, so it's positive reinforcement for me in that what I'm doing is working. Continue to do what you're doing." Jane had a similar reflection about a satisfying clinical interaction: "It's nice and it's validating. That is validating, because it shows that it works for me. That there's an impact being made."

Pam repeatedly reiterated throughout her interview that her work had weight and was significant, in a way that may have suggested a desire to be seen as doing important work, by herself or others. "I guess what I was feeling was kind of the weight of that moment… it felt to me very significant that she was able to be that present with me and with herself… I was just feeling the weight of it, if that makes sense… So it just felt very significant."

Kate's reflections on her need for validation acknowledged the personal struggle that she sees in that need. "I feel that sense of… my own anxiety if I'm not helping them when it's a person, for example, a child with autism, or a kid who… who just can't really give me a lot of response. Who can't verbalize their enjoyment. Or an adult. It could be anybody who, due to whatever condition or circumstance, can't give me that positive feedback. And I have to check myself because, you know, it's not about me."

As Kate articulates, validation has two sides, since its presence is reassuring, but its absence can cause considerable anxiety. Carl, Lynn, and Jane all spoke to this phenomenon, but Kate may have stated it most effectively:

> I'm constantly second guessing everything I'm doing and saying, and wondering if I'm doing the right thing, or if I'm doing something good or if I'm just… doing something neutral, or… bad! You know, like I'm constantly thinking and overthinking and second guessing everything that I do. Just until I get some glimpse of… um… "this is benefitting the person I'm working with." … It's anxiety provoking, and I think that that's one of the… one of the things that… you know, makes being me (*laughs*) as a music therapist, makes me being a music therapist hard, because, because I… because sometimes I lack that self-confidence and I have skills and I have, you know, an ability to help people, and I just am always looking for that outside reassurance that I know what I'm doing. You know? Instead of the internal reassurance.

Kate's need for validation can thus cause quite a bit of suffering.

The element of music, and the therapist's musicianship, is a potential aggravator of the music therapist's insecurity or need for validation in session. Carl spoke about this most openly, identifying his own feelings and the potential impact on the treatment: "To me, one of the worst things, like whenever I feel the worst about myself is if there's something in the music that I'm not—that I feel bad about… If you call me a bad musician, it can really hurt me." Regarding the potential for not pleasing a patient with his music, he continued:

> I feel like I'm doing something wrong. Which, in a way, I am. Sometimes I'm messing it up or something, the music. I think when that happens my musician side takes over and I… like… become critical of myself. As opposed to using it in a therapeutic way, which is what I should do.

> Pam spoke of the possibility for judgment from clients who might be musicians: It can feel particularly vulnerable because they may or may not be, they sometimes are, better at a certain instrument than I am, or I'm afraid they're going to ask me to play a song by memory that I've never heard of… to be so transparent about the fact that while I think I'm a good musician… it doesn't mean that I know every piece of music ever.

Anne focused more on the self-judgment from her own music performer self:

> It's always tension in any session, even though I've been doing it for so many years, of what I should play and is it going to be good enough. There's always that tension. And sometimes I like what I played and sometimes I don't like what I played.

When the music performer identity of the therapist is part of the clinical space, the potential for feelings of vulnerability and need for validation are seemingly more present.

Chapter 5

Discussion and Conclusion

Discussion

This study has explored the lived experience of music therapists in the intersubjective field with their patients. Through the analysis of seven participant interview transcripts in the previous chapter, four essential themes emerged: complexities of being with emotional experiences in the clinical space, concern about boundaries, struggle to attend to internal world of self or client in the clinical space, and need for validation.

In addition to the specific research question "What is the lived experience of music therapists in the intersubjective field with their patients," several other questions were identified at the start of this study, in the introductory chapter. These included questions about how music therapists understand their own emotional experiences with the patients they see for individual treatment, in what ways they draw upon or discard these reactions in their work, and how they understand the relationship as a whole in the context of treatment. After sitting with these seven experienced, caring music therapists and carefully and repeatedly reviewing the experiences, struggles, and insecurities that they so bravely and generously shared for this research project, I feel that the answers to these questions have the same thread of confusion and anxiety that is also apparent in the four essential themes. The music therapist participants are all obviously thoughtful, conscientious therapists who care deeply about their patients, want to help them, and frequently do. At the same time, there are aspects of the work that are confusing, overwhelming, and anxiety-provoking for all of them.

Another way to talk about the complexities of being with emotional experiences in the clinical space is to talk about the management of affect. The participants at times expressed confusion and anxiety about the mere presence of affects, as well as how to work with them and how to understand what they mean. In a way, this is unsurprising, given the limited understanding that several participants expressed openly about psychodynamic concepts, and the often conflicting and pathologizing messages about affect that are reflected in the music therapy literature, mentioned in the second chapter of this study.

However, it seems important to acknowledge that music therapists and their patients may face an emotional landscape that is more treacherous than one that would necessarily be traversed without the presence of music. As has been mentioned earlier in this paper, music provides an exciting, but frightening, deep and powerful connection to primitive parts of the mind. Psychoanalyst Michael Eigen expressed it this way: "Music can show, music can hide. One can go further. Music can foster music or kill music. By that I mean, too, music can mediate psyche or kill psyche" (in Bloch, 2010, p. 163). The potentially devastating impact of music, when really acknowledged, can be chilling. In some clinical situations, it is possible that it's the music that is stimulating affects that can be, and were, overwhelming to the participants in this study. Often, these music therapists told stories of clinical situations in which they were not sure, or did not know how to articulate, what they felt. Without the ability to identify one's own emotional states in the clinical moment, it may be even more difficult to learn how to use affect as a tool. So instead, music therapists talk about splitting off parts of themselves by saving

their feelings for later, and seeing an outward expression of their feelings in the clinical space as a weakness that will lead them to therapeutic ineffectiveness.

The power of music may also impact why boundaries were such a concern to the participants in the study. Music intensifies emotionality and also makes boundaries more porous. With music, the inner and the outer blur. As Nass (1971) states, "The holding and immersing power of music often results in an ambiguous state of cognition in which the discrimination between inside and outside becomes less precise" (p. 303). Music stimulates these primitive parts of the mind not only in the client, but in the therapist as well. The task of managing both at once, especially without adequate training in psychodynamic processes, is a great one. Given all of the above, as well as some of the strong warnings about the dangers of emotionality that exist in the literature mentioned in Chapter 2, likely filtering down through training programs, music therapists' anxiety about boundaries seems unavoidable. A clinician would need to understand the utility of their emotional experience and how to understand it through the lens of the transferential field in order to confidently meet those challenges. In the participants' descriptions, desire for deeper emotional connections with their patients—people about whom these therapists frequently have a lot of caring and affection—are apparent. But when therapists are disempowered from trusting their draw to feel emotionally connected to their patients, and not given the tools to know how to traverse the emotionally intimate psychic landscape together, it's likely that, at least in some cases, both therapist and patient are left wanting, and important clinical ground is left untouched.

Most of the participants felt that psychodynamic principles were a part of their work, but they were clearly challenged in attempting to explain the concepts of

transference, countertransference, and projective identification and how they used them. What was perhaps more powerful than the directly communicated feelings of confusion, however, was the suffering that these therapists were experiencing in moments they related when transferential dynamics were at play, impacting them without their recognition. These music therapists often wanted to understand what was going on in the affective and relational field with their patients, and when they didn't know how to see or understand the projective elements at play, they frequently turned to self-criticism and doubt, not only about their clinical choices but about the utility of their presence with the patient in the first place. The struggle to attend to the internal world of self and other in the clinical space could easily be influenced not only by an unconscious avoidance of primitive anxieties stimulated by music, but also by an understandable desire to circumvent such painful questioning of one's own abilities to be effective in one's chosen field.

Without a trusted lens through which to see and understand relational dynamics, and without fully knowing how to use their own internal worlds as a tool, the therapists are forced to rely on external factors to tell them whether they are on the right track, connecting with the patient, adequately meeting clinical challenges. They rely on doing—rather than sitting with—in pursuit of observable and sometimes immediate change, perhaps because it's hard to imagine the purpose of something more internally focused that can only be assessed using qualitative, subjective criteria. The work becomes more about what they must do, provide, or be than what the patient must do, contemplate, or become on his own. One problem with these external factors is that they cannot account for the complexities of human functioning and relationship. As several

participants noted, there are patients that cannot provide direct feedback because of various physical, medical, or neurological concerns. But additionally, sometimes patients who seem capable of giving guiding feedback will not do so overtly because of complex relational dynamics and/or psychopathology. Any therapist who focuses exclusively or primarily on external factors when working with such patients will likely come up short in their understanding of this sort of clinical situation.

Working with patients of any kind who cannot or will not give helpful feedback about the treatment they are receiving is likely particularly difficult for therapists who are concerned about personal validation, consciously or unconsciously. As the data suggested, with this group of music therapists the concern about validation was sometimes connected to a confusion between music therapist and music performer identities. This important theme in this study has already been documented in the literature. Austin (2008) suggested that "therapists sometimes use musical communication to serve their own needs. This can be because the therapists have a narcissistic need for recognition and validation that has not been worked through" (p. 129). Turry (1998) states:

> There is a part of the improvising therapist similar to that of a performer that wants to be heard and acknowledged. These needs are natural but must be brought to awareness in order for the therapist not to be unconsciously influenced by them, as they can detract from one's focus on the client. (p. 181)

Then again, some of the participants' experiences suggest that even a conscious awareness of their personal needs does not change the struggle with that need for validation, and the potential for acting in service of that need rather than the client's need.

The desire for admiration might be considered a natural and even important motivating factor for a music performer. The question of whether it's possible to completely remove one's performer identity when making music in a clinical situation is an interesting one. But carrying the need or desire for admiration into a clinical situation puts the therapist squarely in her own mind rather than allowing her to experience the interpersonal space and/or the patient's mind. This may be another barrier that can stop music therapists from engaging deeply with psychodynamic phenomena.

That desire for validation can also hinder music therapists from making themselves available to receive their clients' negative projections. As has been mentioned, most of the participants expressed some degree of discomfort with "negative" feelings in the clinical space, and some described their desire to avoid engaging with negative projections. This focus on the positive transference, and desire to avoid the negative, is also reflected in the music therapy literature referenced in Chapter 2. Although the "positive" aspects of the psyche and human experience are certainly valid ground for therapeutic inquiry, emphasis on that realm leaves out half of the psyche, and half of the person. The need to keep treatment in the positive space, to guide it in that direction actively, or to influence it indirectly with unspoken preference, will keep any treatment from being truly depthful. This can also create unmanageable or overwhelming clinical situations, as some of the participants related, when patients refuse, or are unable, to comply with the therapist's need to keep the treatment positive.

Recommendations

As Langer (1980) states, "Music is our myth of the inner life—a young, vital, and meaningful myth, of recent inspiration and still in its 'vegetative' growth" (p. 245).

Based on the findings of this research, especially taking into consideration the struggle and suffering of the music therapist participants who generously shared vulnerable aspects of their experience, recommendations of how depth psychological concepts can more helpfully inform the field of music therapy seem important. If the experience of the seven music therapist participants is in any way indicative of the field at large, current understandings of psychodynamic theory are not helping music therapy clinicians to connect deeply with their patients, and confusion about psychodynamic phenomena is causing distress.

It therefore seems obvious to this researcher that the most important recommendation is for music therapy training programs to include more comprehensive training in psychodynamic concepts. A more contemporary and accurate understanding of psychodynamics than is currently reflected in the music therapy literature is necessary. However, these are the kinds of concepts that cannot be learned from a book, or exclusively in a classroom. Nor can such things as transference, countertransference, and projective identification be presented as "tools" to be picked up or put down—such an approach to psychodynamics will always be insufficient if a therapist is looking to understand their work as being depthful. A clinician who wishes to work with the transferential field must be able to use her own internal world as the tool, and developing that tool requires extensive training.

In considering some of the specific themes that arose in the participant interviews, it seems that music therapy training requires more attention to the understanding of professional boundaries and the therapist's own affect regulation. Learning to view boundaries as a more fluid construct, rather than a rigid and restrictive absolute, may help

music therapists to make space for a more organic development of therapeutic relationship. Targeted training in affect regulation, in addition to participation in a depth psychological therapy process, may help therapists to manage their own challenging feelings that can arise in session, such as anger, resentment, or distress.

A necessary component of training to work with transferential phenomena is the experiencing of those phenomena as a patient. Although several music therapy authors encourage personal work as part of professional development, I have not seen it presented as a requirement for doing this kind of work. I personally have had a faculty member of a music therapy university program that purports to teach with a psychodynamic orientation tell me that she cannot recommend that her students pursue personal therapy, she can only give them referrals if they ask her. This is truly a problematic practice, which in some cases seems to originate at the administrative level of higher learning institutions. When recommendations for personal therapy do exist, in literature or elsewhere, they do not typically specify that therapists in training must pursue long-term psychoanalytically oriented therapy over other types of personal work that might be available. This is also troubling, since experience as a patient in cognitive-behavioral therapy, or any other therapy where transferential phenomena are not addressed, provides the therapist-in-training with no orientation to how the psyche expresses itself through these aspects of the intersubjective field. How could such a therapist ever be expected to work effectively with transference, countertransference, or projective identification?

When music therapy trainees are not interested in working from a psychodynamic orientation, this research suggests that it still may be prudent to include more emphasis in their training on the power of music to impact the therapeutic relationship in

overwhelming ways. A therapist can be prepared for this impact without being knowledgeable about transferential phenomena. This research has also elucidated the impact of the therapist's need for validation on her own comfort level in the work, and therefore it also seems appropriate to suggest that the training for all music therapists, including those who do not pursue a psychodynamic orientation, include more exploration of how natural but potentially problematic a desire for validation may be in the clinical space, and how the performer identity impacts the clinical one. Such changes may help therapists who are not interested in psychodynamics to focus their work on helping clients to pursue changes in the external realm, while also maintaining awareness of some potentially disruptive aspects of working clinically with music.

And yet, a paradox emerges when one truly considers this possibility of working without psychodynamic training in light of the data from this research. Several of the music therapist participants interviewed did not identify with a psychodynamic orientation or the use of psychodynamic concepts as part of their work. However, powerful interpersonal dynamics, including transferences and projections, were clear aspects of the work they described—and the confusion resulting from the emergence of these unexpected psychic phenomena were causing distress for these therapists, and perhaps their patients as well. It may be possible that the intensity of the music experience makes working without an understanding of transferential dynamics more difficult. The unavoidable interpersonal emotionality of music may render a confrontation with complex intersubjective phenomena unavoidable as well. With this in mind, it becomes challenging to truly "recommend" that any music therapists should work without comprehensive training in psychodynamics.

Conclusion

A famous quote from Carl Jung (1967/1983, pp. 265-266) states, "One does not become enlightened by imagining figures of light, but by making the darkness conscious. The latter procedure, however, is disagreeable and therefore not popular." The process of this research project has led me to disagreeable places within myself, as I have been challenged to examine my beliefs and biases and return repeatedly to texts from music therapy and depth psychology, as well as the seven participant interview transcripts, to be sure that I'm always clear about what I'm reading and what I am saying about it. Calling attention to difficulty and struggle, especially in the context of a field that is clear about its desire to focus on the positive, presents a potentially treacherous path to walk as researcher. At the same time, I have accepted the responsibility for this project and the words that I have chosen to describe my data and my interpretations of that data. Honoring the participants who were brave and generous enough to articulate their ambivalence and struggle in this work, both by treating their vulnerability with respect and care and by not glossing over the confusion and suffering that they shared, has been my utmost priority. I hope that they will feel that I held their words and feelings with the reverence that is genuine to my experience.

This study has endeavored to explore, through qualitative, phenomenological methods, the lived experience of music therapists in the interpersonal field with their patients. An exploration of the music therapy literature established a gap in regard to this topic, and some concerns about how the music therapy literature presents and frames depth psychology concepts. Interviews with seven music therapist volunteer participants about their experience engaging with their individual patients in the intersubjective field, and phenomenological reduction of interview transcripts into themes, suggested that the

music therapist's experience of this work can be fraught with confusion and anxiety. Discussion of four major themes included consideration of the role of music, and the musician's identity, in raising emotional stakes and further complicating the already dynamic and unpredictable clinical space between therapist and patient.

I close this study with hopes that its findings will be able to inform future decision-making within the field of music therapy, and to support music therapists who experience confusion and anxiety about their work but do not understand why. I hope that my holding of criticism and challenge, while perhaps causing some discomfort or pain, can also help to clear the way for honest conversation that can hold the deficiencies of how psychodynamics are treated in music therapy dialogues. I know that as music therapists feel empowered to connect more deeply with their own emotional experiences in the clinical situation with clients, and are given the tools to do so with understanding and confidence, that their experience of their work and their connection to their clients can be greatly enhanced.

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